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Exclusions within Healthcare in a Regional Australian Setting: Voices of the Hardly Reached

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Abstract

Health initiatives to improve inclusion of vulnerable people have tended to focus on a specific group with little evidence of improvement in health outcomes or attention to intersectionality. This study proposes that exclusion within health services can first be addressed through identification of common practices underpinning exclusion. A total of 119 seemingly hardly reached residents participated through individual interviews, small group interviews and focus group discussions. Undertaking a Derridean deconstruction analysis, the study identified three exclusionary practices commonly experienced by respondents when seeking healthcare in a regional setting. These are: i) language and communication, ii) assumptions and prejudice, and iii) exclusionary processes and systems. Although exclusion manifests differently between and within service user groups, the three identified forms of exclusion were commonly experienced by the hardly reached. Identifying and addressing common exclusionary practices in health services could focus inclusion strategies for health services with benefits to many service users.

Keywords: Inclusion, Equity, Patient Centred Care, Vulnerable Service Users, Health Professionals, Rural Health

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Introduction

It is widely recognised that exclusions occur in healthcare (Bond 2005; DeSouza 2014; Ford et al. 2018; Fraser et al. 2020; O'Shea et al. 2020; Polonsky et al. 2018; Sturman & Matheson 2020). In Australia, governments and health organisations have undertaken initiatives to improve inclusion, including trainings for working with specific consumer groups, drafting of diversity and inclusion action plans, diversifying health workforce through the recruitment of consumer consultants, employing Aboriginal Health Liaison officers and/or Bicultural workers, and changes to national accreditation standards and drafting policies for specific populations (Australian Commission on Safety and Quality in Health Care 2017; Australian Government Department of Health 2021; Victorian Government 2018a, 2019). Despite these attempts, studies have found that experiences of accessing and utilising health care tend to be negative for many groups with diverse social and cultural identities (Fredericks 2009; Henderson & Kendall 2011; Kang et al. 2020; O'Shea et al. 2020; Sturman & Matheson 2020; Temple et al. 2019). Consequently, Sokol et al. (2016; 2015) identified that some groups are 'hardly reached' by health services and these groups often have significant and complex healthcare needs. When a health service is unwelcoming and unsafe in a rural setting, the lack of choice of services restricts access to health care (Malatzky et al. 2018; Durey et al. 2013). Before barriers to health care can be addressed, first they must be identified, and this is best achieved by listening to and prioritising local voices of the hardly reached (Bourke et. al. 2021). This will assist health services to be better equipped to deliver quality, responsive and compassionate patient centred care in their local settings (Wallace et. al. 2020).

Literature surrounding exclusions from healthcare has focused on specific groups of the hardly reached - either culturally or socially defined - and the ways in which a specific group is excluded (Kang et al. 2019; Kelaher et al. 2014; Kneck et al. 2021; McNair & Bush 2016; Renzaho & Oldroyd 2014; Robards et al. 2019). As a result, inclusion initiatives tend to be limited to one group with an emphasis on their collective health need. This maintains focus on the cultural or social attribute of the group rather than the drivers and practices of exclusion within institutions. Further, such focus on homogeneity denies nuances, place-based differences, and intersectionality of identities by constructing ways of practicing that are deemed inclusive for all of one group and not others. Additionally, inclusion initiatives focused on specific groups can be information-heavy and lead to competition for priorities between different groups (Shannon et.al. 2022).

