

# What is health anyway? Perceptions and experiences of health and health care from socio-economically disadvantaged rural residents

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## ABSTRACT

*The divide between rich and poor in Australia is starkly apparent in health status statistics; the poorest Australians have the poorest health, and many live in rural Australia. However, little is known about financially deprived rural citizens' perceptions of their own health and their expectations of health care services. As a result, exploratory in-depth interviews were conducted with eleven rural residents dependent upon government income support. Ten of the eleven participants had chronic health problems, and these were being addressed symptomatically. The children of the participants also required interventions for a range of physical, emotional and mental problems. The participants relied on local services and local practitioners to provide suitable interventions and to direct them to other services if required. They had minimal knowledge, control or choice in the type of intervention or outcomes. In this group, poor health was normalised and future health not considered. Thus, those with most to gain from health promotion and prevention activities and social inclusion programs are unlikely to benefit because they may normalise poor health. Concepts of good health, health literacy, informed consent, choice of intervention or practitioner are meaningless in this rural context of deprivation. These findings suggest that the population who endure the burden of ill-health will be by-passed by current and popular public health techniques of health promotion because rural people with poor health have low expectations of their own health and health care. Similarly, health service providers have high expectations of health and the rational choices of the population they serve. Thus, there is a major disconnect between the expectations of both.*

**Keywords:** Income level, health status, rural health care services, low rural health expectations, poor health norms, social inclusion, health promotion and prevention

## INTRODUCTION

In 2009, Australians were consulted by their federal government on the need to protect and promote human rights. Simultaneously, the government has social inclusion goals that include promoting access to resources, such as employment, education, health and community services and encouraging participation in formal and informal networks (Vinson, 2009a). The preventative health agenda is likewise concerned about the ways citizens can be engaged in lifestyles that support good health (NPHT, 2008). Socio-economic disadvantage has a significant impact on achieving human rights, social inclusion and prevention goals (WHO, 2008).

The divide between rich and poor in Australia is starkly apparent in health status statistics. The poorest Australians have the poorest health (Germov, 2002). Indigenous Australians, rural dwellers and those reliant on government payments for income are significantly affected by health system inequities and health risk factors (AIHW, 2008; Lynch, Due, Muntaner & Smith, 2000; Bhalla & Lapeyre, 1999). While income inequality in Australia has fallen since 2000, poverty (meaning people who live on less than half median incomes) has not fallen and at 12% is above the OECD average (OECD, 2008). Health is Australia's largest industry, consuming 9.5% of gross domestic product in 2003 and growing rapidly (Gray, 2004). Yet its processes and products are unequally distributed across the nation. Australian citizens reliant on income support are also reliant on public sector healthcare. These citizens are more likely to experience mental health problems, chronic disease, social isolation and chaotic personal relationships indicating increased need for supportive and responsive health and community services (Ackerson, 2003; Sands, 1995).

### **Socio-economic disadvantage and the relationship to health**

The relationship between poverty and health is complex. Those on low incomes are more likely to experience poor health (Germov, 2002; Tur-

rell, 1995). However, it is not only access to treatment that influences health consequences. This is conceptualised by the International Federation of Social Workers as health chances and health experience, where:

health chances are a person's chances of being ill or staying well, of living a long life or having their life cut short, are a product of economic, social, political and environmental factors, while health experience is a person's experience of living with and combating illness, is a product of the resources they can access for preventing, treating or alleviating illness and promoting health. (IFSW, 2007)

Health chances highlight the significance of social determinants influencing health status, whereas health experience emphasises the health consumer's perspective of access and availability of treatment, intervention, support and prevention for a country's citizens. Others have written about the social determinants of health, including education, income, housing, access to health services, work places, social inclusion, racism and mastery (Marmot & Wilkinson, 2008). Regardless of approach, there are tangible health benefits of higher income and stable well-paid employment experienced by middle and high income earners, including higher levels of health status, high expectations of health care and reduced health risk factors. This suggests attention to income support and employment is critical to improving health. Family income levels experienced during childhood are the best indicator of adult health status (Lynch et al., 2000; WHO, 2008). Low family income may mean that necessary health care is not obtained for children because of financial barriers even though it is high on the family's priority (Li, McMurray & Stanley, 2008). Thus, health chances and health experiences are intertwined.

