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ORIGINAL ARTICLE

Revisiting rural healthcare access through Held's ethics of care

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Abstract

Access to healthcare and health seeking behaviours of rural people often hinge on the existing relationships between healthcare providers and (prospective) healthcare users. However, rich micro-level health professional-healthcare user relationships and the unique relational context of rural settings are largely missing from dominant rural healthcare access conceptual frameworks. We argue rural healthcare access conceptualisations require revisiting from a relational perspective to ensure future healthcare access policy accounts for the relational nature of healthcare in rural contexts. Ethics of care is a moral theory informed by feminism which rejects liberal individualist notions and emphasises interdependence. We used Held's ethics of care characteristics to examine Russell and colleagues' healthcare access framework and dimensions for rural and remote populations. This process revealed Held's ethics of care characteristics are only somewhat evident across Russell et al.'s dimensions: most evident in the acceptability and accommodation dimensions, and most absent in the availability and affordability dimensions. Future rural healthcare access frameworks need to pay further attention to the relational aspects of rural healthcare, particularly around the availability and affordability of healthcare, to bolster future efforts to improve healthcare access for rural people.

Keywords Healthcare access · Health professionals · Rural · Held's ethics of care · Rural relations

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Introduction

As one of many determinants of health, access to healthcare is an internationally wicked problem that has been conceptualised and considered from various paradigms (Solar and Irwin 2010). These conceptualisations involve many stakeholders including health services and populations (Aday and Andersen 1981), emphasise the balance between supply and demand for healthcare services (Penchansky and Thomas 1981), and highlight the context of access (Khan and Bhardwaj 1994; Ryvicker 2018). In other conceptualisations, access is viewed from the healthcare user experience and from the healthcare process of having healthcare needs and the perception of these needs, healthcare seeking, reaching, utilisation and healthcare consequences (Levesque et al. 2013). Generally, access to healthcare is considered twofold: the ongoing efforts by healthcare users to present for services, and health services identifying healthcare users with service needs within the broader healthcare process (Dixon-Woods et al. 2006). These conceptualisations reflect a range of social theories, including social stratification (Weber 1947), health belief model (Rosenstock 1974), self-determination theory (Deci and Ryan 1985), and paradigms of thought surrounding spatial distribution, human rights, social justice and equity. Common to these theories and paradigms is the focus on processes and interactions between people and their environment. However, largely missing from these is a focus on human relationships, reflected in the traditions of Parson's (1951) independent patient within the health professional-patient relationship, and health professional neutrality.

Human relationships are at the center of healthcare (Kerasidou et al. 2020). The relationship between health professionals and healthcare users is crucial to healthcare quality (Beck et al. 2002) and user outcomes (Gordon and Beresin 2016). Effective health professional-healthcare user relationships allow each party to understand each other beyond the healthcare user's presenting issue, and enable the development of trust, loyalty and positive regard (Ridd et al. 2009). A relational approach to healthcare allows the health professional and healthcare user to co-create the path of healthcare that potentially shapes the user's life, taking into account the complex context in which healthcare is performed (Olthuis et al. 2014). It focuses on the ongoing and open-ended process of care within health professional-healthcare user interactions, rather than on any single healthcare transaction (Mol 2008). In rural settings, the health professional-healthcare user relationship may be more complex or richer than in metropolitan areas due to overlapping relationships as a result of geographical and social proximity (Bourke and Sheridan 2008). The complexity of this relationship is particularly true for health professionals who live and work in the same region, compared to visiting health professionals. Within this context Bourke et al. (2012) provided a rural health framework which emphasizes the place-based interactions of rurally-located healthcare users and health professionals. Rural health, they argued, is a dynamic phenomenon related to geographic isolation, shaped and reshaped by factors in a systems schema, including the rural locale (the social relations and actions between local people) and local health responses (actions taken by local

service providers). Given the centrality of relationships to rural healthcare, it could be argued that relationships are central to rural healthcare access. Thus, rural healthcare access conceptualisations should capture micro-level, relational aspects of access.

Ethics of care theory provides a scaffold to explore healthcare access challenges innate to a rural context, such as confidentiality concerns, interdependent or dual relationships of healthcare providers and users, provision of equitable access with constrained resources and a generalist approach (Nelson et al. 2007). In this paper, we draw on ethics of care theory to critique one rural healthcare access conceptual framework (Russell et al. 2013), and to bring relationships to the fore within a rural healthcare access paradigm.