Because exclusion in health services occurs in multiple ways and impacts users of diverse backgrounds (Ford et al. 2018; Jennings et al. 2018; O'Shea et al. 2020; Smith et al. 2015; Temple et al. 2019), studies have highlighted how exclusions operate from the perspectives of such groups (Canuto et al. 2018; Gisselle et al. 2019; Henderson & Kendall 2011; Newman et al. 2021; Polonsky et al. 2018; Renzaho & Oldroyd 2014; Robards et al. 2019). Exclusionary healthcare practices and processes identified in some of the literature include racism, discriminating towards a person's and/or their support network's identity/ies and/or capabilities, negative interactions between service user and health professionals, navigating a convoluted and unclear healthcare system, cost of attaining care and other related expenses, and eligibility to access certain types of care. Categories of identity and/or social circumstances are the marked difference in highlighting these needs. These studies have been somewhat useful for services that are looking to improve engagement with groups that they have identified as hardly reached. This body of work has informed professional development activities, including upskilling staff in cultural competency trainings, and has also supported health and community services in other ways, such as developing action plans, audits and/or communication strategies to engage the hardly reached (Tervalon & Murray-Garcia 1998). Moreover, such approaches have supported and enabled specific services to start their journey of inclusion (Bourke et. al., 2021; Mitchell et. al. 2020).

On the other hand, this singular approach to improving inclusion for specific groups has been criticised within the scholarship of intersectionality (Collins 2019; Crenshaw 1989; Geordan et. al. 2022). Standalone training programs, whether it be cultural or diversity-related, do not sustain long term behaviour or practice change (Boutin-Foster et al. 2008; Chun 2010; Downing et al. 2011; Durey 2010; Johnstone & Kanitsaki 2008; Kumaş-Tan et al. 2007; Lie et al. 2011). Further, one-off, culturally specific training activities have failed to acknowledge the intersectionality that exists within groups and has instead essentialised and reinforced stereotypes that then further exclude service users (Berger & Ribeiro Miller 2021; Downing & Kowal 2011; Lekas et al. 2020, Tervalon & Murray-Garcia 1998). Such approaches place emphasis on the marked difference, whether it be cultural or social, of 'the other' which can manifest into implicit racism and discrimination (Downing & Kowal 2011; Lekas et al. 2020; Mitchell et al. 2020; Mohamed Shaburdin et al. 2020). Stipulating that constructs of colonialism, racism, sexism, ableism, nationalism and many other systems of oppression occur in interconnected ways, intersectionality offers an alternative way of seeing and doing inclusive work (Collins 2019; Evans 2019). An adoption of intersectionality creates opportunities for health services to look at ways in which multiple and overlapping oppressive structures can impact on their local community as well as an individual's access to services. Intersectionality provides practitioners with a lens that question how oppressive structures such as race, class, and gender, can and do exclude the most vulnerable (Collins 2019).

Whether it be through systematic processes or interactions between health professionals and service users, experiences of exclusion have led some to avoid, or in some instances, not access healthcare at all (Browne & Fiske 2001; Canuto et al. 2018; Levesque & Li 2014; O'Shea et al. 2020; Sturman & Matheson 2020). Underpinning exclusions are long held beliefs and attitudes towards people who have been oppressed and pushed to the margins. Using a Derridean deconstruction lens together with an intersectionality approach, this paper seeks to deconstruct the boundaries of singular identities to reveal the commonalities of exclusionary practices. Derridean deconstructionism views language and its associated meaning(s) as unstable, dynamic, and constantly evolving. For Derrida, language and its associated meanings play an important role (Derrida 1978) in health systems and settings that support it to include or exclude service users. Hence, this study explores the ways in which exclusion operates often at times under the intention of exercising inclusion. For a health service to embed and sustain inclusion within their service, they must first identify and deconstruct exclusionary practices that obstruct users' access to care (Bourke et al. 2021). Some studies have approached this by describing the exclusionary practices of health professionals (Anderson et al. 2012; Durey et al. 2011; Grant & Guerin 2018; Moore et al. 2014). However, to improve understanding of how exclusion operates, this study adopted an intersectional approach by centering perspectives of health service users from diverse backgrounds who are often hardly reached by health services in a regional place. Guided by Derrida's deconstructionism, this paper explores their experiences of exclusion and identifies common exclusionary practices when service users are seeking and accessing health care in a regional Australian location.

Methodology

This study presents findings of data collected from 117 respondents gathered as part of a larger project to explore the process of inclusion that rural, generalist health services can undertake to increase access for hardly reached rural residents (Bourke et al. 2021; Malatzky et al. 2018; Mitchell et al. 2018). This study received ethics approval from The University of Melbourne Human Ethics Committee (Ethics ID 1852528).

