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Navigating and making choices about healthcare: The role of place

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ABSTRACT

In this paper, we examine the intersections between place and healthcare choice, drawing on Bourdieu's concepts of distinction and social space, and engaging with data from interviews with 78 Australians living in varied geographic locations. We find the status of an area is used to judge the quality of its healthcare services. Areas with high status are assumed to have better quality health services than areas of disadvantage. Where people live shapes the choices they make and their judgements about the status of a place. Moreover, having less choice is not necessarily problematic. Participants in regional and remote areas with less choice tend to report positive experiences with healthcare providers. Place can constrain people's ability to make good healthcare choices, yet participants have differing capacities to mobilise resources to overcome the constraints of place.

1. Introduction

There is now considerable evidence showing that place of residence is important for both health status and health outcomes (Cummins et al., 2007; Macintyre et al., 2002). Most research examining healthcare and place has focused on the physical characteristics or resources of geographic areas. For example, the number and type of health services provided locally, their geographic proximity to residents, or the level of movement of residents to access healthcare (e.g., journey time, access to transportation, ambulance services) (Field and Briggs, 2001). In such research, place is typically conceived as an area geographically bounded and fixed and, as a consequence, is applied as a variable indicating the effects of proximity and distance. Studies have also tended to focus on the effect of the socio-economic environment, showing differences between individuals with similar characteristics who live in specified socio-economic areas, or differences between urban and rural areas (Dixon and Welch, 2000; Meijer et al., 2012; Pearce and Dorling, 2006; Pickett and Pearl, 2001; Singh, 2003). Predictably, they demonstrate that living in urban and affluent areas (where health services are most concentrated), provides better physical access to healthcare services than living in rural and/or socially disadvantaged areas (Bourke et al., 2012; Haynes et al., 2003). However, the relationship between place and the ability to navigate and make choices between healthcare services is far from straightforward. Geography may be a critical factor for individuals living in very geographically isolated areas. Yet the choices people make about their healthcare are not only based on what is provided in their local area, and having access to a variety of services does not necessarily equate to better healthcare outcomes (Haynes et al., 2003).

There is a growing body of work from fields including sociology, cultural anthropology, human geography and social psychology which conceptualise place as an unbounded, relational, dynamic and fluid space (or network), and while individuals move between places, their activities and interactions *both* shape and are shaped by places (Cummins et al., 2007). Scholars sharing this theoretical perspective argue that social and cultural dimensions of place are important in people's choices about healthcare. Dimensions that have been studied include the social relations occurring within spaces, the socio-cultural features of communities (e.g., history, traditions, norms and values), the meanings ascribed to a place (Davidson et al., 2008; Stead et al., 2001), and how individuals relate to them (Castleden et al., 2010; Cummins et al., 2007; Curtis and Rees Jones, 1998; Macintyre et al., 2002, 1993). A small number of qualitative studies have examined the impact of both the physical and social context on individuals' experiences of health and healthcare. However, such studies have tended to focus on residents in one particular setting, such as a rural area (e.g., Bourke et al., 2012), rather than offer a comparative perspective. Davidson et al. (2008) argue that where you live shapes the extent to which you see place (including its structural and symbolic features) as important in producing inequalities in health. Currently missing from our understanding of the intersection between place and healthcare choice, is an analysis of how perceptions of one's geographical

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surroundings impact on one's judgements of its healthcare services and providers, and how these judgements influence one's choices.

2. Towards understanding the role of place in healthcare choice

Bourdieu theorises that a central dimension of human behaviour is the need to belong to a specific social group, and in doing so, distinguish oneself from those belonging to other social groups. Thus, humans are constantly making judgements, either consciously or unconsciously, about the relative worth of those around them. Moreover, all actions and practices are aimed, intentionally or unintentionally, at securing a place within a valued group. Bourdieu uses the concept of distinction, which he defines as 'a certain quality of bearing and manners, mostly considered innate' to describe the process by which groups of people develop tastes and preferences ('distinctive features') which mark or distinguish them from others in social space (1984 p. 466; 1996 p. 10). Bourdieu's (1984, 1989, 1996) various works describe the many aspects of social life in which these largely unconscious judgements about one's social placement are made through choices: whether these be through preferences in sport, religious affiliation, food and nutrition, or the wide array of consumer goods desired or purchased. Bourdieu theorises these choices as shaped by one's position or location within social space (Bourdieu, 1989 p. 19). Those located similarly tend to share similar dispositions and thus practices.

