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Understanding rural and remote health: A framework for analysis in Australia

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ABSTRACT

People living in rural and remote areas face challenges in accessing appropriate health services, many of which struggle to recruit and retain staff. While researchers have documented these issues in Australia and internationally, rural health remains reactive to current problems and lacks comprehensive understanding. This paper presents a conceptual framework that can be used to better understand specific rural and remote health situations. The framework consists of six key concepts: geographic isolation, the rural locale, local health responses, broader health systems, social structures and power. Viewed through Giddens' theory of structuration, the framework suggests that rural health is understood as spatial and social relations among local residents as well as the actions of local health professionals/consumers that are both enabled and constrained by broader health systems and social structures. The framework provides a range of stakeholders with a guide to understanding rural and remote health.

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1. Introduction

Ruralsville is an Australian rural town three-hours drive from the next town, with a population of 1400 residents and an additional 600 people residing in the surrounding hinterland. Local health services comprise a hospital, a GP clinic and a community health centre, all of which struggle to maintain staff and fund necessary services. Local residents value their health services but worry about the constant difficulties of recruiting and retaining doctors and nurses, due to their onerous workloads and high on-call ratio. They are also concerned about the future of the hospital, which operates essentially as an emergency evacuation centre and aged care facility. All health professionals experience multiple roles, difficulty in 'distancing themselves' from patients, and high and complex workloads resulting from the poor health status of the community. Nonetheless, they enjoy many positive aspects of their work, such as a diversity of roles, autonomy, being able to address health problems innovatively, connection to the local community, witnessing the impacts of their care, and working in a collaborative team focused on patient care. Unfortunately the constant lack of financial and human resources continue to concern health managers, as does the

ageing of the local health workforce, difficulties of recruiting new staff, and isolation from specialist care, professional development and other health services key to providing whole-of-patient care. Meeting these challenges and maintaining quality local healthcare services depends largely on a few committed champions in Ruralsville and a very supportive local community.

This hypothetical scenario typifies Australia's rural and remote communities (Wakerman et al., 2008) and resonates strongly with rural communities in Canada, the United States, the United Kingdom and Europe. Globally many rural and remote residents face considerable challenges in accessing appropriate health services, many of which struggle to secure resources and recruit and retain staff. Much has been written about issues in rural and remote health, including workforce shortages, workloads, differences in health status between rural and urban residents, and appropriate models of health care for rural health (AIHW, 2008; Dixon and Welch, 2000; Hartley, 2004; Hemphill et al., 2007; Humphreys et al., 2002; 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; Wilkinson and Blue, 2002). Clearly, the geographical isolation of rural and remote towns in conjunction with their small population, small health service and small team of health professionals all contribute to the situation described above. But there are also significant structural issues beyond the characteristics of individual localities that impact on healthcare in places like Ruralsville.

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While rural and remote health researchers have investigated these and other rural/remote health problems separately, rural and remote health research has generally lacked a strong conceptual base. Rural and remote health have been largely reactive to specific problems rather than systematically and comprehensively considering rural and remote health and identifying points of connection and change (see Bourke et al., 2010a; Farmer et al., 2010). Further, rural and remote health research are multidisciplinary and do not stem from an overarching theoretical position. Although a dominant evidence-based, biomedical approach exists, concepts from the social (structural) determinants of health and political economy theory provide different perspectives. But rural and remote health researchers are not explicit in their theoretical position and their research in clinical, community and more macro settings is not connected. Consequently, rural researchers often confuse terms, meanings and assumptions, fail to effectively integrate diverse research findings, and lack a reflective, critical and conceptual basis to their work. Thus, a comprehensive understanding of rural and remote health that is not problem-based and acknowledges the interconnectedness of the micro and the macro levels is lacking (Bourke et al., 2010a; Farmer et al., 2010).