Data were collected in 2018 and 2019 from regional residents living in a shire[1] of approximately

[1] The shire's name not declared for privacy and confidentiality reasons.

70,000 people located in northern Victoria, Australia (ABS, 2021). Previous research on inclusion, exclusion and racism in this region has identified racism as a barrier to accessing healthcare (Bourke & Geldens 2007; Bourke et al. 2017; Tynan 2007; Tynan et al. 2013). Henceforth, local researchers gathered the perspectives of diverse rural resident's access to and use of their local health services to inform change within health services. Taking an intersectional approach, the study intentionally sought to recruit participants whom, historically, are hardly reached by health services, including First Nations Australians, immigrants, refugees, asylum seekers, new settlers, and young parents. Prior to data collection, researchers attended community group meetings as well as community events to meet and consult with groups and individuals. The team took the time to build relationships and engage people with the research project. Places visited included community hubs, Mens Sheds, tertiary education organisations, places of worship and community organisations. Some of these places were visited once or twice while others were visited multiple times. Furthermore, to recruit participants who may not access health services or be involved with any organisations, researchers visited public spaces such as playgrounds and skate parks. Additionally, four community researchers with one or more of the abovementioned identities as well as established networks within their respective communities were employed to promote the research, recruit participants, and in some situations, conduct individual and small group interviews. Co-researchers were provided with interview training and supported with debriefing sessions following difficult interviews.

Of the 119 participants, 76 participated in individual semi-structured interviews, 15 in small group discussions (2-3 participants) and, 28 in five focus groups of four or more participants. Two participants from two separate focus groups chose to participate further in individual interviews. Participants were of diverse cultural and social backgrounds, including 12 identified First Nations participants, 63 people from non-English speaking backgrounds including 12 refugee and/or asylum seeker participants, 24 young people, 15 members of the LGBTIQA+ community, and 43 parents. It is important to note that authors of this paper view social and cultural locations as fluid and that these can shift according to context. This is evident with many participants identifying with two or more of the identities specified above. Participants were asked about their experiences accessing and using health services, what inclusive and exclusive healthcare looks like, and their experiences (if any) when accessing four specific health services in the regional centre. All participants were given a Plain Language Statement – one of which was translated to a community language – as well as a consent form. All participants received a $30 gift voucher in recognition of their time and the deeply personal experiences they shared.

All individual and small group interviews as well as focus group discussions were audio recorded except for one participant that requested for notes to be taken during the interview. One community co-researcher conducted interviews and small group discussion in their community's language. All recorded individual interviews, small group and focus group discussions were transcribed verbatim. Transcripts of interviews and small group discussions conducted in a community language were sent to a specialist service for translation and transcription. These were subsequently checked by the interviewer for accuracy and appropriate meaning. Additionally, handwritten notes of the non-recorded interview were typed and added to the pool of data.

For analysis, transcripts were grouped by identity of the participant(s). However, it became clear that many of the exclusionary practices across the groups were similar and that many participants did not identify with only one identity. Positive and negative experiences with health services were identified and patterns of exclusionary practices were agreed by all authors (Braun & Clarke 2013; Lambert & Loiselle 2008). Following, a deconstruction analysis was undertaken to identify and unpack the common exclusionary practices shared by participants. Drawing upon Derrida's approach to deconstruction, the analysis highlighted that

although exclusions manifest differently between and within service user groups, three types of exclusionary practices were commonly shared by participants when accessing or utilising health services, namely use of language, assumptions, and exclusionary structures.

Findings

While there were positive stories of utilising health services, three exclusionary practices were identified that were commonly experienced by participants; namely: (i) the way language was used and/or the way care was communicated to them, (ii) assumptions and prejudices that manifest in various ways, and (iii) exclusionary structures in health service processes and systems. Identifying these three key exclusionary practices can pinpoint areas for health services to address as a way of increasing inclusion within their organisations.

