Journal of Rural Studies 45 (2016) 157–164

Contents lists available at ScienceDirect

Journal of Rural Studies

journal homepage: www.elsevier.com/locate/jrurstud

Re-producing rural health: Challenging dominant discourses and the manifestation of power

Christina Malatzky*, Lisa Bourke

Department of Rural Health, The University of Melbourne, PO Box 6500, 49 Graham Street, Shepparton, VIC 3630, Australia

A R T I C L E I N F O

Article history:
Received 13 April 2015
Received in revised form
3 March 2016
Accepted 11 March 2016
Available online 6 April 2016

Keywords:
Rural health
Power relations
Deficit discourses
Subjugated knowledges
Normative healthcare models

A B S T R A C T

The field of rural health in Australia, and elsewhere, is known for its problems - the difficulties of providing accessible health services, recruiting staff and providing quality healthcare. This paper challenges dominant knowledge surrounding rural health as the product of power relations that work through discourse to construct rural as problematic, inferior and undesirable compared to its urban counterpart. In particular, the deficit discourses surrounding rural health are contested by considering the systematic comparison to urban health through workforce ratios, research and the challenges of rural clinical training. The commonly held perception that 'working rural will be disadvantageous to a practitioner's career' is also unpacked by examining the place of General Practice and rural practice in the medical hierarchy. Constructions of rural people as stoic and rural communities as inferior and homogenous are challenged, along with the notions that rural life is boring and rural practice monotonous. The paper calls for a re-framing of the field of rural health by promoting knowledge of its distinctiveness, the attractions of rural practice and the diversity of rural people. Such re-framing can challenge the dominantly produced discourses about rural health and shift the relations of power embedded in rural health's challenges.

© 2016 Elsevier Ltd. All rights reserved.

1. Introduction

The field of 'rural health' in Australia has been re-produced by media, policy and health disciplines as an area of need. The 'needs' in rural health include a lack of access to health services for rural residents, workforce maldistribution and poorer health outcomes for rural Australians (Australian Institute of Health and Welfare (2008); Blue and Wilkinson, 2002; Dixon and Welch, 2000; Hartley, 2004; Hemphill et al., 2007; Humphreys et al., 2002, 2008; Jian, 2008; Lagacé et al., 2007; Liaw and Kilpatrick, 2008; Mitura and Bollman, 2003; Ranmuthugala et al., 2007; Serneels et al., 2007; Sibley and Weiner, 2011; Smith et al., 2008). Literature has focused on the difficulties of attracting a workforce and developing a model of care to provide quality services to a small population in rural and remote locations (Australian Institute of Health and Welfare, 2008; Dixon and Welch, 2000; Hartley, 2004; Lagacé et al., 2007; Serneels et al., 2007; Sibley and Weiner, 2011). This evidence is used to call for more resources to address the pervasive issues in rural health, which has, in turn, stimulated political attention and constructed rural health as an area of need (Bourke et al., 2010; Wakerman and Humphreys, 2011; White et al., 2004).

Underpinning rural health's calls for more resources, improved health outcomes and a larger health workforce is the realisation of health inequities between rural and urban areas in multiple ways (see Smith et al., 2008). We argue that at the heart of these inequities is a power imbalance between rural health and mainstream 'urban health' (Bourke et al., 2012a). Little has been written about power relations in rural health (notable exceptions include Bourke et al., 2012a, 2012b, 2013; Durey, 2004; Farmer et al., 2012; Harding and Pilotto, 2010). This paper seeks to unpack some of the power relations underpinning commonly cited problems in rural health in order to highlight what is at the heart of rural health's challenges. Recognising the core reasons for rural health's problems can identify new and meaningful directions for change.

Foucault's concepts of power and discourse facilitate this analysis (see Ohman, 2010). We trace the relations of power operating through discourse to construct knowledge of rural health, rural health careers and rural communities. We focus on how particular perceptions of rural health come to be normalised through what is learnt. We further critique the normalising judgements that are

* Corresponding author.

http://dx.doi.org/10.1016/j.jrurstud.2016.03.005
0743-0167/© 2016 Elsevier Ltd. All rights reserved.

made about the field of rural health and rural communities through the subjugation of alternative knowledges (see Bell et al., 2013; Foucault, 1995). Our analysis concentrates on regimes of disciplinary power, which operate to create a particular kind of subject through a particular kind of governance (see Foucault, 1995; Foucault, 2002). We argue that re-constructing these discourses is necessary to attract a workforce and re-position rural health practice in health, social and political hierarchies.

2. Defining places and 'rural health'

In this article, rurality and urbanity are defined as socio-politically constructed categories, informed by historical and cultural processes (Carter and Hollinsworth, 2009; Panelli et al., 2009) as well as interactions through which power is exercised (Bell, 2007). From this perspective, places cannot be neatly classified into the rural/urban dichotomy; people and ideas, as well as finance and products, flow across space, between different places (Carter and Hollinsworth, 2009; Cummins et al., 2007; Heley and Jones, 2012). People may then be shaped by the context of 'multiple places' and places are, in turn, shaped by people who do not necessarily live in them (Cummins et al., 2007; Murdoch, 2006; Woods, 2009). How particular places are constructed through dominant discourses as well as their physical and spatial geography has an important impact on how places are defined (Bell, 2007). This makes places diverse, heterogeneous and understood differently in multiple arenas.