Access to healthcare in rural areas

The diverse access conceptualisations have informed international efforts toward ensuring all people have access to healthcare, and led to some global health improvements (World Health Organisation 2015). Access to healthcare in regional, rural, and remote areas internationally is highly dependent on a range of contextual factors including geography, population distribution, population needs and capacity, health system capacity, resourcing, and policy. However, we argue access to healthcare, particularly in high income countries, has been made more complex by a rapidly changing health system context. In the last 70 years, healthcare systems have shifted focus from acute care to primary health and chronic disease management due to: billowing healthcare costs leading to policy and system reforms resulting in healthcare privatization (Braithwaite et al. 2011); an emphasis on healthcare user right to choice (Tritter et al. 2009); and increases in life expectancy and chronic ill health (Holman 2020). Increases in life expectancy, chronic disease and hence healthcare utilisation is requiring healthcare users to adapt, particularly to develop sophisticated skills to navigate the health system (Ryvicker 2018). The nature of relationships between health professionals, healthcare users and the government has also changed, evidenced through the use of self-management models (Grady and Gough 2014; Ervin and Jeffery 2013), where healthcare users assume increased responsibility for gaining access to and navigating healthcare (Herd and Moynihan 2020; Tran and Gannon 2021). These shifts have resulted in the innovative use of available resources to promote healthcare access (Phillimore et al. 2019), and have emphasised the importance of relationships in healthcare for healthcare users and providers. Despite healthcare policy and system reforms, gaps persist between access to healthcare for people with and without adequate resources.

Location is an important factor determining access to healthcare (International Labour Office 2015). People living in regional, rural, and remote areas (referred to as rural people herein) have poorer access to healthcare than their metropolitan counterparts, and experience higher rates of illness, injury, disability and early death, even in high income countries such as Australia (Australian Institute of Health and Welfare 2019). Rural people travel further than their metropolitan counterparts to access care, and often receive care later than required, in an inconsistent

and inappropriate manner, or not at all (Australian Institute of Health and Welfare 2019; McBain-Rigg and Veitch 2011; Grant and Nash 2019; O'Callaghan et al. 2005). Lacking services in rural settings perpetuate the normalisation of self-reliant behaviours, and at times delay health seeking behaviours until emergency care is required (Page-Carruth et al. 2014). Access to healthcare and health seeking behaviours of rural people can therefore hinge on the nature of relationships between healthcare providers and (prospective) healthcare users (Ervin et al. 2014). Rural health professionals and healthcare users often hold memberships with the same community groups and networks. Consequently, they develop dual relationships where they know each other through and outside of healthcare (Endacott et al. 2006; Nelson et al. 2007; Crowden 2010). These dual relationships can support access to healthcare, for example, using informal personal networks and enabling continuity of care. However, dual relationships also challenge healthcare access, particularly around maintaining healthcare user confidentiality and managing health professional wellbeing due to additional expectations of accountability in the community (Bourke and Sheridan 2008). Healthcare access is consistently discussed in the rural health literature (Morgans et al. 2005; Sibley and Weiner 2011; Thomas et al. 2015), although very few healthcare access theories or conceptualisations have adopted a rural focus.

The rural healthcare access dimensions and conceptual framework offered by Australian rural health researchers Russell et al. (2013) is one exception. Russell et al.'s (2013) access framework for rural and remote populations was developed to support policymakers' evaluation of policy impacting rural healthcare access. They defined access to healthcare as "the potential ease with which consumers can obtain health care at times of need" (p. 62). Drawing on past conceptualisation dimensions, particularly Penchansky and Thomas' (1981) notion of service user-healthcare system fit and Khan and Bhardwaj's (1994) notion of spatial and aspatial access barriers, Russell et al. (2013) argued that the fit between health systems and population characteristics determines access across seven dimensions: availability, geography, affordability, accommodation, timeliness, acceptability, and awareness (pp. 62–65, see Table 1).