Language and communication

A common exclusionary practice identified by participants was the way in which language was used and how it shaped the way healthcare delivery was communicated to them. Some spoke about the struggle to understand 'medical stuff' while others remarked that the language used by health professionals to explain diagnosis process and treatment excluded service users. By using language which excludes, the interaction creates an 'us versus them' dynamic whereby the health service and/or health professional remains the expert and the one to be listened to rather than consulted. A small group participant who spoke English as a second language described the unfamiliarity with medical terminology when filling out forms:

> Like you know how you put some medical terms and I said to her I don't even understand it and they gave me a form to fill. And honestly just something, I can't even understand what to, how to answer the questions (on the form).

Some found the language used in patient information forms and documents to inappropriately enforce categories. An LGBTIQA+ focus group participant commented that ...

> … Ms, Mr, X, Other. I don't believe that Other is appropriate, I don't believe that X is appropriate either. If you're a gender-diverse person, then you should have somewhere on that form to put in your title, put in your preferred name, put in what your pronouns are and stuff like that.

Participants from refugee and immigrant backgrounds described situations where lack of fluency in English created multiple barriers to accessing and receiving care. In addition to the difficulty in understanding staff and completing forms, some participants experienced further discrimination and exclusion when requesting an interpreter:

> They told us that we have been here (in Australia) long enough, and we should learn it (English) by now… I felt terrible.

These stories indicate how language excluded and reinforced health practitioners and services' position of power, rigid categories of identity, and judgements of the hardly reached. The language used, whether written or verbal, clearly impacted on a service user's experience of accessing and utilising care.

Participants also described different ways communication barriers played a role in their access to healthcare. Various barriers were interpersonal and included health professional's body language, facial expressions, and verbal communication. Some participants, regardless of their English proficiency, had trouble explaining their health issues. When encountered together with other exclusionary practices such as rudeness by reception staff or clinicians

portraying busy-ness or lack of interest, the resulting negative experience was further compounded, and for some, a precursor to avoiding seeking care in the future. An interviewee described how repeated miscommunication and negative interactions with health professionals regarding management of their chronic pain led to them feeling disillusioned and resulted in self-medication. Many described health professionals as not exhibiting empathy or understanding during their interactions ("they don't care") and felt their concerns had been dismissed. Others also described interactions with health professionals where they felt they were not listened to or that the health professional did not believe them, and they put it below:

> She (General Practitioner) told me that it's problematic when the patients think they know more.

In some instances, participants described being ill-informed about the details of the treatments they were being prescribed due to unclear and/or lack of appropriate explanation by health professionals. A First Nations interviewee recalled a time when they attended an appointment and felt confused by the doctor's referral because it was not explained why the test prescribed was necessary or how it was related to their health issue. The impact of these negative interactions resulted in many participants expressing feelings of confusion, helplessness, nervousness, and frustration; one focus group participant described it as:

> Pretty bad because they didn't tell me like what's the problem of me losing a lot of weight. That's why I get sick a lot because I lose a lot of weight. The fact that I eat normal food, I don't know what's the point.

In addition to the lack of explanation, there was inconsistency both in the explanation of a health problem and in health professional's choice of treatment. One small group participant described their experience regarding the inconsistency of treatments during their pregnancy:

> In my last trimester, when it's like, every two weeks, when I had one visit, the doctor told me, "Your baby size is large. You have GDM. You'll go for a C-section." I made my mind for C-section. After two weeks, I'm visiting a different doctor who says, "No, we'll try for the normal delivery"… so we have to decide it ourselves what we have to do. The doctor wasn't guiding us that... is the normal delivery better or the C-section better?

In some instances, interactions with health professionals became difficult and awkward when participants revealed their social identity and enquired on whether the service was safe for them. In a LGBTIQA+ focus group participants shared:

> When I rang to make the appointment and I said 'Is this an LGBTI inclusive place' and the person that I spoke to on the phone was like 'What do you mean by that?'