### **Rural health discourse of access and availability**

Rural health discourse strongly describes unmet need alongside the impact of centralised and

urbanised policy and planning for healthcare delivery that does not understand or care about rural context (e.g. Gillespie, 2007; Young & Dobson, 2003). The discourse of deficits and problems is typical of the way rural stoicism, in the face of economic, social and geographical hardship, is depicted (Winton, 2009; White, Wall & Kristjansen, 2004). The focus of healthcare provision has been to remedy those deficits by drawing in expertise from outside using outreach and Telehealth models of service delivery (Gruen & Weeramanthri, 2002; Norris, 2002). This is an understandable response when rural inland areas are particularly vulnerable to healthcare shortages. With only 18% of the nation's population, all public and private sectors are under pressure from limited resources, workforce shortages and infrastructure problems (Allan & Ball, 2008). However, provision of healthcare does not necessarily equate to improved health outcomes.

Access to healthcare encompasses supply, utilisation and outcomes (Guiliford et al., 2002). Strategies to address supply can be seen in Australian healthcare policy. For example, payments to General Practitioners to work in rural areas and expansion of the Medicare scheme to include allied health professions reflect the ways workforce development is given significant importance. Private practice is an important option for creating flexible employment within allied health professions so they can be responsive to local health needs. However, there are no incentives for servicing small, rural locations, making availability limited outside large population centres (Battye & Roufeil, 2008).

Barriers to access may include affordability and social or cultural acceptability that limit use of supplied services (Guiliford et al., 2002). The difference between supply and utilisation is noted in the resilience literature (e.g., Ungar, 2008). The emerging research on cultural context and social ecology identifies stark differences between availability of healthcare and usage by different social groups in the same geographical location (Ungar et al., 2007). In seeking to understand and address

inequitable health outcomes, it is important to consider if barriers exist and how they influence health disparities in marginalised or disenfranchised groups within rural areas (Braverman & Gruskin, 2003).

Developing healthcare access strategies assumes a relationship between health services and health. However, the majority of health services are remedial or rehabilitative, treating those with existing health problems. The number of individuals who are returned to good health is unknown. Health outcomes are dependent on social, cultural and economic factors as well as good and effective treatment (Guiliford et al., 2002). For example, in Australia Indigenous patients have poorer health outcomes than non-Indigenous patients with the same conditions receiving the same care (Westerman, 2004; Gruen & Weeramanthri, 2002). The relative contribution of treatment or intervention processes compared to experiences of racism or financial hardship has not been quantified.

### **Solutions to poor health – health promotion**

Health promotion and prevention are the less costly alternatives to maintaining health than treating illness. Global frameworks, such as the Ottawa Charter for Health Promotion (WHO, 1986), note that social and community action as well as policy frameworks are critical for individuals to take control of their health (Wass, 2000). Individual control over health status and information promoting good lifestyle choices are key concepts in preventative approaches that assume individuals will, and can, be in control of their health, illnesses and health care delivery (Sofaer & Gruman, 2003).

Information and behaviour-change programs are the key strategies of health promotion approaches. However, they frequently fail to change the behaviour of those in low socio-economic groups (Laaksonen et al., 2003; Schrader, 2004). There seems to be an intrinsic conflict between the health promotion view of the right

choices for good health and the view of those who behave differently. Health chances and health experiences exist within the ways people act. Health needs, personal, family and financial priorities and constraints will affect an individual's desire, ability and motivation around health and healthcare. Individual choices and actions will not always or even often be rational or informed although health promotion and health policy approaches assume this is possible (Sofaer & Gruman, 2003).

Investigating the perceptions and experiences of healthcare in a particular location is critical to understanding the actions and agency of those in that setting (Charmaz, 2005). There are inherent assumptions in descriptions of disadvantage and related definitions of health chances and health experiences. With the weight of literature reporting the problems and barriers facing those who are disenfranchised, disadvantaged, marginalised and rural, there seems little chance of escaping an unhealthy destiny. This is in contradiction to the health promotion literature that emphasises informed choice and action resulting in good health. However, both discourses are deterministic and normative rather than related to subjective interpretations of rural people and their health experiences (Burrows & Wright, 2004).

The expectations that people have of health care and stories of their care experiences identify the relational aspects between ideas of health and the control of health care. Poverty and ill health have been described as frequent companions highlighting the multiple impacts of deprivation including low subjective well-being (Saunders & Davidson, 2007). However, the voices of disadvantaged citizens are absent in debates about policy matters, such as the cost and distribution of health services, and were absent from the research team's previous project investigating health needs in two rural communities (Allan, Ball & Alston, 2007).

The population of poor rural residents, particularly families, is growing as people move to small towns for affordable accommodation creating a web of disadvantage that can be geographi-

cally located in Australia by postcode (Vinson, 2009b; Rawsthorne, Hillman & Healy, 2009). The list of the most disadvantaged locations included one of the study towns in the previous project (Vinson, 2007). Socio-economically disadvantaged residents did not participate in the focus groups held at a number of community events and meetings. The research team decided additional effort would be made in this town to investigate the experiences of those habitually excluded from social and research processes by seeking interviews with socioeconomically disadvantaged health and welfare service users.