'Rural health', in this article, refers to a particular field of academic, clinical, public health, policy and advocacy work revolving around the health experiences and outcomes of people living in rural and remote areas, and the provision of healthcare in these places. In contrast to most fields of knowledge, rural health in Australia is a political construct (Bourke et al., 2013). It was created by government bodies as a means to allocate resources to non-metropolitan regions of Australia (Farmer et al., 2012; Wakerman et al., 2009), including academic departments, funding for education and training, support for rural models of service and trials of First Nation Australian health initiatives. Consequently, those working in rural health do not share any particular training or set of practices that unite them, resulting in an eclectic, disparate and geographically-dispersed personnel (Bourke et al., 2013).

3. Using Foucauldian concepts as tools for facilitating analysis

French thinker Michel Foucault's extensive works on the concepts of power and discourse are used in this analysis to analyse how particular constructions of rural health, rural practice and rural communities have become constituted and the implications of these constructions (Foucault, 1978; Ramazanoglu and Holland, 2002). Foucault characterised power not as an object that can be consciously 'possessed', but rather as an embedded part of social life: "its capillary form of existence, the point where power reaches into the very grain on individuals and touches their bodies and inserts itself into their actions and attitudes, their discourses, learning processes and everyday lives" (Foucault and Gordon, 1980). From a Foucauldian perspective, power is productive rather than repressive; it produces knowledge and discourse (Foucault, 1978, 1995; Gibson et al., 2008; Sawicki, 1991). Power is maintained because of its production and re-production (Foucault, 2002; Foucault and Gordon, 1980).

As effects of power/knowledge, discourses operate to structure what can be written, said and/or thought about social phenomena (Kuper and Whitehead, 2013). Power relations operate through discourse to guide and normalise particular perceptions and actions (Amigot and Pujal, 2009; Foucault, 1995; Foucault and Gordon, 1980; Herbert-Cheshire, 2000; Holloway et al., 2014). Normalisation is then a critical instrument of power, imposing homogeneity and defining what is considered good and bad, normal and abnormal (Foucault, 1995). By structuring the field of action most readily available, discourses direct individuals' ideas and actions (Foucault, 2002). Human actions, and their consequences, are manifestations of power relations (Foucault, 1995). Functions of discourse thus shape human experience (Scott, 1991) and produce subjectivities (Skeggs, 1997). The way a subject is constituted reflects a type of governance (Ohman, 2010) directed through discourse (Foucault, 2002).

A Foucauldian perspective is relevant to the analysis of power in rural health because it enables an examination of how various (rural) health actors, including academics, policy makers and practitioners, are disciplined to perceive and act in response to the construction of rural health. Using a Foucauldian framework illuminates how these perceptions and actions are manifestations of power. Yet power is enigmatic (Foucault, 1978; Sawicki, 1991). Resistance to relations of power also circulates in the social field, moving through alternative discourses, meaning that a reversal or modification of current power relations is always a possibility (Foucault, 1978; Sawicki, 1991). Using such a framework in this paper, we examine how a deficit perspective of rural health is normalised in wider public and policy discourses. Then we analyse how the discourse that 'working rural will be disadvantageous to a practitioner's career' governs the perceptions and actions of medical practitioners, and maintains the low status of the field of rural health. Finally, we consider how the discourses of rural inferiority shape perceptions of rural communities and rural life and contribute to the construction of rural practice as monotonous. These constructions, we argue, reinforce rural health as deficient compared to urban health, reinforcing its lower status within broader health, social and political hierarchies.

4. Rural health – a discourse of deficits

The most dominant discourse producing rural health is the deficit discourse (Bourke et al., 2013). The deficit discourse refers to the construction of rural health as deficient because it is compared to urban health as the norm (Bourke et al., 2010). Rural health is presented for what it lacks compared to urban rather than what it achieves in its own context. For example, rural health outcomes are noted to be poorer when compared to those of urban patients (Alston et al., 2006). Yet rural health outcomes could be applauded for almost reaching urban outcomes despite lower patient-health professional ratios and less access to specialist care (Smith et al., 2008). And clearly, there is diversity within rural health and urban health statistics that makes these comparisons simplistic (Bourke et al., 2013; Smith et al., 2008).

Foucault (1995) discusses the technologies of power/knowledge in an institutional context, which create "a whole domain of knowledge and a whole type of power". Such a domain can operate to destabilise the legitimacy of alternative discourses (see Biggs and Powell, 2001), which also circulate in the social field. Applying Foucault's (1995) technologies of power/knowledge to the dominant discourse of deficits in rural health, the normative perspective of health operates to undermine the legitimacy of alternative perspectives that seek to improve rural health systems from a (rural) place-based context. This is illustrated here through dominant discussions of rural health workforce, research language and agendas, and the challenges of rural clinical training in Australia.

Rural workforce is one issue considered deficient in comparison to urban and a problem that needs to be 'fixed' (Bourke et al., 2010, 2013). In the deficit discourse, the narrative pervades that ratios

Download English Version:

https://daneshyari.com/en/article/6545415

Download Persian Version:

https://daneshyari.com/article/6545415

Daneshyari.com