This experience suggests an inherent lack of understanding on the part of the health service of the need for service users to feel safe. Exclusion through communication was experienced across all groups, and while it manifested in different ways, these practices used language to demonstrate the power differential, to reproduce normative identities and to judge non-normative actions and health conditions.

Assumptions and stereotypes

Many participants spoke about the ways that health professionals made assumptions about them based on their physical, cultural, and social identities. They described feeling humiliated and losing trust in health services because of prejudices and assumptions they had experienced. An interviewee with a hearing disability described feeling humiliated and stopped

going to a medical centre after repeatedly informing the practice and General Practitioner (GP) that they would need to "come up and get me from the waiting room rather than yell my name." By ignoring a person's disability and assuming ability, whether intentional or not, the health service created an unwelcoming and unsafe environment. This is further compounded when a health service is in a regional place where concerns of privacy and anonymity are even more pronounced for service users (Bourke et al. 2012).

Some interviewees spoke about how health professionals made assumptions about their proficiency of the English language while others spoke about the assumptions that health professionals make when a family member steps in as an interpreter to assist a consultation:

> They think I put things into my own word.

Assumptions based on cultural background was a common experience of exclusion with two interviewees sharing similar stories where clinicians wrongfully assumed that they had gestational diabetes during pregnancy:

> Because it's women like you, meaning my size and my culture…they, you know, usually overweight and they have diabetes.

Such assumptions made of groups could arguably stem from evidence and approaches that categorise, generalise and simplify the experiences of service users from a culturally-specific background.

Some also spoke about how health professionals made assumptions about their health literacy based on their socio-cultural backgrounds. In a LGBTIQA+ focus group, a young person spoke of their encounter with a GP who was dismissive of their mental health issue and made assumptions about them seeking anti-depressant medication:

> I was like I know what depression is, I'll just say the actual thing that was going on. Then she (the GP) was like "Okay you're going to see a psychologist" and she was like "You don't do drugs (referring to anti-depressants); do you? You're not allowed to take (anti-depressants). You're only a young person. It's not that big of a deal. You're overexaggerating" about (referring to mental health issue).

Similarly, a young white male interviewee described how health professionals assumed that he was seeking prescription pain medication for recreational use when, in fact, he was attending the emergency department for care after sustaining injuries in a car accident. These assumptions seemed to be based on participants' social identity and/or presentation. Another interviewee shared their perspective that assumption-making occurs when health professionals are caught up in categorising service user's identity and 'processing' information:

> I know you need to process those things because you're a professional and you need to be like alright if some person mentions this and that, that means that (or) means this, could be a mental health issue here, this could lead to family violence… "This could be this, this could mean that", but can you just slow down on the processing and start being human?

Although health professionals receive extensive training on specific population groups and ways to meet their needs, this can become problematic, lead to assumptions, and reinforce the interpretation and categorisation of information into rigid categories. By not listening deeply and quickly making conclusions, health professionals risk making assumptions about their clients' health and wellbeing. This too was experienced by another interviewee, a young parent, who spoke about their interaction with a clinician:

> …I felt like they didn't understand me and what I was saying. I felt like they believed they knew what I was on about but they had no idea."

Another interviewee, a young mother experiencing homelessness, spoke about feeling ashamed of her mental health condition when overhearing health professionals talking and cautioning amongst each other to "be careful of her, she has XXXX.[2]

Participants of multiple and diverse backgrounds have experienced exclusion when health professionals made assumptions of their needs, the ways in which they presented or based on their culture. As a result, some participants reported that they have stopped or avoided seeking health care and some spoke of how they would only seek care in acute circumstances. These stories of exclusions through prejudice highlighted the various ways normative assumptions and homogenisation of specific groups can lead to exclusionary practices.