## STUDY CONTEXT

The case study town was in central New South Wales. It had a population of 1563 (ABS, 2001) in an agricultural region, 70 kilometres from the nearest large regional centre. The town was chosen for the original study because it was not remote and did not have a culturally diverse population. Therefore, the location did not attract any specialist funding or programs for those groups. There were no major tourist attractions or industries drawing in people from other areas.

The town had two General Practitioners who also provided services to the local hospital. The hospital had 15 aged care and in-patient beds providing primarily rehabilitation and recovery services. There was an ambulance service to transport people to the regional centre in the case of serious illness and emergencies. Allied health services included a pharmacy, a community health centre with community and child and family health nurses and visiting social work, sexual health, dietetics, sexual assault, speech pathology, psychology and mental health services. Visiting services had variable availability. Some were in town twice a week, others once a month. Welfare services included aged care social support, home and community care, a drug and alcohol residential rehabilitation service, early intervention and family support and community transport. All of these services except the drug and alcohol centre operated on a part-time or occasional basis.

The original project identifying health needs in this and a neighbouring case study town used Bradshaw's (1972) typology of needs to analyse the ways in which government policies, health and community services, population characteristics and local peculiarities combined to influence health and welfare service delivery. This needs assessment found that primary health care was adequately supplied but that specialist services, including mental health care, were in demand and frequently unavailable and/or unaffordable (Allan et al., 2007). Rigid policy and funding guidelines along with inflexible work practices and work roles limited services that were available (Allan, Ball & Alston, 2009). Healthy lifestyle opportunities such as recreational facilities, sporting clubs and social and cultural events were seriously limited in recent years because of insurance and risk assessment requirements increasing the financial regulatory burden on volunteer community leaders already under pressure from drought (Allan et al., 2007).

## METHODS

Ethics approval was gained from Charles Sturt University's human research ethics committee (2007/140). Health and welfare practitioners from the research sites were contacted and the project described. Health and welfare practitioners were asked if they could identify any of their clients who might be prospective participants and if they would inform clients about the project. They then supplied the researcher with contact details of clients who were agreed to be contacted by the researcher.

The intended sample size was 15 interview participants. However, participants were difficult to recruit. Some arranged interviews did not occur because the person did not keep the appointment or because they had relocated between the initial phone contact and the interview time. Practitioners were reluctant to pass the information on to some potential participants because of concern about the link between the service and the research project. The health care

manager perceived that clients may not report a true picture of their service experience if the researcher contacted participants within the service itself. In particular, the manager's worry was that clients may expect services to be denied to them if they were critical of the service provided or the organisation. The health service perceived the research to be valuable and was keen to find out about service user's experiences to assist in improving care. However, when the researcher was unable to contact service, users within the service some people who had expressed an interest in participating were potentially excluded as the onus was on them to contact the researcher by phone. It would have been preferable for the researcher to expend the time and call costs in setting up the interviews.

Snowball sampling, where a participant contacts a friend or acquaintance to be interviewed, is usually successful in identifying suitable participants from clearly identified population groups (Rice & Ezzy, 1999). However, the barriers described appeared to affect the process and this method only recruited four participants. Seven interviews were completed soon after commencing the project and four months later a further four interviews were completed. With no further contacts from prospective participants, data collection ended.

Semi structured interviews were conducted with participants either in the garden of a local service provider, in a rain shelter at a local park or at the participant's home. Formal consent was obtained before recording the interviews on a digital recorder. The interview participants were asked about their living situation, their general health and wellbeing currently and in the past, their experience of local health and welfare services and any unmet needs they had. The interviews lasted from 20 to 90 minutes and the recordings were transcribed into word documents. The data analysis was informed by both the earlier project findings and the research literature which had shaped the interview questions. In particular, the interview transcripts were examined for statements about control of, and knowledge about,

health and health care. The interview data was reduced into themes and stored in the QSR software program NVIVO 7. Three themes emerged strongly in the data analysis. The themes were access to health and welfare services, perceptions of health and expectations of future health circumstances.

## RESULTS

Participant demographics and three key themes arising from the analysis are presented. Quotes from interview participants are used to illustrate the themes. Pseudonyms are used for each participant.

### Participant demographics, housing and health

The 11 interview participants, 4 male and 7 female, ranged in age from 20–57 years. All participants described government benefits as their main income source, although 6 received irregular income from casual jobs and one had a partner who was employed full time in low paid employment. This family with 5 children relied on government payments to supplement limited employment income.

