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ORIGINAL RESEARCH

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

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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 individual's 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 client's problems as related to poverty and rural decline with limited options for successful intervention through the health system.

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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 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 healthcare worker and by the value system of the health worker. 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. Such a work should include investigation of multidisciplinary models of service provision. This will optimise the range of health care available to small rural communities.

Key words: Australia, pharmacists, professional role, social workers, rural community, rural workforce.

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 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 healthcare workers are problematic for rural and remote health services[4].

Healthcare providers and rural communities need to encourage people to make the tree-change to maintain or improve healthcare services. While healthcare professional development and workplace issues have been researched, the personal factors that drive people to or from rural/remote areas are less well known. Some research literature considers the impact on families of relocating to rural areas and the importance of strong personal relationships to support health workers is acknowledged[4,5]. However, the way local context affects personal and professional decisions, and consequently service delivery, is not well documented.

Healy describes rural workplaces as 'professional nurseries' where new graduates get their first experiences of their chosen profession and move on[6]. Consequently staff vacancies and continual turnover add to the general decline in rural areas[7]. The preparedness to go anywhere for a first job is understandable, and it could be argued that few people spend years in their first job. However, some health workers do stay in rural areas and others are tempted to make the tree-change. The professional and contextual factors that can encourage people to stay or leave are the subject of this article.

Pharmacists and social workers are both allied health professions working within Australia's healthcare system.

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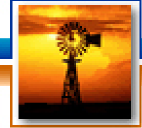

However they have quite distinct training and separate roles. Pharmacists supply medicines and provide advice about these as well as health and lifestyle problems (WHO, unpubl report, 1988: 'The role of the pharmacist in the healthcare system. Report of a WHO consultative group'). Social workers identify need and structural and contextual inequity. They aim to address these by providing advocacy, support and information for disadvantaged individuals, families, groups and communities with the intention of empowering them and effecting change[8]. Both professions work in small rural communities across Australia.

In the past 15 years the political context of health work has changed significantly with the decline of the welfare state and increased emphasis on individual responsibility for accessing and paying for health care[9]. These changes, and others, have affected the roles and tasks of all health professionals. For example, pharmacists work with GPs to carry out medication reviews and pharmacy technicians are a new category of health worker who undertake some of the traditional tasks of pharmacist[10]. In social work advocacy and development, roles have become focussed on individuals rather than communities[8].

To explore and compare the professional and personal experiences of pharmacists and social workers, a qualitative study was completed in 2006. Its aim was to inform recruitment and retention strategies in the health sector. The study investigated the rewards and barriers of rural health work for pharmacists and social workers and found that allied-health workers experience similar rewards and barriers in their work as GPs experience[11]. 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 and professional issues described by participants that affect healthcare delivery in rural areas and some significant aspects of difference between the two professions. This article reports on these findings from the workforce project. Following an overview of the project's methodology, this article explores the issues of local context and professional role and the way they influence participants' perceptions of professional achievement and access to rural health care. Avenues for future research are identified.

Methods

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 New South Wales (NSW).

A convenience sampling method, that is, a sample drawn from an available or convenient group that reflects the problem being investigated[12] was used to identify participants. The participants had to be working in a town with less than 5000 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, 11 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,

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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.

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. An inductive analysis was also employed to develop the conceptual framework emerging from the data reduction process[13]. The inductive analysis concentrated on issues not identified in the GP recruitment and retention literature. Of particular interest were statements about the role of pharmacy and social work and tasks related to this role. Also noted were frequent positive and negative statements participants made about towns they worked in and the pressures of their position in a small town.

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.

Results

Work roles and networks

Pharmacists and social workers are described as healthcare 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. Consequently 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. Social workers in the health system primarily describe themselves as 'counselling' or 'accessing information and resources' when they describe their work role. The information and resources are associated with social care, not physical care, although clients may be referred because of contacts made via treatment for physical conditions.

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.*

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:

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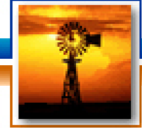

> *I've known several generations of some families. It is not uncommon for me to go to funerals and know all the family and all their illnesses.*

The work context of social workers was described very differently to that of pharmacists. 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.