Russell et al.'s (2013) framework derived from these dimensions has informed the development of rural health workforce and service need indicators (McGrail et al. 2017), and has drawn attention to, and distinguishes rural healthcare access thinking from that relating to broader populations. The framework focused on influencing change at a policy level (Russell et al. 2013), where policymakers draw on their own (limited) knowledge and work with other policy actors within a complex, time-pressured policymaking environment to devise policies (Cairney and Oliver 2017). The framework has limitations in applicability to other contexts where healthcare access is influenced, for example, at the micro-level, where the health professional-healthcare user relationships and other relational connections within rural settings are at play (McCullough et al. 2020). Thus, it is difficult to apply Russell et al.'s (2013) framework to the day-to-day experiences of rural people accessing and providing healthcare, despite its intention to inform policy thinking and thus the day-to-day experiences of rural people. Further, the world has changed since 2013, when Russell et al.'s (2013) framework was published. Changes in societal expectations have

Table 1 Dimensions of rural healthcare access, adapted from Russell et al. (2013, p. 64)

Dimension	Definition	Example
Availability	The type and volume of service, according to population needs	Appropriate services, adequate resources
Geography	The proximity between healthcare providers and users, and the ability of users to travel this distance	Location, distance between home and health service and time to travel, access to transport
Affordability	The direct and indirect costs of healthcare, and ability of consumers to pay	Out of pocket costs, travel costs, socioeconomic disadvantage
Accommodation	The way the health system is organised, and the ability of the healthcare user to contact, enter and navigate the health system	Functionality, usability of service, referral and appointment systems, opening hours
Timeliness	The time until the healthcare is provided to users, according to urgency of need	Waiting times
Acceptability	The attitudes and beliefs of healthcare providers and users toward each other	Consumer perception, sociocultural understanding, trust between healthcare providers and users
Awareness	Communication of health service and health information to healthcare users and the user's understanding and knowledge to meet health needs	Health literacy

resulted in healthcare users becoming more vocal and organised about their human rights to access health services, particularly through information technology platforms (Schofield et al. 2019b). Russell et al.'s (2013) framework invites revisiting within this changed context.

Ethics of care

Normative moral theory, ethics of care, was informed by feminist theory and particularly second wave feminism around the mid-twentieth century (see Gilligan 1982). Ethics of care sits apart from other normative moral theories such as deontological, utilitarian, and justice moral theories that emphasise rights, justice, and societal wellbeing (Pettersen 2011). According to Held (2006), ethics of care rejects the liberal individualist notion that individual people are able to freely interact with others, or not, on their own terms, and instead emphasises how people live in relation to, and are interdependent with, each other. Pettersen (2011) argued the normative core value of ethics of care draws on the welding of the principles of non-maleficence and beneficence, albeit with the expansion of non-maleficence to permit occasional interventions, and the restriction of beneficence to prevent carer self-sacrifice. Applying an ethics of care lens to conceptualisations of healthcare access enables an exploration of the human-to-human, relational elements involved in healthcare access. Importantly, Held's (2006) ethics of care recognises the relevance of political and global contexts. Being able to transform the structures within which care takes place thereby reducing oppression, can be highly politicized, hence Held's (2006) theory can extend current healthcare access thinking, to enable that transformation to occur. In this theoretical analysis, we use ethics of care theory characteristics described by Held (2006) to explore the relational aspects within Russell et al.'s (2013) conceptual framework of access to rural healthcare. Held (2006) proffers five characteristics of ethics of care: (1) dependency on care/moral importance, (2) valuing emotions, (3) intertwined care, (4) public and private spheres, and (5) people are relational, interdependent and interconnected (see Fig. 1).

Dependency on care/moral importance

The first characteristic describes meeting the needs of people for whom we have responsibility to (Held 2006). This characteristic proposes that all people will require and be dependent on care, at least at some point in life. It places great significance on the relational processes involved with care giving, including the moral importance associated with meeting the needs of those dependent on care. This characteristic is visible in all of Russell et al.'s (2013) dimensions, although often not emphasised. The availability and geography dimensions are strongly correlated with the characteristic because they acknowledge the inequity in healthcare resources available to rural people and propose that location does not absolve policymakers of their obligation to provide healthcare. The moral obligation to attend to the needs of others is visible in the affordability