In the previous study, there was a strong perception that recent arrivals brought health and social problems with them overstressing existing services (Allan et al., 2007). Interview participants were asked how long they had lived in the area. Recent arrivals were asked why they chose to move to the location. Four of the 11 participants had moved to the area within the past two years. Affordable housing was a significant reason for moving to the area for 5 of the participants. Another participant also noted that accommodation was a reason for staying in the area longer than he expected to:

I thought it would suck mate but it's been okay. The old fellas and the old ducks say hello to you down the street. They're probably thinking 'jeez where's he from' but they don't say it. (Mark)

All except 2 of the interview participants identified chronic health problems or risk factors that required on going treatment. These included Hepatitis C, complex post traumatic stress disorder, post-natal depression and sleep apnoea. However, only four of the participants were receiving continuing assistance for these problems. Three participants were receiving counselling services for emotional distress and mental illness at the time of the interviews. One participant also received regular medical treatment for chronic pain. Another received opiate replacement therapy at the local hospital. The other participants were receiving medical treatment for some of the effects of their chronic illnesses but were not being treated for the cause of these symptoms. For example, Karen required major dental treatment and was receiving frequent courses of antibiotics to control the regular mouth infections she was experiencing. The children of 7 participants required regular intervention from allied health practitioners to assist with their chronic health problems, learning and mental disabilities. These were described by their parents as significantly affecting their progress at school.

### Access to health and welfare services

All participants reported accessing health and welfare services in the past. All except one participant needed some type of treatment or support service at the time of the interviews. General practitioners were most frequently relied upon, and most easily accessed, for treatment and information about all types of health and welfare needs. For example:

The first port of call is always the doctor. (Tom)

Emergency departments were frequently used for accidents and crises of all types. Where the GP also serviced the hospital, the hospital was another point of contact with the doctor. For example:

We've been to the hospital heaps lately. All the kids had the gastro, [child] broke his arm,

[child] got stitches in her chin from falling over at school. I go there if I need antibiotics or something on the weekend when the doctors not open. (Karen)

The pain is bad at night mostly. I go the hospital all the time. They know what to do. The doctor comes pretty quick, sometimes he's already there. (Anne)

One participant described a different strategy to access medical services. A strategy more useful during working hours:

It's easier just to go down to his surgery and wait. Then he decides if you have to go to hospital or what else you need. Otherwise you can sit up there [hospital] for hours. (Sally)

Most of the participants were confident in being able to access health care particularly for medical conditions. They knew the names of the two local GPs, pharmacist and other health workers. This level of access and familiarity described in the local setting was not experienced in other settings, nor did it necessarily predict positive outcomes. Participants who experienced mental illness or emotional distress reported using a variety of counsellors and support workers with varying success. Most gave examples of contact with services from the time they were children. For example:

I been having workers since I was two and mum left me at Barnardos. Some of 'em are okay but they don't do much. They might find you a house or give you some counselling for a while but it doesn't last, basically you're on your own and nobody gives a fuck. They don't stay around for a long time. (Mark)

R: I've seen lots of counsellors since I was a kid. I've had a mental health worker since I was about 25, lots of different ones. I've seen psychs and got a few diagnoses.

I: Have they been helpful?

R: Some have. Telling the same story all the time is not good. The workers change a lot. Some are better than others. When they decided I had traumatic stress it got better. The medication was better. But you just take what you can get and hope it helps. (Anne)

Most participants reported positive experiences with locally based healthcare, such as the pharmacist and the health centre. However, participant statements suggest they had little control over service types relying on and expecting professionals to determine what was available and appropriate. There was a high degree of trust and respect for health professionals to know what they were doing and for it to be effective.

Compared to physical health or biomedical interventions, the purpose of allied health counselling, support and welfare interventions was sometimes unclear and the likely outcomes unknown. For example, one participant discussing the multiple needs of her children stated:

R: It can be hard to find out what will help and then if you can get it 'specially for the kids. Like you don't know what questions to ask and they don't just tell you. If you keep on about it, it gives them the shits.

I: So have you been able to get what you need for the kids?