Exclusionary structures in health service processes and systems

Many participants spoke of feeling confused, unsatisfied, and disappointed when faced with multiple issues related to health service processes and systems. The expectations of users may not match the type of care or quality of care received, or the process involved in attaining care. Users with diverse cultural and social backgrounds often held expectations of care stemming from experiences in other countries and differing understandings of health and healthcare that may not align or be available within the Australian public health care system. In a focus group discussion with young people of colour, one participant suggested that the expectation gap exists because of the health services' familiarity with white cultural ways of understanding health:

> I don't know if it's to do with like the ethnicity – the Australians, but like I'm an ethnic person and they don't get exactly what I'm going through, so they just think, "Yeah". They see as you're probably going through something a white person would go through and think it's the same.

Some service users from immigrant backgrounds spoke about their preference of seeing a health professional of similar background. One interviewee relayed this by describing what they have heard in their community:

> You'll hear a lot of our Elders say, 'The doctors in XX (referring to a specific country) are better' and it's sort of like – I don't think the doctors are better, I think they just get you better.

This demonstrates how some hardly reached participants perceived the lack of safety they experienced when accessing care from local white health professionals. Moreover, it emphasised the perspective that white health professionals enhance whiteness in their practice, which in many ways excluded those from non-white communities.

In a focus group discussion with young people from the LGBTIQA+ community, a participant explained the constraints of receiving care where the body is not seen as a whole but as separated parts that required care from different specialists. For the participant, this practice does not address health issues from a holistic perspective and promoted specialised healthcare that was more expensive and disadvantaged service users thus further excluding and marginalising them:

[2] The condition not revealed to ensure full anonymity.

> You get one Doctor for one thing, one Doctor for something else, one… it might be your ankle it might be your knee. All separate Doctors and they're all joined together and they all affect the rest of your body. And wherever you go it's a specialist and it's always we only deal with this bit. We don't deal with that bit. And I say well how are you supposed to deal with the whole thing when they just split it.

The lack of holistic practice, particularly in rural healthcare, means that when a hardly reached service user has multiple health issues, it becomes more difficult for them to access the many services they need. This was evident in the story of a young parent experiencing multiple mental health issues in addition to homelessness. They experienced difficulty when they were continuously relegated from one service to another without appropriate referral and support. Left to navigate a healthcare system without adequate resources, hardly reached service users in need of additional support become excluded, disillusioned and resort to accessing care only in acute circumstances. By assuming that the health system is understood by all, health services can exclude those that are most in need of care.

Many participants also described the difficulty in understanding how to seek and access healthcare. Reasons for this varied with some commenting that each health service operates differently while others were concerned about the lack of information and clarity as to how the health system and individual services operate. This sentiment was shared by many, including those from non-English speaking backgrounds, new settlers and those who grew up in Australia. For many, issues centred around not understanding how the health system worked, the cost of services, waiting times and referrals, and which health professionals to see. Of particular concern was the experience of protracted wait times at the Emergency Department of their local hospital and the frustration and confusion about the reason(s) for these extended waits and how cases are prioritised. Some spoke about their experiences of waiting when suffering acute pain, experiencing complications during pregnancy that led to miscarriages, and of care not being prioritised for the vulnerable such as the elderly and children. A First Nations interviewee spoke of their community's past and current experience of waiting in a health service:

> I know that even going in for an appointment, a lot of our mob gets picked last. They will wait and they will wait. In the end, they will just get up and leave especially if they have got some real issues around their health and they need to get in really quick. If they are sitting in there too long, they will leave. And the problem is, they will just tell you to take a seat and that's it. Instead of engaging with you and communicating and checking in on you and seeing if you are all right, most of the mainstream institutions, medical institutions, just say to take a seat and make you sit there.

Some did not understand why they were told to go home or to see their GP with no further action taken at the Emergency Department, and believed they were given unsatisfactory explanations for their symptoms and treatment. There is an assumed understanding by health services that users know when, how and what order to access healthcare; not knowing systems of triage and others resulted in the hardly reached feeling frustrated, disillusioned, and not wanting to seek care.