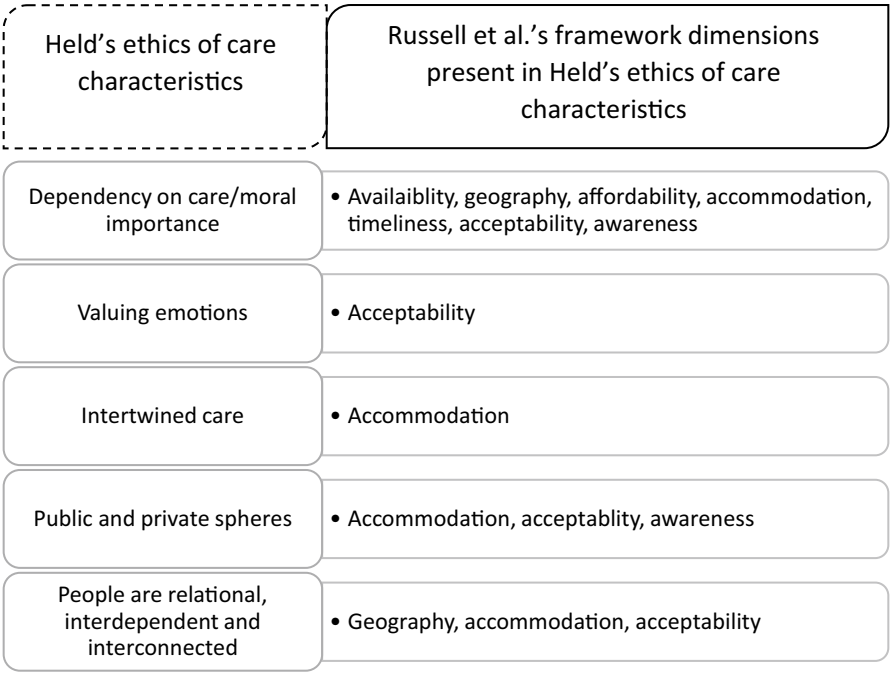

Fig. 1 Mapping of Held's (2006) ethics of care theory characteristics to Russell et al.'s (2013) rural healthcare access conceptual framework dimensions

and accommodation dimensions, through recognition that rural populations are often poorer and incur more direct and indirect costs by travelling to access healthcare, and may require additional health service flexibility and resources to access healthcare. However, Russell et al.'s (2013) accommodation dimension could be more explicitly extended in determining the moral obligation of health services to create accommodating services. Health services may need to adopt an ongoing flexible approach to meet this moral obligation, as the needs of healthcare users change over time.

The moral obligation to attend to the needs of others in the dimensions of timeliness, acceptability and awareness is evident through the emphasis on equitable timeframes for accessing healthcare, obligation for service providers to provide care in a culturally responsive manner and use of communication and language styles that support access. However, the awareness dimension could be expanded to acknowledge that healthcare user awareness is influenced by health literacy. Despite the moral obligations of care being visible in Russell et al.'s (2013) framework, the focus on governance excludes Held's (2006) ideas about caring work carried out by some stakeholders, particularly female health professionals on the frontline and their moral commitment and practices that support access to healthcare (Green 2012).

Valuing emotions

The second characteristic involves valuing emotions rather than rejecting them (Held 2006). Emotions such as empathy, responsiveness, sensitivity and even sadness or anger (for example, at injustice) are considered a necessary part of the caring process. In contrast, reason and rationalist deductive behaviour is considered inadequate to meet the needs of people requiring care. In contrast to Held's (2006) first characteristic, the role of emotions within accessing healthcare is barely visible in Russell et al.'s (2013) dimensions. The availability, accommodation, and awareness dimensions adopt rational, logistical and emotionally removed approaches to meeting the healthcare needs of rural people. These dimensions neglect the need to establish or use existing positive regard between health professionals and healthcare users to support access, negotiate service accommodation and leverage emotion to encourage rural people to learn about and access healthcare, despite the importance of health professional-user rapport in practice (Ridd et al. 2009).

Held's (2006) valuing emotions characteristic is absent in the geography dimension, where geography is viewed in a deficit manner and as a logistical barrier to overcome. This dimension could be extended to value emotions within healthcare by exploring the role of geography as a place where people live, have a sense of attachment and spiritual connection to, and feelings about (Devik et al. 2015), for example, emotions relating to feeling safe while accessing healthcare in place and with known providers. The affordability dimension also fails to account for the role of emotion in spending (or not spending) money on accessing care in rural contexts, where the impact of healthcare costs on other family members may be considered (Verde et al. 2004). The timeliness dimension could be developed to consider the role of emotions within timely access to care for both rural health professionals and healthcare users. Knowledge of poorly timed care is often shared through rural communities (Bourke and Sheridan 2008), although the implications of this process on general trust in rural health professionals is unknown. In addition, the emotional burden associated with poorly-timed care can profoundly impact health professional well-being, especially if the consequences for healthcare users are serious (Ozeke et al. 2019).

Acceptability is the one dimension where emotion within healthcare access is visible. Russell et al.'s (2013) description emphasises the subjective experiences that inform the attitudes, behaviours, and beliefs that in turn, inform decisions made by healthcare users to access care and by health professionals to support healthcare access. However, the acceptability dimension could further emphasise the role of emotions within health professional-healthcare user interactions that lead to services being trusted, acceptable and tailored to rural people's needs.