R: They see people at school sometimes; up at the health centre a couple of times. I don't know if it's what they need. (Mel)

Another participant knew what her child's problem was, but lacked information and was unsure of the most effective treatment:

Just [child's] ADHD [is the main family need]. I 'spose if the psych came more often or spent more time with him it might be better but I don't know what they do anyway – just talking and stuff, they don't tell me anything that its about. What else can you do for it? (Karen)

Information about the healthcare system and about the conditions children or interview participants experienced seemed to be lacking from their interactions with services. They did not describe seeking alternative services, second opinions or information about the way particular interventions were supposed to assist. Only one participant noted some dissatisfaction with advice given by health practitioners:

I've been a parent for longer than half of them nurses have been born. I don't need them to tell me how to look after my kids. (Karen)

However, this statement of direct complaint was an exception in this sample of interviews. More frequently participants appeared to have low expectations of outcomes of intervention other than to relieve immediate pain or distress. This was available and freely accessible locally. Participants relying on services delivered from other centres or who had to travel to access services experienced financial barriers and longer waiting times. For example, one participant needing mental health services stated:

I can't get an appointment with the psychiatrist but I need my medication reviewed. They say 'we're raising awareness of depression' and then what happens. 'Hello, I'm depressed can someone help me?' and no they can't. It's a three month waiting list. I can't afford to pay privately, there's less rules with them. (Sally)

Cost of services was a significant factor limiting access to needed care in other locations. Two participants with children described a welfare service that made access possible because the organisation located the service provider, paid for the service and provided transport:

They were fantastic. I couldn't believe it. After [child] had his seizure they paid for the scan. It was \$120 after Medicare. We couldn't have done it. (Sally)

They paid for two days of pre-school every week after I had the baby and couldn't cope looking after both of them. (Jo)

Access to the support service was via contact with local health services. The networks of service providers and knowledge of other agencies was very important to facilitate access to services.

### Perceptions of health

Only one participant in this study did not have any current or past health and welfare needs. Mick, a 27 year old man, described rarely being sick and only one admission to hospital as a child with a broken collar bone. While he relied on government payments for income support as well as earning some money from casual work, he did not view himself as needing any support or assistance to change his circumstances. He described himself as a heavy smoker, drinking alcohol and using other drugs occasionally and recognising the risks of these activities:

I know I shouldn't smoke and so on, drinking and so on. I know lung cancer and all that but I don't want to stop. When I want to I will. (Mick)

Mick's statement indicates a rejection of health information that he was well aware of. Participants had a good knowledge of behaviours that influence health such as smoking, diet and exercise but did not describe a need to reduce risk factors or that changing behaviour would affect their health. For example:

Yeah it's alright, I cook most meals for the kids, we don't have much junk food, can't afford it. There's no Maccas [fast food chain] or anything here so we only get that in town. I walk too cause I haven't got a licence. I used to do drugs but not anymore. I dunno what'll happen when I get older, my mum got cancer, I don't want that but there's nothing you can do to stop getting it. (Mel)

Most of the interview participants had chronic health problems, some stating these emerged in

childhood. However, the problems were not described as needs for healthcare or as possible to address. Participants normalised chronic health conditions including pain, as part of life. For example:

My teeth need doing and I keep getting infections so I'm getting antibiotics all the time. There's no dentist here but I couldn't afford it anyway. I have to get them all pulled out cause they're broken from too many drugs. It will cost thousands. I probably won't get it done because the kids come first and I'm used to it now anyway. (Karen)

Karen described being on the waiting list at the dental clinic in the regional centre to have her teeth repaired. She had had initial assessments and a treatment plan developed. She said it was likely it would not cost much if anything. However, Karen was not expecting that the treatment would eventuate. It was 'too good to be true'. When asked why, Karen explained that she expected barriers to be put up either by her circumstances or the health system:

I can't count on it. The clinic rules could change or it will close down or something or I won't be able to make the appointment or something. Or you know, knowing [husband] we'll be off to Queensland, we always talk about going there, and on some other list somewhere else. (Karen)

Mark described the way life problems and health experiences, including moving from place to place and drug use, affected his health and his ability to access treatment even though he knew what was required:

I: Have you had many health problems in your life?

R: Nah mate not many, been sick from the drugs a bit. Oh I got Hep C. I might go on treatment when I get to Tassie. Had other problems, legal stuff, debts, been homeless a lot. (Mark)

The view that 'there's nothing you can do' to affect health outcomes pervaded all the interviews with a similar sense of stoicism. Interview participants used their physical and emotional resources to deal with their immediate day to day needs and those of their families.

### **Expectations of future health needs and experiences**

The theme of access to health care provision continued into discussion of future needs and likely experiences. Some participants were quite clear about the impact of their current chronic problems on their future health, but less clear about what that might mean for healthcare services. For example:

I have cancer – it'll kill me in the end. I won't be going to Sydney to die. I couldn't afford that for my treatment the first time. My choice is to stay here and get treated with whatever they have here. (Tom)

Mental illness doesn't go away. I'll just keep taking the medication. Don't think they're going to find a cure for it. (Alice)

Other participants without a current experience of serious or chronic illness were less likely to predict their needs for health care taking a more pragmatic view of the future. For example:

Well, we're all going to die. (Mick)

I don't know what I'll need but whatever. If its there I'll use it and if its not, well you don't know about it, you don't miss it so you don't. (Tori)

Participant's expectations of both their future health and access to healthcare were generally low and perceived as out of their control.

