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"*Rural health is subjective, everyone sees it differently*": Understandings of rural health among Australian stakeholders

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ABSTRACT

In Australia, a diversity of perspectives of rural health have produced a deficit discourse as well as multidisciplinary perspectives that acknowledge diversity and blend in social, cultural and public health concepts. Interviews with 48 stakeholders challenged categories of rural and remote, and discussed these concepts in different ways, but invariably marginalised Aboriginal voices. Respondents overwhelmingly used a deficit discourse to plead for more resources but also blended diverse knowledge and at times reflected a relational understanding of rurality. However, mainstream perspectives dominated Aboriginal voices and racial exclusion remains a serious challenge for rural/remote health in Australia.

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1. Perspectives of rural health in Australia

Australia is one of the most urbanised countries in the world but also one of the largest in terms of landmass. While two-thirds of the population live in metropolitan centres and a further 23% live in so-called 'regional centres', the remaining 11% live in small and isolated places scattered across a large, arid landscape. Only three percent live in 'remote areas' but over half of remote residents are Aboriginal or Torres Strait Islander people (AIHW, 2008). The challenges of providing health services to small and isolated populations, many of whom have poor health status, are faced by those working in rural and remote health.

Australian health practitioners have responded to these challenges for many decades, however it is only in the past three decades that problems in rural health have been documented. This was largely in response to disgruntled rural voters who gained influence in key election outcomes. Australian policy-makers constructed a category of 'rural health' to represent the health of populations who reside in non-metropolitan locations (Australian Health Ministers Advisory Council, 1993, 2002). Australian localities were then categorised as 'rural' or 'remote' or something else based on geographic location and/or population size (ABS, 2003; AIHW, 2004; DHA, 2007) and these classifications have been the basis for allocating health resources (DHA, 2007). Acknowledging that rural populations were under-served and rural practitioners under-resourced, a range of specifically 'rural health' policies were developed which boosted funding, attempted to increase access to services and support to practitioners, and funded training, research and community programs in areas designated as rural.

These initiatives have increased the scope and range of rural health practice, models of service, and research and writing about rural and remote health in Australia as well as the number and type of health professionals, advocates and stakeholders in rural health. Unlike other health disciplines, where everyone receives training in core health practices, professionals have come to rural and remote health from diverse and unrelated fields. As such, there is no core to the field of rural health, no agreed upon essence, practice or goal, no common identity, teaching or introduction. Consequently, an increase in stakeholders and writings about rural health in Australia has led to diverse perspectives that are not well understood. This paper explores the perspectives of senior practitioners, advocates, policy-advisors and academics in Australian rural health and what underpins their perspectives. How they understand their field provides insight into how these stakeholders approach their work, the ways rurality and remoteness are embedded in their work and the discourses of rural/remote health that they reproduce.

2. Key discourses in rural health in Australia

Diverse perspectives have emerged from Australian stakeholders in rural health but there has been little analysis of these

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perspectives or the discourses that they are producing. We propose that a deficit discourse is dominant in rural health which normalises particular assumptions about rural health and has consequences for those living in rural spaces and/or working in rural health (see Foucault, 1972). Further, we propose that there is an alternative discourse embedded in rural health which has eclectically borrowed concepts from public health and social science to provide more detailed perspectives. Finally, we suggest that contemporary theories in social science, in particular a relational perspective of rural health, are relevant to, but largely absent from, writings in Australian rural health.

2.1. The deficit discourse

Stakeholders in rural health have advocated for more resources by identifying the ways in which rural health consumers are disadvantaged in comparison to their urban counterparts. It is widely acknowledged that Australians living in areas defined as rural and remote have poorer health status than residents of urban Australia (AIHW, 2008). Rural voters and practitioners have expressed concerns about shortage of doctors, health service closures and lack of access to health care. Australian and international research reinforced these rural health concerns, particularly in relation to remote health (AIHW, 2008, 2005; Andreasyan and Hoy, 2009; Bushy, 2002; Dixon and Welch, 2000; Hartley, 2004; Hemphill et al., 2007; Humphreys et al., 2002; Jian, 2008; Lagacé et al., 2007; Liaw and Kilpatrick, 2008; MacLeod et al., 1998; Mitura and Bollman, 2003; Pong et al., 2009; Ranmuthugala et al., 2007; Serneels et al., 2007; Sibley and Weiner, 2011; Smith et al., 2008). Political attention enabled state and national governments to develop specific policies and 'make-up' programs to address rural health 'problems'. This new found 'status' along with evidence of what rural areas/services lack compared to urban areas/services and the range of problems confronting rural health has reproduced a deficit discourse of rural health (see Bourke et al., 2010). What is heard are the repeated calls for more services, more staff and more funding along with a growing body of research listing increasing problems in rural health. Collectively, these have created a discourse that rural health is *itself* problematic.