To address this lack of theory in rural and remote health, this paper presents a comprehensive conceptual framework for the analysis of specific rural and remote health situations in Australia. Importantly, this framework moves beyond detailed case-studies to outline an overarching framework which increases understanding of the diversity of rural and remote health. The goal of the framework is to provide rural and remote health practitioners, students, managers, policy-makers, researchers and others with a better way of understanding the context they are working in/for. The framework enables these professionals to observe their specific rural or remote situation and apply their observations to each concept in the framework, using structuration as a guide to understanding the concepts and their interconnections. For example, the framework could be the basis for teaching rural and remote health, it could move research beyond isolated problems and a deficit approach to a focus on inter-relationships, it could influence policy-makers to include multiple, interrelated factors in their decision-making, and it could bridge the debate between local and macro level change. While it highlights connections between rural and urban healthcare systems, it also identifies points of difference and provides rural and remote healthcare professionals with an understanding of the contexts, approaches and requirements of their work. In order to be utilised by rural and remote health professionals from widely differing backgrounds, the framework draws on and applies social theory with minimum theoretical jargon. As such, the framework does not develop new theory but applies different theoretical concepts and explains them here in practical terms. Without such a framework, rural and remote health research is likely to continue to produce primarily reactionary, often inappropriate and ad hoc strategies to solve problems (Bourke et al., 2010a). Before the framework is presented, background about how the framework was developed is summarised.

2. Development of the framework

The framework was developed by a team of researchers from diverse disciplines (geography, public health, medicine, health policy, social work, community development and sociology), who have worked as practitioners, academics and public servants in rural health and remote health for at least 20 years each. An iterative process consisting of a series of workshops and syntheses of relevant literature was undertaken. As a starting point, the

team identified four topic areas, namely defining and differentiating rural health, access to rural healthcare, community and community action in rural health, and rural health policy. For these and subsequent literature reviews, a systematic search of international and Australian peer reviewed published literature was sought through a range of databases. Then, 25–50 papers were selected for each topic/concept based on reviewing abstracts for their conceptual discussion and attention to rural or remote health. The material found in each topic area was read by all team members and a three-day workshop determined that another seven concepts warranted exploration. These were disadvantage, equity, place, community, social capital, primary health care and remote health. The literature was again read (selected using the same process) and the concepts were discussed and debated at another three-day workshop where selection of concepts began. The process continued over a total of nine workshops plus six teleconferences which discussed and critiqued the literature, the concepts, the interrelationships between concepts, and the authors' draft papers exploring these concepts. Between the latter workshops, further literature reviews were undertaken on definitions of health, Aboriginal writings, the Aboriginal term 'country,' models of care, health status, healthcare, social determinants of health, power, political economy approaches, post-structuralism and structuration. From this process, six key concepts and the theoretical lens were selected on the basis of their relevance, theoretical connection and cultural inclusion.

The framework has been developed specifically in and for the Australian rural and remote context. This is where much of the rural health literature has been developed and where rurality exhibits considerable diversity. However, the framework has extensively utilised the literature, concepts and theories developed internationally. As these concepts as well as many other rural health issues (workforce, access, social determinants, Indigenous health) apply internationally, the framework must be relevant internationally. However, the paper focuses on the Australian context, is inclusive of Australia's Indigenous people and draws on examples, issues and evidence from Australia. Therefore, while the framework was developed for Australia, the relevance of the issues, framework and analysis extend beyond these borders.

Further, to be inclusive, the framework adopts a broad perspective of health:

not just the physical well-being of an individual but ... the social, emotional and cultural well-being of the whole community in which each individual is able to achieve their full potential as a human being, thereby bringing about the total well-being of their community (NACCHO, 2001, p. 1).

This Australian Aboriginal and Torres Strait Islander people's perspective of health extends beyond just the "absence of disease or injury," includes "a state of complete physical, mental, and social well-being" (WHO, 1978, p. 1) and refers to health on a collective as well as an individual level (see Evans and Stoddart, 1990). It follows, then, that the term 'rural health' is used to not only indicate the health status of individuals and communities physically, mentally and socially in rural and remote areas but also the organisational, social and cultural arrangements that create the health of individuals and communities in rural and remote areas. This includes individual actions, the services provided, social networks and support, and local cultures. As stated, the framework is inclusive of remote as well as rural communities although the umbrella term 'rural' will be used henceforth. It is emphasised, too, that not all rural or remote locations are the same. The framework aims to provide understanding when applied to specific circumstances and does not intend to

homogenise rural health in different places. Rather, conceptual elements allow for diversity and guide understanding of a local situation.

