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Improving Access to Healthcare for Farming Communities: The Farmers' Health Project

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Summary of project

The Farmers' Health project was launched in July 1999 with the aim of bridging the gap between rural health care need and service provision in the farming communities of South Lakeland and North Lancashire. Far from enjoying an idyllic picture of rural living, the farming community is a population with significant unmet health needs and are at high risk of suffering from serious stress and mental health problems, occupational diseases and accidents.

It was important that the initiative was relevant to the needs of hard-pressed farmers struggling with falling incomes, food scares, multiple hazards, and mountainous bureaucracy. A Nurse Practitioner-led mobile outreach scheme was developed to provide flexible access to primary health care services by taking account of the geographical areas in which farmers operate, their time constraints and the pressures

presented by their work. A purpose-designed and equipped vehicle was used to offer access to the health service in places that the farmers frequented; mainly auction marts, but also agricultural shows and other gatherings. It also made farm visits by invitation.

Evaluation of the project has demonstrated that a mobile outreach clinic is an effective way of addressing the unmet health needs of an isolated community. However, the initiative was developed before the onset of Foot and Mouth Disease (FMD) in Spring 2001, which presented a range of new challenges.

Nature of the problem

Farming communities are by their nature isolated from mainstream services and have developed a culture of self-sufficiency and stoicism. Research has identified that farmers are a high risk group whose health needs are not being met and evidence suggests that their health needs are actually greater than in many other sectors of society (Gerrard, 1998). Against these clear needs was an observation by general practitioners and community psychiatric nurses that farmers were under-users of the health services.

Shared concerns about the health problems experienced by the farming communities were recognised among health professionals, social agencies and charities in the South Lakeland and North Lancashire during the 1990s. As well as the culture of stoicism, a lack of professional understanding about farm-related health problems (e.g. zoonoses and the effects of pesticides); geographical isolation and the organisation of primary care services were all identified as reasons why farmers and farming communities found it difficult to access health care services. There was particular anxiety about the effect on the mental health of livestock farmers during the drastic fall in income resulting from the BSE crisis and other market factors (Westmorland Gazette, 1998). But the concern was also more general, encompassing the vulnerability

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of farmers to the dangers inherent in their work from accidents, risks associated with the use of chemicals and chronic occupational conditions such as arthritis (Burnett, 1994).

In recognition of these issues and the findings of a study by Gerrard (1998) which called for an action research study to pilot a dedicated farmers' health scheme, a multidisciplinary Rural Mental Health Working Group (health workers, academics, agencies and charities) was formed in 1998 to explore possible ways forward. This group strongly believed that the physical and mental health problems among farmers were particularly, and perhaps uniquely, inter-related in the rural/farm context. Conventional healthcare provision was seen to be failing and an innovative approach was called for.

Development of Nurse Practitioner-led outreach scheme

Funding was secured for a two year development project that would incorporate both action and ongoing evaluation of a Nurse Practitioner-led mobile outreach scheme to test the feasibility and workability of such a model for improving the access to healthcare for a marginalised community. In July 1999, a Nurse Practitioner, a community nurse and two support workers, all with either a farming background or experience of life in agricultural communities were recruited. Whilst having bases at clinics in Carnforth and Grange over Sands, the nurses were empowered to work outside the traditional boundaries of health care and took health expertise and resources out to the places farmers frequented; auction marts, agricultural shows and farms by invitation.

Initially, much of their time was spent making the farming community aware of the service they could offer, building trust and breaking down barriers. They had use of a specially adapted high roof Transit van which acted as a mobile surgery equipped to carry out medical examinations and health screening. Confidential consultations without an appointment and free of charge were offered from the 'drop-in' vehicle. If referral to a GP or specialist service was indicated, necessary follow-up was arranged. The nurses were able to work autonomously in offering practical clinical care in the field, operating at the interface of primary and secondary care.

There was also a commitment to health promotion and accident prevention. It was considered important that

information concerning relevant health issues be shared with the farming community. An example of this work is the organisation of displays and talks in auction mart cafes on topics such as organophosphate exposure and correct lifting and handling techniques. The nurses also gave regular presentations to branches of the National Farmers' Union, Young Farmers and other farming groups, offering advice and information to raise awareness of health issues relevant to the farming community and providing first aid training.

Take-up of the service was slow initially, but usage steadily increased until the outbreak of FMD in February 2001, when the formal casework of the scheme was halted after it had been fully functioning for just 12 months. In this period, 277 clients were registered with the scheme. This represented 500 consultations in total. It is estimated that more than 2000 clients were also given informal advice.

Ongoing action and evaluation

A combination of quantitative and qualitative data were collected throughout the project to evaluate the scheme and inform the ongoing development. This data included:

- Regular activity reports and reviews by Management and Steering Groups
- Analysis of case notes (anonymous)
- Telephone evaluation
- Analysis of anonymised reflective diary entries

Working through the many practical developments and implementing change experimentally became a very important aspect of the action research and informed the recommendations which could be made for service development once the project came to an end.