This deficit discourse is even more prevalent in Australian Aboriginal and Torres Islander health. Research has identified high rates of poverty, morbidity and mortality, low levels of formal education and a 12 year shorter life expectancy (Carson et al., 2007). Highlighting the 'needs' of Aboriginal and Torres Strait Islander Australians, these mainstream indicators have labelled these populations as poor, unemployed, uneducated, chronically ill and dysfunctional. This historically and culturally contingent evidence has privileged mainstream indicators over the lived experiences and cultural insights of Aboriginal people, thereby continuing the process of colonisation that created many problems for Indigenous Australians (Baker, 2012; Smith, 2001; Wilson and Rosenberg, 2002). The problems faced by Aboriginal and Torres Strait Islander people, two-thirds of whom live in rural and remote spaces, have become *the problem of Indigenous people/cultures* (Baker, 2012).

2.2. Blending and borrowing perspectives

While the deficit discourse remains, within rural health, there are also discussions of heterogeneity between and within rural health and remote health, with messy, inconsistent and complex phenomenon at play. In these writings, concepts from public health, social science and Aboriginal health have been adopted to explain the complexity and diversity of rural and remote health that other forms of evidence have not been able to explain. However, these writings sit beside, rather than as a challenge to, the deficit discourse. Four examples are briefly provided here: (i) expanding definitions of health, (ii) including Aboriginal and Torres Strait Islander perspectives, (iii) distinguishing remote from rural health and (iv) inclusion of place-based approaches.

First, in rural and remote health there is often rejection of medical understandings of health (absence of disease) and incorporation of the social model of health (World Health Organization, 1978), the social determinants of health framework (WHO, 2008) and/or the Aboriginal definition of health: "…the social, emotional and cultural well-being of the whole community" (NACCHO, 2001, p.1). In drawing on broader perspectives of health, there is focus on the need for a primary healthcare philosophy emphasising prevention, health promotion, local empowerment and community partnerships (Wakerman et al., 2008). These broader perspectives of health are now commonly accepted (Thomlinson et al., 2004) but how they are theorised, applied and operationalised in rural and remote health policy, practice and research is less clear. Second, there is increasing acknowledgement of the differences between rural health and remote health, including differences in population, burden of disease, access to services, style of practice and cost/type of service provision (MacLeod et al., 1998; Wakerman, 2004). For some, remote health is understood as conceptually distinct from rural health (Wakerman, 2004). These distinctions have challenged a singular category of 'rural health'.

Third, there is a focus on improving wellbeing among Aboriginal and Torres Strait Islander communities. To do this, attention has been placed on cultural security, Aboriginal and Torres Strait Islander empowerment and community control, and/or the need to challenge the social determinants of health and dominant White healthcare systems (Anderson et al., 2007; ANTaR, 2011, 2012; Best, 2003; Carson et al., 2007; Coffin, 2007; Fredericks, 2010; Houston, 2002; Mitchell, 2000; NACCHO, 2012). The breadth of concepts suggest diverse pathways rather than singular directions and outcomes, but the lack of a singular approach is problematic for policy-makers and scientists seeking 'one' solution. Fourth, rural health has borrowed concepts from the social sciences to explain the local influence on health, including the concepts of place, community-of-place, social capital, empowerment and country. While traditional science has largely ignored local context (by aggregating rural Australia), those giving attention to 'the local' in rural health have described complex, variable and dynamic places (Bernard et al., 2007; Elliott-Schmidt and Strong, 1997; Farmer et al., 2012a; Fredericks, 2010; Macintyre et al., 2002; Panelli and Welch, 2005; Strang, 2005; Wilson, 2003). But these local studies, which identify strengths, power, resistance and diversity, tend to sit alongside rigid categories in rural health, albeit uncomfortably.

These broad definitions of health, diversity within and between rural and remote health, cultural perspectives and place-based concepts are woven through writings of rural/remote health, advocating for diversity and local control rather than a 'one size fits all' model. However, there is little explanation of how they are theorised, blended or debated within rural/remote health and how individual stakeholders integrate, apply or reject these concepts; the power relations are unclear.

2.3. Missing from discussion—a relational rural health

Lacking in writings about rural health are understandings of 'the rural' and 'the social' from contemporary geographers. Within rural studies, functional and political economy perspectives, dominant in rural health and remote health, have been critiqued for being "closed and deterministic." Social construction perspectives critiqued representations of 'rural' as simple, ordered, disadvantaged, traditional, White and culturally homogenous as discourses which do not reflect all rural places but privilege the position of a few (Murdoch and Pratt, 1993; Panelli et al., 2009).

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