3. The framework

This conceptual framework of rural and remote health comprises six key concepts: (i) geographic isolation, (ii) the rural locale, (iii) health responses in rural locales, (iv) broader health systems, (v) broader social structures, and (vi) power relations at all levels. The framework applies Giddens' (1986) theory of structuration as a theoretical lens to assist in defining the concepts, connecting the six concepts and understanding the interrelationships between structure and agency (Giddens, 1986). Using Giddens' (1986) terminology, this framework considers space boundaries (geographic isolation), social practices (rural locales and local health responses), systematic responses (broader health systems) and structural constraints (broader social, political, economic and health structures) all embedded with power relations. Integrating these concepts from disparate fields assists in explaining rural and remote health and the complex inter-relationships between health and context in rural settings. Before discussing each of the six concepts comprising the framework, an overview of the theoretical lens is provided to outline a broad perspective the authors have adopted in analysing rural health which has shaped thinking about each of the concepts and their interconnections.

3.1. The lens of the framework: structuration

Giddens' theory of structuration is applied to rural health to explain the connection between agency (what people do) and structures (established rules and understandings that enable and constrain repetitive actions) (Giddens, 1979, 1986). Structuration also connects what happens in one rural locale with broader structures and actions, simultaneously integrating health policy and community action as well as political decisions and rural service delivery/management (see Giddens, 1986). Further, structuration emphasises the importance of context (space and time) and power, as rooted in all social practices and embedded in both agency and structure (Giddens, 1979, 1986; Miller, 1992). Structuration is an appropriate lens because it simultaneously connects individual actions, community level responses and broader influences of policy, resource allocation, health systems and dominant discourses entrenched in rural health (see also Delormier et al., 2009). Other aspects of the framework draw from different perspectives while structuration connects them.

3.2. Structuration applied to rural health

Giddens argued that structure and agency are a duality rather than competing influences (Giddens, 1986; Miller, 1992) and that all social phenomena reflect structure and agency simultaneously (Giddens, 1986). Agency refers to people's "...capability of doing those things in the first place (which is why agency implies power...)" while structure refers to "the properties which make it possible for discernably similar social practices to exist across varying spans of time and space and which lend them 'systematic' form" (Giddens, 1986, p. 17). Giddens places structure as part of an individual's social understanding, where people act based on these social understandings (Miller, 1992).

Agency and structure are connected through a process of reflexivity whereby a person monitors their actions, intentions and character within their social lives based on what they know and understand, both about themselves and the context around

them (Giddens, 1986). Simply put, actions are based on an individual's interpretations of expected social action (the doctor role) in a particular time and space (at Ruralsville's GP clinic), resulting in a decision (conscious or subconscious) to conform to existing ways of doing things to reproduce existing social practices (listening, diagnosing and treating patients) or to challenge ways of doing things and contribute to producing social practices in an altered form (visiting schools to conduct education). As particular practices are undertaken repeatedly, they become what Giddens (1986, p. 25) termed structural properties, "medium outcome of the practices they recursively organise" extending across space and time (Giddens, 1986; Miller, 1992). These are then interpreted by other social actors (other rural doctors) as they decide to reproduce existing practices (stay in the clinic) or to challenge them (also visit schools), which contributes to maintaining or altering the structural properties. Therefore, structural properties influence the agency of the individual while the actions of individuals contribute to the re/production of structural properties—they are inseparable (Giddens, 1979, 1986). While the process sounds simplistic, social actors have substantial knowledge which they use in the production and reproduction of social interaction and situations (Giddens, 1986). In this way, structural properties can be constraining (dictating how things are done) or enabling (providing choices or clear ways of acting in a given situation) and are often both (Giddens, 1986).

Structuration explains how rural health manifests in geographically isolated spaces but is also the product of connections between actions in rural locales with macro level policies, funding, health systems, social determinants and a range of broader processes. What is happening in Ruralsville is not separate from what is happening at the broader, structural level. In this way, rural health is not solely produced in rural areas but through a complex process of relations in specific rural places and in more urbanised, social, cultural, political, economic and health arenas. This perspective is used to integrate six concepts into a framework for analysis. The concepts are presented individually to demonstrate how they contribute to understanding rural health but their interconnections are noted here at the outset.