Social workers, while finding difficulties in some professional relationships, did not rely on any other single profession as pharmacists did. They tended to refer to a number of support services, and have contact with other government departments outside the health field. Most said they participated in network meetings, consistently referred to as 'interagency meetings'. For example:

> *It depends which town I'm in exactly what's available but I talk to DoCS* [child protection agency], *Housing* [state government agency], *Centrelink* [income support agency] *and Family Support all the time.*

Even though each profession participated in different networks of healthcare providers, both groups had concerns about the networks in their towns. Participants commonly expressed concern about limited services and worries about future availability of health care. 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.*

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.*

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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 3 to 25 years long. Social workers discussed the characteristics of different areas, noting local issues and atmospheres, describing some places as better to work in 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)

The statements about local context generally reflected social rewards and barriers. The statements were about availability of social activities and groups. They were also about

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personal experiences of fitting in or having a sense of belonging.

Impact of personal and professional values on service provision

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.

The types of services a pharmacist provides depended on the way the pharmacists viewed 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. While 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 access to care, local context and individual personal and professional issues as factors that impact on healthcare 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. Health workers were concerned about their ability to continue providing care if other health workers left the area, and about the limited availability of what was already provided. However services can be limited by the health workers or the organisation. For some pharmacists, not providing methadone was a personal decision based on their own values and view of drug users as risks to their personal

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safety. For potential methadone users in some communities this decision makes an enormous difference to their healthcare options.

Access to is not only determined by the care existing. It needs to be understood within the personal dimension. Some clients are perceived to feel stigmatised by needing health care and visible in the small community choosing to travel to access services. It is a limitation of this study that healthcare recipients other than health workers are not asked why they might access health care in another town. Although, health workers also need to be recognised as health service users and potentially personally stigmatised when confronted by needing care. While there is no suggestion that other health workers would not maintain confidentiality and privacy, both pharmacy and social work participants noted that professional and personal relationships with other local health providers limited their options for their own health care.

Research participants highlighted the difficulty of separating professional and personal life in a small town. Not only in accessing health care for themselves but in being visible as a health worker even when not at work. Health education needs to consider the way concepts of professional boundaries, professional identity and duties and personal needs are portrayed in relation to rural work contexts. Privacy has limited meaning when the health worker's professional role is well known. For new graduates in a small town, the degree of visibility and lack of privacy could be very confronting. The effect and persistence of gossip contributes to the lack of privacy, and indicates a need for professional confidence and personal strength to stay in town.

Access to rural health services is affected by an individual's concerns about privacy and confidentiality, by the reputation of the healthcare worker, by the value system of the health worker, and by 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 to stem from the 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[14]. Social workers bear the burden and can be at personal risk from individual clients. The poor health status that funds healthcare workers and brings community members to social workers in rural health centres is as likely to be caused by poverty and disadvantage including drought and its effects, as individual pathology[7].

Pharmacists may recognise problems of disadvantage but professionally perceive less responsibility for dealing with it. Pharmacists are more visible and more accessible in small towns than social workers are. Their main street location, free and instant advice and provision of prescribed medications are vitally important to those towns that have a pharmacy. It is perhaps a more clearly defined and practical role within the health system than social work. Pharmacists 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 concern about the ability of individual work to address structural disadvantage 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 in than others, and that local context plays a part in developing community

capacity and in the experiences health workers have in the workplace.

Conclusion

The factors that retain health workers in particular jobs and locations are a complex combination of local context, professional role and personal strength and relationships. These may vary from individual to individual. However, it is significant that pharmacists in this sample were more confident in their role and perceived more success than did social workers. The responsibilities of the particular profession will have an impact of the way a person fits in a rural location.

Health workers taking up the tree-change option should be aware that many aspects of their personal and professional lives are going to be magnified in small communities. They 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 prevailing government's 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.

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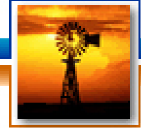

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