### **DISCUSSION**

The findings about availability of healthcare and usage by different social groups in the same geographical location were consistent across both the

authors' studies. Most participants reported limited knowledge and information about what services would help and difficulty finding out. Barriers to use of healthcare are likely to be systemic and are also likely to impact disadvantaged people more seriously than those with more resources (Ungar et al., 2007; Braverman & Gruskin, 2003).

Choice and control were absent from participant's experiences of health care described in this study. A wide range of healthcare was available, accessible but regulated by providers. The interviews contained a consistent matter-of-factness towards health and health care. Constant reflection on daily decisions and routines are probably unlikely for most people (Charmaz, 2005). Given that health care was used frequently by most of the participants in this study it was a routine response to illness, pain or accident rather than a planned and negotiated course of action.

Participants in this study had frequent experiences of healthcare services, although some did not understand the potential outcomes or intentions of services. Those who did attempt to find out what was intended were unsuccessful. This results in an inability to evaluate services received and their effects to make an informed choice or give real informed consent for interventions, procedures or courses of treatment. Although as several noted, choice of care was not an option in their rural location.

Participant's experiences of not knowing the purpose or outcome of interventions is a good example of the power relationship between those with professional knowledge compared to those with health needs. Expectations of care were mediated through the contexts of personal experience of ineffectiveness and high levels of trust and respect for health professionals to do their best. For those participants who had experienced long term health and welfare intervention it was clear that the best was only temporary not something that they expected would change their future circumstances. In this context it makes sense that the purpose of healthcare is to relieve immediate pain or distress rather than improve future health.

The health workers had control over what services were provided and how and when they were delivered. Therefore, the responsibility for improving the health of service users was with health workers. The health workers were also responsible for determining what was required to achieve better health. The nature of power relationships is further reflected in the way healthcare is controlled by professional groups, particularly doctors. While expertise is necessary, given doctors' specialist medical knowledge and diagnostic skills, it is at odds with the health promotion messages of choice and self-determination (Sofaer & Gruman, 2003). For example, Sally noted the health promotion messages about depression but was unable to access what she needed to manage her own condition because of the requirement of a doctor who is unavailable. Sally also pointed out that choice in that situation is linked to financial resources.

The power relationship, where appropriate access or intervention is determined by the health system, was also expressed in the recruitment process where open communication (about participating in research) between service providers and users is problematic. The requirement not to contact potential participants at the health centre seemed sensible at the time because of the important ethical considerations about relationships between research, services and participants (NHMRC, 2007). However, on reflection, the resulting barrier to participation in project interviews appears consistent with the themes of control and professionals knowing what is best for their clients, that was reiterated throughout the interviews.

In seeking to understand and address inequitable health outcomes, it is important to consider if barriers exist and how they influence health disparities in marginalised or disenfranchised groups within rural areas (Braverman & Gruskin, 2003). Choice of care is not possible for those with limited financial resources even though it is sometimes framed as a choice. For example, Tom will choose a course of treatment that is local because

he cannot afford treatment provided in a city. The chance of treatment is mediated through financial resources even though Australia has a public health system. For other participants, attempts to take control and be autonomous, particularly around the care of children, were met with disapproval. Both Mel and Karen indicated that they were not part of determining what would assist their children or how interventions might work. Thus, rural health systems are less effective for those who cannot seek specialist treatment out of the local area when required. This has implications for young people, older people, those without transport, those who cannot travel and those with low incomes.

There are multiple and complex challenges associated with identifying and explaining rural residents' perception of health care and community service need and resolving policy and health promotion strategies to meet need. The challenge is multiplied when focusing on the circumstances of those rural residents experiencing socio-economic disadvantage. In particular, promotion of health literacy and disease self management are likely to be irrelevant to the population most intended to benefit (Schrader, 2004; Sofaer & Gruman, 2003). Simply providing information and then leaving the individual to be responsible for their health choices and access to care ignores both the barriers to individual action within the existing health system and societal responsibility to uphold human rights. The health system seems to cater less for those who need it most (Germov, 2002).

It seems unlikely that healthcare or health promotion messages will do much to improve health within the current healthcare system. There is a serious disconnect between health workers control over healthcare messages and processes and the expectation that individuals will be in control of their health.