3.3. Key Concepts in the framework

3.3.1. Geographical isolation

The starting point for understanding rural health is the geographical elements or the material aspects of rural (see Bell, 2007). A cardiac arrest on a dirt road 1200 km from a city and 200 km from a town with a small hospital accentuates the geographical dimension of rural health. Distance from larger centres alters access to health care for local consumers, the type of practice provided by local professionals (for example, generalist care, high levels of autonomy, overlapping relationships), the lack of appeal for 'going rural' among health professionals, and so forth (Bourke et al., 2004, 2010b; Hays, 2002; Humphreys, 2005; Liaw and Kilpatrick, 2008; Wakerman, 2004). This concept specifically refers to spatial isolation and proximity to other places and services that, in turn, relates to accessibility and social relations. But the concept does not suggest any particular definition or boundary of 'the rural,' nor does it suggest that rural is necessarily deficient in relation to the urban (see Bell, 2007; Bourke et al., 2010b).

The framework views significant differentiation in geographic locations, distinguishing variations in rurality, remoteness, isolation, environment and power (Humphreys, 2005; Lockie and Bourke, 2001; Wakerman, 2004). Most social theories have not included the importance of spatial contexts on social systems (Giddens, 1979) and many discussions of health do not prioritise contextual influences, thereby homogenising individuals and

contexts (McCubbin, 2001; Nilsen, 2005; Popay et al. 1998). Geographical isolation embraces location by virtue of where a particular place is relative to others without homogenising or assuming sameness. For example, being the same distance from a metropolitan centre does not assume locations are similar. In the case of Ruralsville, identifying its location relative to larger towns with more health services and routes of accessibility to these larger services (travel by road, ambulance, aircraft, etc.) is critical to understanding local responses to health care needs (what services are provided, whether, when and how to transfer, how to respond to emergencies, etc.).

Beginning with geographical isolation highlights the impact of spatial isolation on specific health needs and service responses. In this way, rural and remote health are much more than merely the practice of health in another location (Wakerman and Humphreys, 2002). Simultaneously, geography is inseparable to the human aspects, meanings and experiences associated with rural spaces (Bell, 2007; Gustafson, 2001; Healey, 1999; Nilsen, 2005) as outlined in the next section.

3.3.2. *The rural locale*

A rural locale is a particular “setting in which social relations are constituted” (Curtis and Rees-Jones, 1998, p. 646; see also Giddens, 1986) and where rural health outcomes occur (see Bernard et al., 2007; Breslow, 1999; Popay et al., 1998; Wilkinson, 1991). Several frameworks have outlined the inter-relationship between place and health (see Curtis and Rees-Jones, 1998, p. 646; Evans and Stoddart, 1990; Macintyre et al., 2002). It follows, then, that the compositional and contextual dimensions (Curtis and Rees-Jones, 1998, p. 646; Macintyre et al., 2002) that re/produce health needs, health status, health behaviours and health services in specific locales result from the complex interplay of social processes and relations that shape what people do in these places and how they connect to others. In rural locales, characterised by limited financial resources and strong local social norms, reproduction of particular behaviours can be constraining, thereby reinforcing health inequities over time.

Several concepts contribute to explaining the complexity of what happens in rural ‘locales,’ including community, place, social networks, social capital, culture and country. Rather than focus on one of these, this framework highlights social relations specific to a rural setting as the essence of this concept, embracing other concepts within it (Curtis and Rees-Jones, 1998, p. 646; Giddens, 1986). For example, writings on place describe social relations in rural settings as dynamic, social processes where multiple meanings emerge that are relative to and connected with other places. The rural place is defined by the meanings, boundaries and interpretations that people confer on a space (Cummins et al., 2007; Gustafson, 2001; Healey, 1999; Nilsen, 2005). Further, the concept of ‘community of place,’ understood as the interactions among residents of a rural locality as they meet their daily needs (Cheers and Luloff, 2001; Wilkinson, 1991), sits within the broader concept of rural locale. In the words of Giddens (1986, p. 118), locales correspond to “the use of space to provide the setting of interaction” which are in turn “essential to specifying its contextuality.”

