

Beyond the Workforce Crisis: Developing Contextual Understanding of Rural and Remote Health

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Rural and remote health developed as disciplines by documenting a substantial body of research on workforce shortages, limited access to care, and inappropriate/alternative models of care, health outcome inequities and Indigenous health. The disciplines document a range of issues, mostly problematic, that have been researched in rural and remote health. However, these disciplines are lacking an understanding of how rural and remote health differ from urban health and what are the bases of these differences for practitioners and policy makers.

While most disciplines have common basics of what is taught to first year university students, the content of what is taught about rural and remote health is varied. Certainly, diversity is a strength, but the lack of conceptual understanding in both rural and remote health mean it lacks strategic direction, a consistent political message and comprehensive understanding. Understanding our disciplines would strengthen rural and remote health both academically and politically, and provide researchers, educators, policy-makers and practitioners with a basis for their work and decisions.¹ To that end, we have drafted a framework to provide such understanding, but this is a work-in-progress. We include it here for discussion and feedback, but understand it is only the beginning and perhaps one of many.

It is important to note the development of this framework has involved reviewing a broad range of literature on place, community, rurality, remoteness, Indigenous health, country, health, primary health care, social determinants of health, social capital, disadvantage, access to health care, remote health, rural health, health outcomes, power, social action and many other topics. These concepts have been discussed and debated by this team, discussed with our colleagues and presented both formally and informally. Once our framework is more developed, we plan to test the theory through a series of interviews with experts in rural and remote health selected from Aboriginal and Torres Strait Islander health, education, research, policy, practice and advocacy.

We propose that rural and remote health can be understood by considering five factors, which increase from micro levels to macro levels. It is noted that all are interconnected and interrelated with each other. These are based on both health research and social theoretical writings, and so are quite complex; only a summary is presented here.

Location: this refers to the geographic location which is the key difference between rural/remote health and urban health. With this comes the size of a town, its proximity to other, particularly larger towns, and the natural environment in which the town is located. In essence, it is the geography.

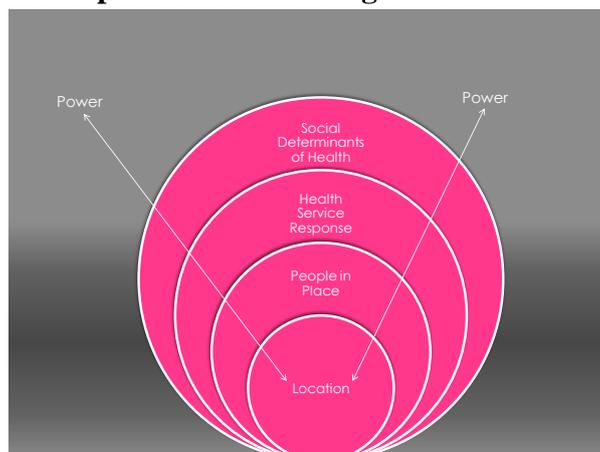
People in place: this refers primarily to the social interactions of people who reside in the rural and remote locations. These social interactions lead to social organisation of local communities, local economies, and all the social connections, actions and communication people have in and about the location.² This includes the meanings people attach to places, the connections they have with the local environment, the social networks both formal and informal, and the ways in which people live in their local community. It also embraces Aboriginal and Torres Strait Islander perspectives of country and connection to land, mother-earth, kinship, relationships, and obligation, acknowledging that these elements are inseparable.³ In relevance to health, it includes the health needs of the local residents along with their use of, response to and actions surrounding health issues.

Health services response: this is the response of the local health services to the health needs given their funding, political and cultural contexts. It is the ways in which health services and organisations respond to local health needs. A Primary Health Care approach is particularly effective in rural, remote and Indigenous contexts because it is designed and driven by the local community, it focuses on the needs, context and input of local residents, it includes health promotion and disease prevention, it is a multidisciplinary approach involving intersectoral action and it involves political advocacy.^{4,5}

Social determinants of health: refers to the broader determinants of health.⁶⁻⁸ These are factors that determine what makes people well and what makes people healthy. These include age, gender, hereditary factors, Indigenous status, lifestyle factors (alcohol and tobacco consumption, obesity, safe sex, etc.), housing and neighbourhood, income, poverty, occupation, country of birth and residence, mastery and so forth.^{7,8} These factors are shaped largely by the distribution of resources, money, status and power, and it is these broader social, economic and political inequities that shape the determinants of health.^{8,9}

Power: intersects each of the other four. By power we refer to the actions and decisions by individuals as well as the development, maintenance and reinforcement of power structures and hierarchies that have health consequences. Power includes the agency of individuals to act or resist; power includes the development and actions of groups to impact health; power includes the funding, political decisions, the impact of markets, economies and capitalistic systems; power includes the ways in which culture and other social processes shape our way of thinking, living, actions and choices. In these ways, the actions of individuals and the existing structures are interdependent and change together. Existing social structures influence human actions and these actions reinforce or transform the existing structures. This is applicable for the individual choice of smoking a cigarette as well as for decisions about funding. Power includes the restriction to act as well as the ability to change.^{10,11}

Figure 1: Conceptual understanding of rural and remote health



Together, these concepts articulate the key layers that provide insight into how rural health and remote health can be understood. The location and people in the place (including their interactions, meanings, social organisation, hierarchies, etc.) develop a health service response within the broader structures of society, namely the social determinants of health (including the unequal distribution of resources) and the broader social processes embedded with power relations (political, social, cultural and economic processes). The intersection of these provides an understanding of health in a particular rural or remote location.

We provide only an overview here as this model is a work-in-progress. We are eager for feedback so as to develop a sound and useful conceptual model for educators, researchers, policy-makers, practitioners and advocates in rural and remote health.

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