Furthermore, a few spoke about how they were discouraged by staff from using the emergency services, with one participant saying that they were questioned rhetorically, "why are you here?" Many participants spoke about the circumstances that led to them needing to access the Emergency Department, including needing acute care after hours when medical centres were closed, being referred to the emergency department by the pharmacist or doctor, and not being able to access available appointments at medical centres because some health services

no longer accepts 'new' patients. The issue of waiting times was raised again within the context of accessing appointments with a GP, a specialist and/or radiology services. Health systems are not easily navigated and many of the participants were unsure when and which service to use, felt intimidated when using them and sometimes found it easier to feel unwell rather than attempt to access care. The lack of communication and clarity of healthcare protocols create an ambiguous environment that excludes the hardly reached.

Discussion

Access to healthcare relies on many different dimensions (Levesque et al. 2013). Literature on access to healthcare has focused on many of these dimensions as well as on the ways in which some groups experience exclusion. Too often this approach results in change in healthcare that assumes and universalises the needs of specific groups without addressing the underlying exclusionary practices. Adopting a deconstruction analysis (Derrida 1976), this study identified three practices of exclusion commonly experienced by service users of diverse and intersecting backgrounds living in the same regional place. Findings described in this study suggests that health services and professionals can address exclusions by being respectful when communicating and interacting with clients, avoiding assumptions, and providing genuine support and advocacy as clients navigate unfamiliar health processes and systems. Training in these three areas may have more impact for staff in health services than the many different trainings for specific groups that can lead to further assumption-making. These three areas are easier to grasp, more open and allow for practically implementing intersectionality. Hence, training around communication, assumption-making and navigating health systems has potential for inclusion (see Bourke et al. 2021).

Most participants identified with one or more intersecting identities, and many shared their, their family's and community's stories of repeated incidents of feeling unwelcome, disrespected, and disempowered within their local health service. Studies have found that those experiencing multiple disadvantages have poorer health outcomes (Bastos et al. 2018; Grollman 2014; Miller & Carbone-Lopez 2015; Robards et al. 2019). Rather than focusing on participants' identity/ies, this paper encourages local health services and professionals to adopt an intersectional approach when working towards an inclusive praxis. An intersectional lens offers a way of seeing how multiple forms of disadvantage can impact on how healthcare is accessed or (under)utilised (Evans, 2019). Reassuringly, intersectionality as a concept has gained momentum in recent years and is used in government and not-for-profit resources (Chen 2017; Our Watch 2021; Victorian Government 2018b). Adapted to local contexts, such resources can support a health service's journey towards inclusion.

Following the literature (Bourke et. al., 2021; Mitchell et. al., 2020) and state government mandates, health services usually have the best intention of working towards inclusivity. Inclusive or exclusive practices can determine whether service users, their family and/or support network have access to care and treatment. More often than not, service users are unwell when seeking and utilising healthcare. Compounding this with exclusionary practices identified in this paper, for some participants in this study, exclusion has had lasting impacts on their access and utilisation of health care. The difference between feeling welcome or being disrespected can potentially impact on future access to the service or healthcare in general. This study is limited to a specific regional location in Australia and deconstructs the experiences of rural residents accessing health care. However, a significant number of hardly reached residents shared their experiences although there is not room here to relay the many stories in depth. What is clear is that their experiences reiterated evidence in studies of racism, discrimination and literature that centres First Nations, LGBTIQA+, immigrant and refugee perspectives both nationally and internationally. This suggests that exclusion has some common underpinnings expressed by victims of exclusionary practices. Rather than focus on the 'other' or sociocultural attribute, focusing on challenging exclusion (communication,

assumptions and navigating health systems) could lead to change for many service users.

Conclusion

Exclusion in healthcare occurs in many ways, whether it is the practice of a health professional, health service or the broader health system in general. Although these manifest differently for diverse groups and individuals, the impact of exclusionary practices and processes means that local health services are perceived by those hardly reached as unwelcoming and unsafe. To support the improvement of health outcomes for those hardly reached, it is vital for local health services to identify and address points of exclusion as a first step in their journey towards inclusion.

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