The Role of Families in Promoting Rural Health: A Case Study of Contrasting Rural Communities

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INTRODUCTION

A wide range of determinants impact upon the health and well-being of individuals and families. Critical among these influences is the health care environment, including the availability of, and access to, a wide range of preventive and curative services. Unfortunately many rural and remote areas do not have adequate access to an appropriate range of health-related services. Despite this undersupply and maldistribution of health care services, families living in rural and remote communities still need to address the same health needs, and often additional ones, as those of their better-served metropolitan counterparts. A sound understanding of how they do this is required as the basis for effective rural health policies and programs. To date, the role of the family in maintaining and promoting the health of rural Australians has been largely overlooked on the rural health research agenda. Yet, families remain a ‘major social support system for most people and will continue to be a major health promotion opportunity’, particularly in those small rural communities which have borne the brunt of the withdrawal and rationalisation of many local health care services.

In an attempt to address the lack of empirical data on the role of the family in maintaining and promoting the health of rural Australians, a major study funded by the Australian Rotary Health Research Fund is currently being undertaken in the Loddon Mallee region in north-west of Victoria. The aim of this project is to identify and explain how families from four contrasting rural environments perceive their health status and needs, use health services and practise self-care and health behaviour conducive to good health. The specific research objectives are:

- to identify the nature of health needs and problems characterising rural families from an intensive study of their perceptions of health and their health behaviours;
- to identify what measures and services rural families use to cater for the family’s need for health care; and
- to ascertain whether the health care behaviour of rural families differs according to their access to health care services.
These objectives accord with those of the National Rural Health Strategy for ‘improved targeting and greater focus on specific health needs...improved delivery of culturally appropriate services... and expansion in primary health care’ including health promotion and use of preventive health strategies.\(^5\)

Given differences in the way that people 'construct' the concept of health and view their health status, one might reasonably anticipate some variation in health behaviour. Evidence exists to suggest that health behaviour and response in seeking care is related to distance and severity of illness, as well as individual information and understanding of the problem.\(^6\)\(^-\)\(^8\) However, in general, the nature of health seeking behaviour among rural Australians and the influences underpinning it are not well understood, particularly those which reduce the dependency of people on curative care and which encourage them to take greater responsibility for ensuring that problems of ill health do not arise.

Hopefully, the findings from this study will increase an understanding of these issues, and, in turn, form the basis for planning how best to deliver appropriate and effective health services and health information to meet the needs of families living in different rural and remote circumstances. This project should help to increase our understanding of what health promotion information is useful and what is not useful in rural areas, how to improve the level of information for families who have limited access to a full range of health and community services, and what information and services (including the ways in which they are delivered) impact most on the choices they make about health related matters.

**METHODS**

Consistent with the requirements of the Australian Rotary Health Research Fund, families form the focus of this study. Families participating in the research include both 'traditional' and 'blended'.\(^9\) The key selection criteria relate to the age range of the children, with a preference for families which included pre school and primary school age children and families with children in early adolescence. A purposive sampling strategy was adopted as the basis for selecting participants.

Almost 120 families in four contrasting rural communities participated in the project. Families were selected from rural locations which vary according to the local availability of, and distance to, a differing range of health services. The remote communities of Culgoa and Ultima, each with around 200 residents, typified locations lacking primary care services. Thus families were required to travel some distance for the most basic health care. Families from Sea Lake (population 1,127) had a limited range of health care services available locally, including a small private hospital with 12 acute beds, 6 nursing home beds and 19 hostel beds. Families also had access to two medical practitioners, a Maternal and Child Health Nurse and a visiting counselling service. In the largest of the communities included in the study, families from Swan Hill (population 9,385) had access to a much wider range of health care services in the local
area, including both primary and secondary services. The major health service comprises a hospital with 80 acute, 64 nursing home, and 15 hostel beds and a Primary Care Division which includes Health Promotion, Drug and Alcohol facilities, Allied Health services and a public dental clinic. Families also had access to a number of other services including mental health services, St Luke’s Family Care and Aboriginal Health Services.

In relation to the issue of how access to health services may influence health care behaviour, this study is largely hypothesis generating because of its pioneering nature. On the one hand, one might hypothesise that the importance of self-care behaviour is greater as the distance from health-related services increases for families and the size of communities diminishes. Such behaviour may be facilitated by the social interaction and intimacy associated with small rural communities that lack formal health care services and adequate access to health programs. On the other hand, many rural communities lack access to information, are characterised by lower levels of economic well-being and educational attainment, and live in a context where the dominant rural culture of stoicism, macho behaviour and independence can operate against optimal health behaviour. Families in these situations may neglect adequate health care behaviour, depending solely on periodic visits to distant or mobile health services.

The project employed a unique methodology in which each family maintained a weekly health diary over a four-month period. These diaries document information relating to the day-to-day health needs of family members, how well family members felt, their daily health behaviour, and their use of health services as well as informal community support mechanisms. The use of a diary methodology has enabled families to monitor and reflect on their actual and perceived health needs, their use of health services, and their constructions of what constitutes a healthy family. This technique enabled families to track how they address the problems associated with meeting their needs for health care in situations where health services are scarce or inaccessible.