The focus of this concept is the social relations, here viewed as the interactions and actions of people in specific rural places. Rather than define types of action or interaction, all social relations are included, such as conversations (between consumers), individual behaviours (jogging, smoking, consulting a GP), the actions of community groups (to fundraise for their hospital, develop support groups, sporting clubs or advocacy groups), relationships with the natural environment (through farming, mining, bush-walking), the networks between individuals that affect the flow of information and action in rural communities (a

local rotary club working to recruit more doctors), the stories among local residents about themselves and their space, and power relations within the community (who are the decision-makers and whose voices are acted on). A smaller local population means that residents of a rural locale are more likely to know (directly or indirectly) other locals, which decreases anonymity, alters networks and the flow of information, and can make some individuals concerned about conflict, privacy and sensitive issues (Wilkinson, 1991). Residents of particular rural locales develop specific means and styles of interaction and behaviour that over time reproduce to become distinct local norms that shape the actions and interactions of their residents in terms of health (Bourke, 2003; Cheers and Luloff 2001; Wilkinson, 1991). In Ruralsville, this results in a strong focus on sport and alcohol consumption, continued stigma associated with mental and sexual health, and Aboriginal people avoiding mainstream health services (see Belfrage, 2007; Bourke, 2003).

Nonetheless, what happens in the rural locale is not independent of broader social relations. Broader and historical cultures, industries and social hierarchies shape contemporary social relations in a rural locale. Further, the connections between local and non-local people are also important. Most rural residents develop networks both locally and non-locally and these networks influence interactions and actions in the locale with respect to health. Thus, social networks and ties within and outside the locale influence health in rural places (see Cheers and Luloff, 2001; Putnam, 1995; Wilkinson, 1991).

Any understanding of rural locales needs to be inclusive of Indigenous residents. In Australia, Aboriginal and Torres Strait Islander Australians make up a higher proportion of the populations in rural and remote areas (ABS, 2007) and have distinct cultural differences. While Aboriginal and Torres Strait Islander cultures are heterogeneous, their cultures tend to provide more holistic understandings. For example, Aboriginal “individuals identify places in both a geophysical and biophysical sense as part of themselves and identity is made up of the land–sea–spirit, culture and people” (Burgess and Morssison, 2007, p. 177). What becomes important are the many and varied meanings that relate to interactions characterising locales, including relationships with nature, spirituality and connection with land which are not well understood in Western contexts (Memmott and Long, 2002; Strang, 2005). The terms culture and country are used more frequently by Aboriginal and Torres Strait Islander people to describe their social relations and connections between people and between people and land (Cummins et al., 2008; Memmott and Long, 2002). These perspectives are included in the framework’s concept of rural locale.

Therefore, the social relations (knowledge, meanings, interactions, networks and actions) between people in the rural location where they live their daily lives are the focus of this section of the framework. In Ruralsville, this requires analysis of local interactions and actions, acknowledging the meanings held about the locale, the composition of the population, the interactions and networks of residents and the local norms and patterns of behaviour, all of which both enable and constrain health. Understanding actions to promote health behaviours, recruit health professionals and secure funding along with exclusion of Aboriginal people from employment and social participation, an ageing population and a declining economy in Ruralsville are all relevant. In addition to the social relations of local people are the local health responses that shape health care and actions to address health in the rural locale.

3.3.3. *Health responses in rural locales*

Health services, programs and actions, however formal or informal, are re/produced in specific rural locales to support the

needs of local communities. They manifest as a range of different entities, including the local health clinic, general practice or hospital, the local community health centre, the Aboriginal Community Controlled Health Organisation and allied health services. There are also regional health authorities and professional support organisations as well as multiple specialist programs, such as maternal and child health and drug and alcohol programs. Other activities may include community services (meals-on-wheels and home help), consumer groups, disease prevention and health promotion projects, and hospital auxiliaries and fund-raising committees.