Bourdieu speaks here of social rather than geographic space, where social space functions as a symbolic space, a space of interacting status groups characterised by contrasting lifestyles (Bourdieu, 1989 p. 20). Symbolic space is not merely a space of differentiation however, for it is always organised, socially ranked, and hierarchical. Just as symbolic space is hierarchical, so too are the agents within all the social spaces. All agents are differentially rewarded according to their location, for each has differing economic and cultural resources (Bourdieu, 1989 p. 17). Bourdieu uses geographic space as an analogy to describe the organisation of social relations – the distance or proximity between groups. He insists on the many similarities between physical and social spaces, arguing that we are both social and physical beings, and that social space is often translated into physical space (1996 p. 12). This is evident, for example, when an individual without a physical residence is considered to be without social value, or where we see commonalities between the invisible social relationships of the city and the very stark material differentiation between wealthier and the poorer degraded areas of a big city (Bourdieu, 1996 p. 12). Bourdieu's work also serves as a timely reminder of the necessity of problematising the relationships between geographic location and social circumstances, telling us that geography is not just an indicator of status differences between neighbourhoods, but of the fundamental divisions in the field of power between residents and other actors.

3. Method

We designed the current study to examine these facets of place and its relationship to choice, and explain the relationship between human behaviour (choices made about healthcare services and practitioners) and the social context within which these choices are made. The study reported in this paper is part of a larger program of research into the navigation of the Australian healthcare system (Collyer et al., 2017; Lewis et al., 2017; Willis et al., 2016). Australia has a universal healthcare system, Medicare, which provides free or subsidised medical and hospital care to all citizens. In addition, individuals can choose to purchase private health insurance (PHI) to cover some of the costs of accessing health services privately.

Purposive sampling was used to select people from diverse locations (inner city, outer metropolitan, regional and remote), with differing experiences of healthcare, with and without PHI, from a range of age groups and socio-economic backgrounds. We classified these geographic areas using the Remoteness Index of Australia (ARIA +) (AIHW, 2004), an index of remoteness of places to service centres. Geographic areas are given a score (from 0 to 15) based on the road distance to service towns. These index scores are classified into categories. Major cities (ARIA + score 0–0.2) have relatively unrestricted access to a range of services. Regional (ARIA + 0.2–5.92) have restricted access to some services. Remote (ARIA + 5.92–15) have very restricted access to services. Major cities were further sub-divided into: inner city (participants who lived up to 10 kilometres from the city centre), and outer metropolitan (participants who lived 20 or more kilometres from the city centre) (Grattan Institute, 2015).

Following institutional ethics approval, in-depth, semi-structured interviews were conducted from July 2013 to July 2015 with participants to gain insight into their experiences of navigating the healthcare system, and what was important in making choices between services. Topics included experiences and use of public and private health services, perceptions of PHI, and the role of social networks in healthcare decision-making. Interviews lasted between 30 and 90 min, and were conducted with participants in their own homes, workplaces or other locations of participants choosing. These were audio-recorded, with participants' consent, and fully transcribed. Interviews were analysed thematically. A coding framework was developed by three researchers informed by initial ideas emerging from the data and relevant literature. This framework was revisited and revised throughout the data collection and analysis process. NVivo10 was used to assist with data management and organisation.

The 78 participants in this study, 28 men and 50 women, ranged in age from 19 to 90 years. At the time of interview, 48 participants had PHI and 30 did not. Participants had a diversity of illness experiences, with some describing very limited contact with healthcare providers; and others (n = 45) having on-going and extensive contact for chronic conditions. Of the participants, 18 lived in a location classified as remote, 15 in a regional location, 28 in an outer metropolitan area of a major city, and 17 in the inner city.

4. Findings

In narrating their experiences of health services, participants often referred to their own geographic location and the location of various health services. They told insightful stories about processes of social access and exclusion, and discussed their belief that some services are of greater value than others. Three key themes emerge from the analysis. First, perceptions of places and judgements about healthcare services are interconnected, for in many cases the status or reputation of an area is used as the basis for judgements about the quality of its healthcare services. Second, geographic location shapes the way participants make choices about their healthcare, and how they determine what constitutes good healthcare. Third, place can enable or constrain the ability to make (good) healthcare choices, yet participants have differing capacities to mobilise resources and overcome the (perceived) constraints of place. Each of these themes will be discussed in turn. In presenting illustrative quotes, pseudonyms are used in addition to a brief description indicating a participant's age, their PHI status and geographic location category.

4.1. Intersecting perceptions of place and perceptions of healthcare

For many participants, perceptions about places, and about the residents of these places, significantly influence their views about the quality of healthcare services and providers in those places. Health professionals and services located in areas perceived as socially advantaged, affluent and high status (typically inner city areas), are seen as good quality, while areas perceived as more disadvantaged (i.e., outer metropolitan and rural areas) are judged to have inferior healthcare services and practitioners. The reputation of an area is paramount when participants judge the quality of healthcare services. The ways in which the reputation of a locale (and its health services)