## CONCLUSION

The human right to maximise health and well being is not sufficiently protected and promoted in Australia because it is not well under-

stood. It could be argued most people do not know what they need for healthcare either now or in the future. This is significant for the social inclusion agenda and other consultative processes that ask people what ways services can adapt and change to meet their needs. In rural areas, individual choice is not a factor in obtaining services but a function of the healthcare system including the networks and follow-up strategies of individual professionals and the ability to pay for what is required. The healthcare workforce has control of a system that is given responsibility for health but does little for improving health chances.

Health chances and health experiences are significantly affected by income levels to the point where those who live in poverty have a limited experience of good health. The good intentions and interventions that aim to change the health of disadvantaged individuals are unlikely to be successful without an approach that considers the impact of structural inequality and personal autonomy on prioritising and decision-making about health.

## References

- Australian Bureau of Statistics (ABS) (2001). *Population census 2001*. Retrieved from [www.abs.gov.au](http://www.abs.gov.au)
- Ackerson, B. J. (2003). Parents with serious and persistent mental illness: Issues in assessment and services. *Social Work, 48*, 187–194.
- Australian Institute of Health and Welfare (AIHW) (2008). *Australia's health 2008*. Cat. no. AUS 99. Canberra, ACT: AIHW.
- Allan, J., Ball, P., & Alston, M., (2007). Developing sustainable models of rural health care: A community development approach. *Rural and Remote Health, 7*(1), 818. Retrieved from <http://www.rrh.org.au>
- Allan, J., & Ball, P. (2008). Developing a competitive advantage: Considerations from Australia for the recruitment and retention of rural and remote primary health workers. *Australian Journal of Primary Health 14*(1), 106–112.
- Allan, J., Ball, P., Alston, M. (2009). Following the policy pathway: The impact of policy processes on children's access to healthcare in rural Australia. *International Journal of Child Health and Human Development, 2*(2).

- Battye, K., & Roufeil, L. (2008). Effective regional, rural and remote family and relationships service delivery. *AFRC Briefing No. 10. Australian Family Relationships Clearinghouse The Australian Institute of Family Studies*. Retrieved from <http://www.aifs.gov.au/afrc/pubs/briefing/briefing10.html>
- Bhalla, A., & Lapeyre F. (1999). *Poverty and exclusion in a global world*. Basingstoke, UK: Macmillan.
- Bradshaw, J. (1972, March). A taxonomy of social need. *New Society*, 640–643.
- Braverman, P., & Gruskin, S. (2003). Poverty, equity, human rights, and health. *Bulletin World Health Organ*, 81, 539–545.
- Burrows, L., & Wright, J. (2004). The good life: New Zealand children's perspectives on health and self. *Sport, Education and Society*, 9(2), 193–205.
- Charmaz, K. (2005). Grounded theory in the 21<sup>st</sup> century: advancing social justice research. In N.K. Denzin & Y.S. Lincoln, *The sage handbook of qualitative research (3<sup>rd</sup> ed)*. (pp. 507–535). Thousand Oaks, CA: Sage.
- Germov, J. (2002). Class, health inequality, and social justice (ch 4). In J. Germov (Ed.), *Second opinion: An introduction to health sociology, (2<sup>nd</sup> edn)* (pp. 67–79). Melbourne: Oxford University Press.
- Gillespie, S.A. (2007). *Estates and sustainable rural development*. Working Paper Series Number 5. Dumfries, UK: Centre for Research into Regional Development.
- Gray, G. (2004). *The politics of Medicare*. Sydney: UNSW Press.
- Gruen, R. L., & Weeramanthri, T.S. (2002). Outreach and improved access to specialist services for indigenous people in remote Australia: The requirements for sustainability. *Epidemiol Community Health*, 56(7), 517–521.
- Guiliford, M., Figueroa-Munoz, J., Morgan, M., Hughes, D., Gibson, B., Beech, R., & Hudson, M. (2002, July). What does 'access to health care' mean? *Health Serv Res Policy*, 7(3), 186–188.
- IFSW (2007). *International Federation of Social Work – IFSW policy statement on health*. Retrieved from <http://www.ifsw.org/p38000081.html>
- Laaksonen, M., Prattala, R., Helasoja, V., Uutela, A. & Lahemla, E. (2003). Income and health behaviours. Evidence from monitoring surveys among Finnish adults. *Journal of Epidemiology and Community Health*, 57(9), 711–717.
- Li, J., McMurray, A., & Stanley, F. (2008). Modernity's paradox and the structural determinants of child health and wellbeing. *Health Sociology Review*, 17(1), 64–77.
- Lynch, J. W., Due, P., Muntaner, C., & Smith, G., (2000). Social capital, economic capital and power: Further issues for the public health agenda. *Journal of Epidemiology and Community Health*, 54, 409–410.
- Marmot, M., & Wilkinson, R. (2006). *Social determinants of health*, 2<sup>nd</sup> Ed. Oxford: Oxford University Press.
- National Health and Medical Research Council (NHMRC) (2007). *National statement on ethical conduct in human research*. Canberra: NHMRC Australian Research Council, Australian Vice-Chancellors' Committee.
- National Preventative Health Taskforce (NPHT) (2008). *Australia, the healthiest country by 2020: A discussion paper*. Canberra: Attorney-General's Department. Retrieved from <http://www.preventativehealth.org.au/internet/preventativehealth/publishing.nsf/Content/discussion-healthiest>
- Norris, A. C. (2002). *Essentials of telemedicine and telecare*. West Sussex: John Wiley & Sons.
- OECD (2008). *Growing unequal? : Income distribution and poverty in OECD countries*. <http://www.oecd.org/dataoecd/44/47/41525263.pdf>
- Rajkumar, S., & Hoolahan, B. (2004). Remoteness and issues in mental health care: Experiences from rural Australia. *Epidemiologia e Psichiatria Sociale*, 12(2), 78–82.
- Rawsthorne, M., Hillman, W., & Healy, K. (2009). Families on the fringe: Mental health implications of the movement of young families to non-metropolitan areas. *Rural Society*, 19(4), 306–317.
- Rice, P. L., & Ezzy, D. (1999). *Qualitative research methods: A health focus*. Melbourne: Oxford University Press.
- Sands R (1995). The parenting experience of low-income single women with serious mental disorders. *Families in Society*, 76, 86–96.
- Saunders, P., & Davidson, P. (2007). Rising poverty is bad for our health. *Medical Journal of Australia*, 187(9), 530–531.
- Schrader, T. (2004). Poverty and health in Australia. *New Doctor*, 80, 17–19.
- Sofaer, S., & Gruman, J. (2003). Consumers of health information and health care: Challenging assumptions and defining alternatives. *American Journal of Health Promotion*, 18(2), 151–156.
- Turrell, G. (1995). Social class and health: A summary of the overseas and Australian evidence (Chap. 6). In G. Lupton, & J. M. Najman (Eds.), *Sociology of Health and Illness: Australian Readings (2<sup>nd</sup> edn)* (pp. 125–142). Melbourne: Macmillan.
- Ungar, M. (2008). Putting resilience theory into