While shaped by the broader health system, local health programs, services and activities are produced by actors (individuals and groups) based on their actions, perceptions of need and available resources. Individuals and groups act to improve health services and programs, albeit within structural constraints of funding and broader health system protocols as well as local norms and patterns of interaction. Some develop innovative models (Wakerman and Humpreys, 2011) while others struggle with health professionals and communities who are resistant to change. In Ruralsville, for example, the local rotary club chapter assists in recruiting doctors, the hospital manager has secured increased funding and a local consumer sits on a national rural health committee while Aboriginal health remains largely neglected by mainstream services. Consequently, local rural health responses vary in types of governance, management, level of autonomy, models of care, the needs of service providers (given recruitment/retention difficulties) and local staff, infrastructure and culture. This results in heterogeneous organisations that both enable and constrain health care, practice and change in different ways.

In Australia, there is now a range of models of care which are fit-for-purpose in rural and remote Australia, including the Royal Flying Doctor Service (Hill and Harris, 2008) and other fly-in, fly-out emergency and medical care services, Aboriginal Community Controlled Health Services (NACCHO, 2001), GP-based hospitals, outreach services for community, mental health and allied health services, online support services, and those targeting specifically rural issues, such as drought, flood or bushfire. Regardless of differences, most adopt a primary health care approach, which has been identified in Australia and elsewhere as particularly appropriate for rural health services (Hartley, 2004; Hill and Harris, 2008; Wakerman et al., 2008, 2009). A primary health care approach is consistent with a focus prioritising local context and the different types of health practices characterising rural health (Wakerman, 2004). This includes commitment to improve equity in health outcomes, working towards a people-centric model of care, involving consumers in planning, and reform in public policy (WHO, 2008a). This approach is suited to a context where health care practice is generalist, locally driven and involves less hierarchical management structures (CHETRE, 2006). Importantly too, a primary health care philosophy is consistent with Indigenous perspectives, which are holistic, focused on prevention/promotion, patient-centred, grass-roots, based on community consultation, linked to broader political issues and multidisciplinary (NACCHO, 2001).

While most responses are primary health care, the framework highlights the importance of understanding differences in local health care responses between rural locales, and identifies the need to understand the actions of local professionals and residents in these responses. These responses are linked to broader structures, including social structures and broader health systems.

3.3.4. Broader health systems

Broader health systems both constrain and enable local health responses and the actions of rural residents. For Giddens (1986), a

system refers to distinct social practices reproduced in an ordered way to shape how health is understood and acted upon. Health systems "...stand out'... because definite structural principles serve to produce a specifiable overall 'clustering of institutions' across time and space" that focus on health (Giddens, 1986, p. 164). Because "a health system consists of all the organisations, institutions, resources and people whose primary purpose is to improve health" (WHO, 2011, p. 1), rural health systems reflect a complex interaction of health policies, funding bodies, advocacy groups and professional organisations (such as the Australian Medical Association), the collective voice of rural consumers, political debate and decisions, media representation, and numerous structures that influence rural health priorities, decisions and funding.

Importantly, in Australia and elsewhere, macro level health systems tend to disadvantage rural residents. Despite universal health care (Medicare), the undersupply of health professionals in non-metropolitan areas has resulted in less health expenditure in rural areas under the fee-for-service funding arrangements, except in some services in the Northern Territory where funding is 'cashed out.' In addition, government subsidies of private health insurance further disadvantage rural populations where private health care is generally not available. Aboriginal and Torres Strait Islander people are even further disadvantaged (Coffin, 2007; Houston, 2002). Although Aboriginal Australians have called for mainstream services to be institutionally secure for their people (through cultural understanding, actions to ensure Aboriginal people are safe, and policies and procedures that guarantee culturally appropriate processes) (Coffin, 2007), evidence suggests that many mainstream health systems are not 'culturally secure' for this population (Coffin, 2007) and this in turn results in less utilisation of health services (Belfrage, 2007; Houston, 2002). In response, many Aboriginal and Torres Strait Islander communities have developed their own community-controlled health services based on their holistic philosophies of health (NACCHO, 2001).

