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COORDINATING RURAL HEALTH INTERESTS: INDIVIDUALS, INSTITUTIONS, AND IDEOLOGIES

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The consideration of how diverse interests are considered and negotiated through rural health development polices and strategies reveals a complex interplay among individual human rights, the sustainability of institutional infrastructures, and the ideological national politics that define economic distribution of goods and services. A qualitative comparative study of rural health development policies, strategies, and actors in Australia and the United States, both Western developed democracies, examines how these interests are negotiated at local, regional, and national levels to provide equitable high quality rural health care at lower costs to tax payers. The particular research question addressed in this paper focuses on understanding how the strategic agendas of particular population groups, institutional structures, and political processes within these two nations address health and health care as a human right. The question was framed out of challenges posed by the Affordable Care Act in the United States to provide equitable high quality rural health care at lower costs to tax payers. An examination of the Australian rural health system, considered one of the best in the world, was conducted in spring 2015 to identify how diverse groups of individual actors are developed to participate within local rural health care service systems.

This study has two inter-related theoretical foci. The primary theoretical focus is ecological. The ecological systems approach integrates the larger political and economic forces that shape public policy with the geographic and community dynamics that reflect investment in

infrastructures and organization of educational and medical institutions that provide health care services. It also integrates the social structures that shape health experiences and relationships for diverse groups of individuals. Closely related to this approach is that of critical medical anthropology, which seeks to identify the political and economic influences on health and health care that contribute to inequities. This approach also critiques the cultural assumptions that perpetuate social and institutional structures and their practices, which is significant to the critique of rural health system development strategies.

The methodological approach is qualitative, based on participatory-observation of both systems. The author teaches a graduate course in Rural Health for the Medical Anthropology Master's Program at Creighton University in rural Nebraska, USA. Creighton University hosts a medical school which has a clinical training contract with CHI (Catholic Health Initiatives), a large health provider network in the region. Both Creighton University (Jesuit) and CHI are non-profit Catholic institutions seeking both federal and state government funding to comply with Affordable Care Act reimbursements for Medicare and Medicaid program health care. Field research was conducted at the Melbourne University Rural Health Academic Research Centre in rural Shepparton, Victoria in Australia. The Centre is connected to a rural hospital clinical field school. Both the clinic and the research centre are funded by the state of Victoria and provide health care services for the general public.

The study methodology is comparative in that it identifies the ecological system categories for comparison that inform development strategies toward more effective rural health policies and strategies in the United States. This includes categories of actors within structures of community engagement, rural health research, education, and care delivery components. These categories may inform the development of new structures within American universities in the United States that host medical schools coordinated with health provider networks.

The main aim of the paper is to identify further policy conversations between and among policy makers, researchers, professional health care practitioners and diverse patient populations to improve understanding of expectations and outcomes of rural health in any national context seeking to develop more effective rural health policies and strategies. The main findings of the research reveal a hierarchy of interests within political ideologies of equity and inclusion that privilege the development policies and strategies of rural health around health care institutional stability over the human health rights of rural individuals. In both contexts, development strategies focus on rural health care, not rural health. The study argues for placing a pro-active priority on protecting, preserving, and promoting rural health

first. It asserts that health care in developed nations is currently largely a reactive response to the loss of health (much of which is ironically associated with economic development).

The study identifies barriers to health in rural regions in the failure to integrate federal and state resources and expertise in recognizing the political and economic forces that fail to acknowledge rural health risks and threats such as poverty, dangerous occupations, and environmental pollution. The study also recognizes the complexity and inequalities embedded in the processes by which higher expectations and outcomes for health can be negotiated from diverse population perspectives. The study further argues for more collaborative strategies between and among health providers, researchers, health education professionals, and local residents to increase local capacities to develop rural health behaviors and outcomes.

The comparison in cultural values and attitudes regarding human rights, health care, and health reveal that both nations focus on providing equity to rural and other marginal population groups as rights due to them as full political participants of democratic societies. Both nations seek to reduce disparities within their health care systems. They do not recognize, however, that health and health care status equity and disparity are more frustrated by social, political, and economic inequality than by lack of access to health care services. Policy comparisons reveal that failure of government bureaucracies to recognize that poverty, education, occupational and environmental quality issues are the starting point for health, not primary care facilities. These comparisons reveal a cultural bias toward supporting bureaucratic health care infrastructures and a professional work force that addresses the health care needs of "populations of consumers," not the health and economic needs of populations at risk. In addition to the failure to focus on unmet needs, this bias reveals contradictions in democratic policy processes that are very costly to state and national taxpayers.

Comparison of the public policy processes associated with tax funding of health care reveals significant differences between the United States and Australia. While both functioning democracies enjoy a high level of freedom to criticize government officials for inappropriate use of public funds and for ineffective or inefficient policies, Australians typically display higher levels of trust in their government than do Americans. There is a voting mandate in Australia and most people agree that tax dollars do provide quality health care benefits to them at a reasonable cost, and they expect it. There is an elective private health care system for those who want faster services and a larger range of care provider options, but even

government officials use the public system. While cost cutting is an increasingly higher priority among policy makers, there is no outcry for total reform of the system. One reason for this is that the health research scholars, educators, and professionals supported by the system articulate a high level of awareness of their responsibilities to provide high quality health care benefits to tax payers. The shared expectations of health care consumers and health care professionals provides a strong base from which greater collaboration and higher expectations can emerge. Scholarly analysis of the effectiveness of rural health programs in Australia recognizes that goals are increasingly focused on investment funding of health care rather than consumption (Liaw and Kilpatrick, 2002).

The most significant findings of this study reveal the differences in health care training. The Australian system has developed more inclusive collaborative training and care structures focused on healing management models that incorporate patients and members of rural communities. Research is focused on context specific models that are both flexible in response to change, and culturally sensitive enough to sustain local participation. The health care infrastructure incorporates more actors at lower levels of economic investment. This model provides greater pro-active health benefits at local levels and shifts expenses away from costly specialists and acute care. Health care system training in rural Australia development strategies increasingly focus on training actors at the bottom up at local levels rather than top down from urban centres. These models provide useful development policies and strategies for rural health in diverse global contexts.

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