Prior to commencing diary entries, each family also participated in a comprehensive interview which sought information relating to aspects of health promotion and preventable illness, including nutrition, immunisation, smoking, sun protection, injury and accident care, screening for heart disease, mental and emotional health, and drug use.

Throughout the four-month period during which health diaries were maintained, each family was contacted by telephone on a weekly basis and visited each month. This regular contact ensured that participants had ready access to all the assistance that they required in order to fulfil the research requirements, as well as any encouragement and reinforcement required to ensure the completion of such a longitudinal study. The process of collecting quality primary data over an extended period of time resulted in the development of close links between families from rural communities and academic researchers.
RESULTS AND DISCUSSION

It should be noted that the results presented here are preliminary. Nonetheless, the initial findings appear to validate the ongoing problems that hinder optimal health and the ability of rural residents to access appropriate health care. Notable amongst these problems are geographic isolation, stressful work and lack of income. Not surprisingly, the effect of geographic isolation was felt most acutely by families in the smaller remote communities.

Families reported many illnesses for which they accessed some health service during the period of study. Access issues aside, families sought assistance from a wide range of health professionals, including health workers dealing with disease prevention, (such as immunisation), early detection (such as dental checks), health maintenance (such as chiropractic care), monitoring chronic health problems (such as asthma) and treatment from doctors for a range of acute illnesses. Given that many of these services are not available locally, families are required to travel significant distances to access them.

In matching the health behaviour of families with their ‘construction’ of health in all its dimensions of physical, mental and social well-being, a significant disjuncture is apparent. In the initial survey, participants considered a healthy family to be one that is both mentally and physically well and subject to minimal stress. However, evidence from the diary suggests that mental health issues remain something of a sleeping giant. For example, while ‘stress’ was recorded by some participants as an event that regularly had an impact on the health of the family, it was not necessarily perceived by these families as constituting ill-health or as being ‘unwell’. Nor was it something for which they sought assistance from health services. In short, it was not regarded as a health issue in the same way as acute health problems such as influenza. Rather it was accepted as something to be lived through and dealt with by the family. Socialising with family and friends and physical exercise appeared to be the strategies most commonly used by families to reduce stress.

For all participants, eating well, family support and exercise were identified in the survey as the most important priorities in promoting health. However, analysis of the data recorded in diary entries showed that while families engaged in an enormous variety of health-promoting activities associated with exercise, there was significantly less mention of ‘healthy eating’ and nutrition. Healthy times were occasions when families spent time together relaxing.

Opinions on the types of things that could help improve the health of families vary in priority across the different communities. For the families from the smallest communities, Ultima and Culgoa, health education and access to medical, nursing, counselling and childcare services were dominant concerns. Specific issues for health education programs included farm safety, mental health, domestic violence and child abuse as well as general health education in schools. In relation to access to services, more outreach services were seen as a means of overcoming transport difficulties confronting many families. For families from Sea Lake, health education relating to farm safety, drug and
alcohol use and abuse, mental health and health issues specific to both men and women was a priority. In the case of Swan Hill (the largest and best-serviced community), more doctors, dentists and other health professionals were considered to be the most important factor in improving the health of families. Associated with this, concern was expressed about the cost and quality of existing medical services.

Much more analysis of the data is required. Nonetheless, it is apparent that the research has produced several important insights and some very beneficial though unanticipated outcomes. A very significant legacy of the study and its methodology has been its impact on the communities engaged in the research. These outcomes fall into three broad categories:

*Health promotion:* The three smaller communities traditionally have had very little in the way of a comprehensive health promotion program, with the local health services concentrating largely on meeting the curative care needs of residents. As a result of their involvement in data collection over four months and their association and discussions with other participants in the study, families are now actively considering what activities promote good health. Given the importance of adopting preventive measures likely to reduce the incidence of premature mortality and morbidity the research has proven to be a valuable catalyst from which families reflect more consciously on their state of health and need for and use of health services, as well as thinking about what is involved in and required for living a healthy lifestyle.

*Capacity building in rural communities:* Longitudinal involvement of families in the study has assisted the community to develop a resource base familiar with the requirements for conducting an analysis of its health needs. Many participants, particularly those in isolated areas, felt the need to contribute to the well-being of their community and completing this survey was part of that responsibility. By engaging in the research community residents have become more familiar with the requirements and process for systematically investigating local health problems as the basis for seeking solutions and acquiring resources necessary to provide appropriate health care services.

*Information dissemination and networking:* Because the research involved university based health professionals with local families on a weekly basis over an extended period of time, academics were seen as a valuable resource for assisting families to access publicly available but little known information and services. Unlike those research projects whose survey methodology constitutes little more than a ‘data raid’ on local rural communities, the commitment to develop and maintain an ongoing relationship between community residents and academic researchers has served to link the university closely with the local community. Perceptions of university research as somewhat esoteric and aloof from everyday concerns have been replaced by positive perceptions of the local university as a resource that is available to work in close partnership with the community to address issues of local concern.
Good health for all Australians has been the goal of governments in Australia. It is critical to acknowledge and understand the vital role played by families as health care providers and carers alongside the wide range of preventive and curative health services provided by governments, so that governments can provide appropriate resources and support to ensure their health care activities are effectively maintained.

REFERENCES