Intertwined care

Held's third ethics of care characteristic acknowledges the needs of the person caring and person needing care are intertwined, and are particular to those involved in the care process, rather than being altruistic in ideal (Held 2006). Caring involves

respecting, and not rejecting the claims of others involved in a relationship and valuing the relationship. These relational needs of health professionals and healthcare users and the nature of care are largely absent in Russell et al.'s (2013) framework, principally in the dimension of availability. The idea of harnessing existing intertwined relationships to deliver services is excluded in Russell et al.'s (2013) positioning of the rural health service delivery, which they see is primarily met through a skilled professional workforce. This dimension needs to be extended to acknowledge the intertwined relationships between rural health professionals and healthcare users and the capacity for other healthcare services to be delivered and accessed through these relationships, because these relationships offer a valuable means of providing services to rural people (McCullough et al. 2020).

The relational nature of healthcare is also absent in the geography, affordability, timeliness and awareness dimensions. Health professionals are referred to as "healthcare providers" in Russell et al.'s (2013) timeliness dimension, thus it is difficult to distinguish health professionals from the health service organisation. Affordability is conceptualised in terms of money and finances, rather than as a process of exchange in a broader sense, inclusive of rural health professionals, healthcare users and their families. In rural areas, affordability may involve a process of exchange that stretches beyond immediate access to finances, for example, to include a sense of belonging or commitment to the community. Healthcare may be made available because health professionals know rural people requiring care and target services to these people via outreach models, rather than via traditional mechanisms to identify healthcare users at socioeconomic disadvantage (McCullough et al. 2020). The awareness dimension focusses on healthcare users' need for healthcare information and fails to recognise the role of the relationship between health professionals and healthcare users in supporting this. Extending this dimension to highlight how intertwined health professional-healthcare user relationships support healthcare service awareness, and how other rural people with relationships with healthcare users, including Indigenous peoples and leaders within culturally and linguistically diverse communities, are well placed to increase health service awareness, is needed.

Finally, the intertwined nature of the health professional-healthcare user relationship is somewhat visible in the accommodation dimension, through the recognition that inadequate service accommodation can negatively impact the provider-healthcare user relationship. However, this dimension could be expanded to emphasise the essentiality of how intertwined relationships may help support accommodation in rural healthcare settings. Along this vein, actively involving health professionals in service processes that support healthcare users to use services, including referral and appointment systems, could be considered.

Public and private spheres

Held's (2006) fourth ethics of care characteristic addresses moral issues around 'public' spheres influenced by shared norms, values and politics, and 'private' spheres influenced by personal identity and open to those who have permission to enter, such as homes (Oxford Reference 2021). Dominant moral theories have

neglected addressing unequal and dependent relationships between those with and without power, in families and community groups (Held 2006). The notion of addressing moral issues around public and private spheres is somewhat visible in Russell et al.'s (2013) accommodation, acceptability, and awareness dimensions. For instance, the elements of a healthcare users' private sphere are highlighted (e.g., family and work, social commitments), although the role of rural actors within this sphere, their collective nature (Ehrlich et al. 2017), and how they impact healthcare access, are not described. Discussion of the power relationships between different stakeholders involved across the diverse rural healthcare settings, both public and private, is largely absent in Russell et al.'s (2013) framework, particularly in the availability, geography, affordability and timeliness dimensions. According to Russell et al. (2013), the healthcare user needs to meet the costs incurred, with no elaboration on the tension between public and private spheres, including the impact of next-of-kin relationships on financial resources to access care (Schofield et al. 2019a). Extending this dimension to acknowledge private sphere relationships and connections and their influence on access to care is warranted. Expanding the geography dimension to examine how dual relationships incorporating personal connections within the private sphere might facilitate development of local strategies to improve healthcare access. Further, the timeliness dimension could be extended to explore how access to timely healthcare in rural areas may hinge on 'who you know', where rural people may or may not have private sphere connections with rural health professionals (Bourke and Sheridan 2008).