Consequently, largely politically-driven macro health systems shape the services, funding and health opportunities in places such as Ruralsville. The health responses in conjunction with social relations in a particular rural locale are not only influenced by broader health systems but also by broader social structures which shape social life, culture, economies and political arenas.

3.3.5. Broader social structures

The framework integrates other broader social structures with health systems and the actions and interactions of people related to health in rural locales. According to Giddens (1986) social structures are the mediums which reproduce similar social practices across time and space, including expected behaviours and social understandings. That is, existing rules, resources, relations and social organisation maintain the reproduction of particular political, social, cultural and economic processes (Giddens, 1986). There are multiple structures at the societal level influencing how rural locations are understood, the knowledge and cultures of rural residents, the roles and actions of local health professionals and the broader health systems. Rural residents, like other Australians, are strongly influenced by Australian cultures, popular culture, national media, global information, political discourses and language (Pritchard and McManus, 2000). Broader historical, social, political and economic structures manifest in Australia to privilege income, Western cultures, medical paradigms, the capitalisation of health care and urban-biased policy, and these contribute to rural health circumstances. Key to this framework is that the societal level structures are interrelated with rural health.

Of particular importance is the reproduction of processes that create/perpetuate social structures which determine unequal

health outcomes, known as the social determinants of health. Health “circumstances are shaped by the distribution of money, power and resources at global, national and local levels” (WHO, 2008b, p. 1). Consequently, the “conditions in which people are born, grow, live, work, and age” are the result of structures which “together constitute the social determinants of health” (WHO, 2008b, p. 26). While these patterns of disadvantage typify rural and urban areas, addressing social inequities in rural locales can be difficult given small populations, isolation and lack of financial and human resources. The most frequently identified social determinants of health outcomes are income, education, housing, work status and type, in/exclusion, access to social resources and health services, and a range of environmental factors (Marmot and Wilkinson, 2006). In Australia, Indigenous status, regardless of rural or urban residence, is a major determinant of health, resulting in 10–17 years shorter life expectancy (AIHW, 2010; Carson et al., 2007). While some believe that Indigenous status along with other class-related criteria (income, education, occupation, access to services, etc.) explain the poorer health status in rural contexts, it is unclear whether or not rurality or remoteness are themselves determinants of health outcomes (see Marmot and Wilkinson, 2006; Smith et al., 2008). The unequal distribution of resources and opportunities in rural areas of Australia (compared with metropolitan areas) is evident, including health and education services, jobs and income, and political pressure and attention (Beard et al., 2009; NRHA, 2010; Wilkinson and Blue, 2002). At the same time, there is ample evidence demonstrating the higher costs associated with providing goods and services in rural areas (Wilkinson and Blue, 2002). In short, the existence of major structural constraints results in systematic inequalities in health across rural Australia.

Paralleling Australia's high level of metropolitan residency, a dominant urban culture has tended to stereotype rural areas as backward, in the ‘middle of nowhere,’ homogenous and politically conservative (Lockie and Bourke, 2001; Pritchard and McManus, 2000). Rural as a whole is often viewed as an undesirable residential location, particularly for professionals. In reality, there are a myriad of cultural, historical, social, political and economic knowledges that construct perceptions of social life in rural locales. These distinguish outback mining towns, coastal towns, towns in the tropics, remote Aboriginal communities and rural locales near larger population centres. Therefore broad social understandings, perceptions and myths about rural life impact on the recruitment of health professionals, political debate about rural health and changing approaches to rural health.

This framework describes how broader social structures, in particular knowledge, culture and the social determinants of health outcomes, are integral to towns like Ruralsville, primarily to reproduce particular behaviours, actions and choices that often serve to reinforce existing structures and further constrain opportunities for groups with low socioeconomic status to improve their health. For example, the Aboriginal residents of Ruralsville maintain low social status, have lower incomes and are socially marginalised which all lead to poorer health status.