- action: Five principles for intervention. In L. Liebenberg & M. Ungar (Eds.), *Resilience in action* (pp.17–38). Toronto: University of Toronto Press.
- Ungar, M., Brown, M., Liebenberg, L., Othman, R., Kwong, W.M., Armstrong, M. & Gilgun, J. (2007). Unique pathways to resilience across cultures. *Adolescence*, 42(166), 287–310.
- Vinson, T. (2009a). *The origins, meaning, definition and economic implications of the concept social inclusion/exclusion*. Canberra: Australian Department of Education, Employment and Workplace Relations. Retrieved from <http://www.deewr.gov.au/Department/SocialInclusion/Pages/ResearchPapers.aspx>
- Vinson, T. (2009b). *Markedly socially disadvantaged localities in Australia: their nature and possible remediation*. Canberra: Australian Department of Education, Employment and Workplace Relations. Retrieved from <http://www.deewr.gov.au/Department/SocialInclusion/Pages/ResearchPapers.aspx>
- Vinson, T. (2007). *Dropping off the edge: The distribution of disadvantage in Australia*. Richmond, VIC: Jesuit Social Services.
- Wass, A. (2000). *Promoting the primary health care approach*. Marrickville, NSW: Harcourt.
- Westerman, T.G. (2004). Engagement of indigenous clients in mental health services: What role do cultural differences play? *Australian e-Journal for the Advancement of Mental Health*, 3(3). Retrieved from <http://amh.e-contentmanagement.com/archives/vol/3/issue/3/article/3369/engagement-of-indigenous-clients-in-mental-health>
- White, K., Wall, D., & Kristjanson, L. (2004). Out of sight out of mind: Reframing remoteness in providing palliative care in remote Australia. *Collegian: Journal of the Royal College of Nursing Australia*, 11(3), 29–33.
- Winton, T. (2009). *Smalltown*. Melbourne: Penguin.
- WHO (1986). *The Ottawa Charter for Health Promotion*. Geneva: WHO
- WHO (2008). *Closing the gap in a generation: Health equity through action on the social determinants of health. Final Report of the Commission on Social Determinants of Health*. Geneva: World Health Organisation.
- Young, A., & Dobson, A. (2003). The decline in bulk-billing and increase in out-of-pocket costs for general practice consultations in rural areas of Australia, 1995-2001. *Medical Journal of Australia*, 178, 122–126.

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