Forgotten Rural Health?
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Introduction

In the large body of health literature and public debates about health and wellbeing, rural health has been largely neglected. The lack of political voice of rural voters, the logistical difficulties of providing health services to rural areas and the heterogeneity of rural communities have resulted in rural health not receiving adequate healthcare services, infrastructure and attention.

Rural and remote contexts, both of which are diverse, shape what health consumers do, including their health behaviours, decision-making and access to care [1,2]. It also alters how health professionals practice, who chooses to work there, and what services are provided. As Wakerman and Humphrey’s stated, rural health is more than health in another location [3].

While the defining characteristic of rural health remains its geography (and related issues of access to healthcare services), rural and remote Australia is also sociologically, culturally, economically and spiritually different from metropolitan areas, as well as internally diverse. It is these characteristics that define the health behaviour of its residents, determine their health status and influence the way health and medical care is provided.

Despite significant variation in health systems and rural contexts, rural health in Australia, Canada, United States, New Zealand, United Kingdom and parts of Europe experience a range of similar issues [1,4-11].

What are the Common Issues in Rural Health?

One of the greatest health needs in several Western countries (Canada, U.S.) and particularly in Australia is the health needs of people from first nations. In Australia, Aboriginal and Torres Strait Islander people have lower birth weights, higher levels of infant mortality, higher rates of chronic illness, infectious disease and mental illness, and higher rates of injury and suicide than non-Indigenous Australians. This greater burden of disease results in an 11 year shorter life expectancy [12]. The pattern of mandating, providing and ‘doing for’ maintains these inequities in Australia, despite pleas for community control and self determination. The failure to address the structural barriers and their determinants has been neglected along with acknowledgement of mainstream’s role in the marginalisation and dispossession of Aboriginal and Torres Strait Islander people [13-15]. But cultural strength remains as individual communities continue to develop culturally appropriate services for themselves [16].

Rural health in Australia and other Western countries is also plagued by workforce shortages and limited access to healthcare [2,10,11,17-21]. The lack of doctors, nurses, allied health and community health professionals in many rural and remote places restricts the ability to provide care [2,10,17-21]. The lack of services, restricted hours of some services, the higher cost of some services and inappropriateness of the type of services in some rural areas results in less access to healthcare for consumers [22-27]. In addition, the lack of support for health professionals, inappropriate models of care, and the need for more generalist, flexible and community models further restrict access [1,21,27-30]. Finally, the lack of funding and infrastructure for rural health services further contributes to the difficulties of meeting the health needs of a geographically dispersed population. While services struggle to sustain themselves, their population has lower health status compared to urban populations, particularly among lower socioeconomic groups and first nations people [4-9,21,31,32]. Together, these create a cycle where isolation and significant health needs in conjunction with workforce shortages lead to greater workloads and ‘on-call’ demands for those who do work in these locations. The long-term result is burnout, retention and recruitment difficulties, and a failure to adequately address the health needs of rural populations.

How can Rural Health be ‘on the Agenda’?

The evidence in rural health paints a negative picture of rural practice, discouraging others from entering rural health. However, there are some positive attributes of rural practice that underpin the passion and commitment of thousands of rural practitioners around the globe [33]. For rural health to be more central in health research and training, it needs to be recognized for its strengths as well as its challenges [34]. Moving beyond an understanding of rural health based entirely on its deficiencies in comparison to urban health will assist in greater appreciation for rural health. Some of these strengths are outlined here.

In Australia, over the past two decades, rural health services have shifted from a smaller version of traditional urban models of care to unique models of care catering to local community needs. Recognizing that rural health professionals are held accountable by their local community and that urban models of care do not suit rural and remote contexts, many rural and remote health services have re-designed their service to focus on the health needs of the local population, the preferences of local consumers and the availability, affordability and sustainability of the workforce [35,36]. In doing so, these models are based on primary healthcare principles, including emphasis on prevention and promotion, community and consumer participation, advocacy and public health [6,30,36].

Rural health practice also differs from urban practice in a range of ways. Not only are practitioners working within different models of care, rural practice is more generalist and teams are more multidisciplinary. There is diversity of cases and less choice of patient/client. Resources and other staff are fewer placing greater reliance on, and autonomy of, each practitioner. Practitioners are more connected with their local community who hold them accountable but are also known to local practitioners and seen outside of the health clinic [1,37,38]. Many rural practitioners experience overlapping relationships where their patients/clients are also known to them in other ways (e.g., as school teacher to their children, team-mate in a sporting club or as neighbor or friend). These dual relationships can collapse personal and professional
boundaries, leading to greater knowledge of patients/clients and greater potential to address community health issues [29,37,39]. Together, these culminate in a different and often innovative style of healthcare delivery within a community-based model of care. Some practitioners love the diversity, the connection with community and to be able to observe the outcomes of their own practice in these environments [29].

Including Rural Health

There are many features of working in rural health that can be appealing. The constant focus on problems in rural health ignores the many strengths of rural practice. But rural health is not only a product of local people and services, it is also shaped by structural processes in broader political, economic, cultural and social arenas [34]. Governments implement policies that impact on local services and communities, who in turn take action to address local health needs. These decisions are based on existent knowledge about rural health, from media, stakeholders and evidence. Researchers contribute to this, through their in/exclusion of rural settings in the development of knowledge about the health needs of communities. Including rural health, with its diverse settings and services, is a first step to addressing these needs. Knowledge and evidence about rural health, including its strengths, could contribute to understanding rural as more than ‘deficient’ and alter understandings of what it is like to work in rural health. Indeed, there are many lessons that can be learned from rural health, particularly how innovative, multidisciplinary teams have redesigned their health services to meet local community needs despite significant resource challenges.

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