3.3.6. Power

Power is a central element of social life (Giddens, 1986) and is reflected in differentiation with respect to rural health services, care and outcomes. Power is defined here as “the capacity to make a difference, to transform something from one state to another,” either as individual action or as an outcome in a larger system (Miller, 1992, p. 90). Power is inherent in all interactions, but is also a resource used by individuals, groups and collectives in their actions to create, maintain or challenge systems and current ways of doing things (Giddens, 1979). Power is the means

of getting things done, resisting change as well as forms of control (Giddens, 1986). Power is both constraining and enabling at the structural as well as at the individual level (as agency) (Giddens, 1986). For example, rural health is constrained by lack of funding, by community and cultural norms that reinforce the social determinants of health, in global markets that determine the viability of agricultural/mining enterprises, and in stereotypes about rural areas. Power can also be enabling in rural health where the actions and leadership of individuals can change models of care, alter approaches to practice, develop innovative projects, or, at a structural level develop improved health systems and/or demand political recognition and resourcing. Existing political, economic, cultural and social structures provide established systems of action, ways of communicating and ways of knowing which are simultaneously constraining and enabling. Therefore, power exists at multiple levels, leading to change as well as maintaining the status quo, and is an ingredient of all actions and interactions.

Power is a particularly important concept in this framework because it explains why rural health is heterogeneous in different locations and how change is achieved/restricted. Power is entrenched in the actions and interactions of individuals and groups, and reflected in structural constraints (such as funding, inequities, social determinants) and enabling processes (such as new models of, or funding for, rural and remote health initiatives) (see Giddens, 1986). It underpins each of the concepts and moulds how each concept manifests both socially and spatially. For example, power is part of the process of attributing meanings to rural locales (viewed as ‘sacred’ or ‘the middle of nowhere’); power relations re/produce community norms and expectations of behaviour, power enables action and agency by local health professionals, power operates throughout health systems (in processes that determine what is funded and what protocols are used), and is the basis of social structures (defining social status and dividing low and high income, Aboriginal and non-Aboriginal). Power intersects these concepts by being embedded in all social relations and is continually negotiated to determine which processes are adopted and re/produced.

3.4. The framework in review

What distinguishes this conceptual framework for specifically understanding rural health from health in general is the importance of spatial isolation. Power is another important element of the framework that is rarely discussed in rural and remote health. In total, the framework suggests that understanding rural health requires understanding geographic isolation and the rural space as it impacts on and is constructed by the rural locale (the social relations, including meanings, experiences and actions, in the space), the local health responses (the local services shaped by geographic isolation, local actors and broader systems), the broader health systems (the organisations, knowledge and political structures that shape health care at a national and state level), broader social structures (including structural constraints resulting in health inequalities and the poor status of rural health), and power (occurring in all social relations as influencing action and the reproduction of consistent social practices). Structuration explains how micro level aspects reflect broader cultural, social, political and economic processes while at the same time the macro level aspects are shaped by individuals whose actions produce rural communities, health systems and the properties of social structures (Giddens, 1986; see also Delormier et al., 2009). This is a holistic and comprehensive way of understanding rural health, not as isolated events ‘out there’ but as actions integrated with broader systems, structures and ways of knowing sharing the vast and diverse impacts of geographic isolation.

4. Conclusion

Because rural locales influence health needs and service responses in specific ways, rural health is much more than simply the practice of health in another location (Wakerman and Humphreys, 2002). Furthermore, because of problems that recurrently emerge in rural health across Australia and around the globe, there are common features to explaining rural health that are more than just 'place' effects. And because rural health is heterogeneous and interrelated with broader health, social, economic, political and cultural structures, any rural health framework cannot be prescriptive nor entirely localised. This framework demonstrates that a comprehensive understanding of the complex rural health mosaic depends on the interaction of geographical isolation, social relations within a rural locale and local health actions as well as broader health systems, social structures and finally power—the key to defining their intersection and diverse health outcomes. Understanding the inter-relationships of these six concepts through the lens of Giddens' (1986) structuration theory provides a framework that can be applied to particular health services, health status and well-being in the many rural places like Ruralsville. What the framework highlights is that improving health and well-being in Ruralsville calls for change at a range of levels by diverse stakeholders, including local residents and health professionals, politicians and advocates at all levels, and all those involved in shaping broader social and health systems. Thus, renegotiating power at all these levels to reproduce actions and structural properties that will improve rural and remote health is a multi-layered and complex process.

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