People are relational, interdependent and interconnected

The fifth characteristic of ethics of care relates to the conception of persons as relational, interdependent, and interconnected beings (Held 2006). Within this, Held (2006) critiques the liberalist notion of individualism and emphasises Gilligan's (1982) notion about primacy of connection rather than of separation between people, communities and societies. The relational nature of persons is somewhat visible in Russell et al.'s (2013) geography dimension, where it is acknowledged rural people and healthcare providers are connected although often impacted by distance. This characteristic is implicit in the accommodation dimension, although the dimension does not consider established relationships between healthcare providers and users in rural settings (Devik et al. 2015). It is also visible in the acceptability dimension, through acknowledging the interdependent nature between healthcare providers and users is driven by the need for a satisfactory match between provider and user in order for successful care provision, and the potential impact of this relationship on healthcare access. However, it could be further extended to acknowledge the importance of socio-cultural connections within access to rural healthcare, and to emphasise the need for developing a diverse rural health workforce comprising people with different cultural backgrounds, ages, genders, and dis/ability.

The relational nature of persons is absent in Russell et al.'s (2013) affordability, availability and timeliness dimensions. In the availability dimension, rural people are not considered as interconnected groups beyond being geographically located

in the same rural location. Hence, this dimension fails to capture the rich interconnectivity of rural people. Availability needs expanding through acknowledging the interconnected nature of rural people and communities, and their capacity to self-determine service need. Widening the availability domain in this manner could challenge current formulaic thinking that identifies rural healthcare need based on population size and other characteristics (Doogan et al. 2018; McGrail et al. 2017), and strengthen the collective and multiple voices of rural people. The timeliness dimension could be extended to explore the capacity of intimate local knowledge within rural health service networks to reduce time delays in access.

Conclusion

The aim of this theoretical analysis was to use ethics of care theory to explore relational aspects within a rural healthcare access conceptual framework. Relational aspects of care, as viewed through Held's (2006) ethics of care characteristics are somewhat evident across Russell et al.'s (2013) conceptual framework, particularly in the acceptability and accommodation dimensions. This makes sense, given these dimensions naturally relate to the fit between healthcare providers and users. Yet, relational aspects of care are largely absent in the availability and affordability dimensions. Rural healthcare access frameworks need to be developed to capture the concepts around availability valuing the intertwined nature and existing relationships between healthcare professionals and healthcare users, and the relational processes underpinning the availability of health services in rural settings (Devik et al. 2015). This may encourage policymakers to develop strategies that foster generalist and multidisciplinary approaches allowing existing care relationships to offer a broader range of services to rural people. By valuing healthcare relationships, rural health professionals' work becomes valued, thereby ensuring rural health professionals have a sense of belonging within the rural communities they serve (Malatzky et al. 2020). Caring then becomes more prominent as a policy priority in promoting access to healthcare for rural people.

Similarly, future rural healthcare access frameworks could extend concepts around affordability to acknowledge the relational aspects of healthcare that underpin equitable access to affordable healthcare for rural people. This is essential if one is to acknowledge and value the relational ethics of care within rural healthcare. That is, rural people, whether prospective or current healthcare users, are not seen as individuals per se but within relation to others, and embodied, co-dependent and linked to their social environment and context. Strategies that emphasise the role of the care relationship and of the rural health professionals—particularly their knowledge of the healthcare user—need to be developed by policymakers. Such strategies would support healthcare user needs to be identified and facilitate their access to required services without enduring financial hardship. This approach might be difficult to implement while marketised approaches are becoming more dominant internationally, for example in Sweden (Kullberg et al. 2018), United States of America (Barker et al. 2019) and Australia (Hodgkin et al. 2020) because these approaches engage a for-profit mentality that could counteract the equitable provision of healthcare for

rural people (Quilliam and Bourke 2020; Kullberg et al. 2018). Adopting ethics of care-informed concepts around affordability in the Australian context would require policymakers to relax Medicare and other government health service funding eligibility and criteria constraints and/or provide flexible funding arrangements and service models that allow rural health professionals to deliver care in a place-based manner, as recently suggested by the National Rural Health Alliance (2022). By acknowledging the relational processes underpinning affordable healthcare for rural people, the need for discretionary funding use by rural health professionals becomes apparent, which in turn could lead to significant innovation and improvement in rural healthcare access.

Critiquing Russell et al.'s (2013) conceptual framework through Held's (2006) ethics of care theory revealed gaps in thinking around relational aspects of rural healthcare access. Rural healthcare access conceptual frameworks need to be developed that position the potential of rural relations as a sustainable solution to improving longstanding healthcare access issues in rural areas. Healthcare can be made more accessible to rural people, particularly more available and affordable, by harnessing rather than disregarding primacy of connection between healthcare users and health professionals in rural communities.

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Declarations

Conflict of interest None declared.

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