Summary of clinic work findings

Overall the ratio of men to women was 5:1 with 70% over the age of 50. These figures suggest that the scheme reached the target group of older men likely to have health problems and who rarely attend GP surgeries.

Of those seen by the Nurse Practitioner, 40% presented with a specific problem, whilst 60% requested a 'check-up'.

Patients presenting with a specific problem – experienced a spectrum of conditions of which the largest group was musculo-skeletal problems (21%) including those resulting from trauma and arthritis.

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Cardiovascular (13%) and mental health (12%) problems featured highly, whilst there were a significant number (8%) of sufferers from chemical poisoning, especially organo-phosphates. Such a high rate of diagnosis of chemical poisoning indicates the likely influence of the nurses acquiring an expertise in this field.

Other conditions included prostate problems, previously undiagnosed cases of chronic obstructive airways disease, hypothyroidism, type 2 diabetes, and problems to do with severe osteo-arthritis, varicose veins and ankylosing spondylitis. Of the patients with specific complaints, 69% were not currently receiving treatment from their GPs.

Patients who presented requesting a 'check-up'

– were given a general health screen and an appropriate medical history was taken. Whilst 44% had no abnormal findings, significant health problems were found in the remaining 56%, with only 24% of these being managed by their GP.

The pattern of problems revealed differed from those which had been presented as a specific complaint. The largest groups were mental health (20%) and cardiovascular (18.5%) concerns, while musculoskeletal problems only accounted for 6%. This may be an indication of what the farming culture perceives that it is and is not, acceptable to suffer from. For example, a farmer may find it far easier to articulate a problem with chronic arthritis than with chronic depression.

As part of the 'check up', all patients were given health promotion and lifestyle advice. Flu injections were offered, and others were referred for financial help, or for counselling for unresolved problems such as bereavement.

The usefulness of health checks is often questioned, but there can be few communities within a Western society such as the UK where a 'check up' reveals significant health problems in 56% of those examined. The fact that the vast majority (85%) of patients were self-referred and willingly used the clinic van to drop in would seem to highlight the success of this sensitive 'user friendly' approach to offering health checks and the Nurse Practitioners' particular skills in carrying them out.

Conclusion

Evaluation of the project has demonstrated that a mobile outreach scheme is an effective way of addressing the unmet health needs of an isolated community. The particular health needs of farmers have been documented in depth, encompassing acute and chronic clinical conditions, mental health problems and occupational hazards such as accidents and pesticide poisoning. The relationship between clinical and non-clinical conditions and between health and social needs has been extensively explored. Farmers' use of the scheme increased steadily until the advent of the FMD epidemic.

Nurse Practitioner skills in a mobile outreach setting have been greatly developed, contributing to the national debate around this role. Such skills include the management of newly presenting undifferentiated clinical problems likely to occur in the target group, which formed a substantial part of the Nurse Practitioners' workload. It was recognised that time was needed to establish networks and communicate with other agencies when trying to solve problems which initially presented as clinical conditions. The location of the project at the intersection of primary, community and secondary care, coupled with the current (much criticised) medico-legal framework unfortunately prevented the Nurse Practitioner from using existing prescribing skills and experience.

The evidence from this project shows that this new model of providing health care to farmers, farmworkers and their families is effective, complementary to that of the general practitioner, and demonstrates a multi-agency approach to addressing the complex problems found in this community.

Recommendations

The principle of outreach should be established in rural health provision, as recommended in Section 4 of the 2000 Rural White Paper. The increased central support for outreach working in rural areas promised in policy documents must be implemented to enable such schemes, when successful, to move from pilot projects into mainstream services.

The role of the generalist in rural practice should be recognised as a nursing issue as well as a medical one. Nurse Practitioners have skills in identifying complex needs that include physical, mental and social problems, and rural health inequalities can be addressed by establishing NP-led schemes.

Nurse prescribing is integral to an outreach health service for a marginalised community. Urgent attention should be given to the legal framework currently inhibiting practice and undermining the effectiveness of initiatives that seek to redress inequalities of health service provision.

The role of Primary Care Support Worker is currently under-developed. In the rural context, this role often demands a level of expertise well beyond the current definition and career progression of this new form of health worker, and there should be ways of recognising such expertise.

Mental health problems/needs in the farming community need to be addressed in ways which are more culturally acceptable. Often, especially in isolated rural areas, problems are not identified until too late, or until the symptoms are severe enough for the Mental Health Act to be invoked. Such situations, with all their destructive potential, can be prevented by providing easier access to mental health workers who are familiar with the culture and problems of such communities.

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Further reading

A copy of the original full report can be obtained from the website: <http://www.fons.org/projects/>

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