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A different perspective on the key challenges facing rural health:

The challenges of power and knowledge

Abstract

Objective: To examine the effects of dominant knowledges in rural health including how they shape issues central to rural health. In particular, the paper examines the role of i) deficit knowledges of rural health workforce, (ii) dominant portrayals of generalism and (iii) perceptions of inferiority about rural communities in maintaining health disparities between rural and metropolitan-based Australians.

Design: A Foucauldian framework is applied to literature, evidence, case studies and key messages in rural health. Three scenarios are used to provide practical examples of specific knowledges prioritised or marginalised.

Result: The analysis of three areas in rural health identifies how deficit knowledge is privileged despite it undermining the purpose of rural health. First, the privileging of knowledge highlighting workforce shortage rather than the type of work in rural practice or the oversupply of workforce in metropolitan areas. Second, the construction of generalist practice as less skilled and more monotonous despite other knowledge that it is diverse and challenging. Third, dominant negative stereotypes of rural communities that discourage rural careers and highlight undesirable aspects of rural practice.

Conclusion: The privileging of deficit knowledges pertaining to rural health workforce, broader dominant discourses of generalism and the nature of rural Australian communities reproduces many of the key challenges in rural health today, including persisting health disparities between rural and metropolitan-based Australians. To disrupt the operations of power that highlight deficit knowledge and undermine other knowledge, we need to change the way in which rural health is currently constructed and understood.

Key Words: Deficit knowledges, Foucault, workforce shortage, generalism, rural communities

What is already known on this subject?

- Some rural health analyses have pointed to the important role of power in defining the field.
- Existing power analyses in rural health scholarship have emphasised the need to centre the focus on power to progress the field.

What does this study add?

- This analysis identifies sources of power that restrict improvement in the health and wellbeing of residents of rural and remote Australia.
- This paper contributes an explicit account of how particular knowledges that are prioritised in rural health construct a version of rural health that undermines its own purpose.
- It is suggested that improving rural health outcomes requires disrupting current power relations in the development of knowledge in rural health.

Introduction

The health disparities between rural and metropolitan areas in Australia are well documented (1-3). To garner the political attention needed to address these disparities, a significant proportion of rural health research has concentrated on the problems associated with providing care to rural populations (2, 4). Much of this research is associated with attracting an adequate workforce to better resource rural health systems. Thus, rural health has come to be understood as an area of need (5). It is this construction of rural health through such deficit knowledges that is the concern of this paper. In drawing critical attention to dominant deficit constructions, we are not seeking to diminish the disadvantage that rural populations encounter under healthcare systems predominately designed for metropolitan conditions (6), nor undermine the evidence currently produced in the discipline of rural health. Rather, we aim to highlight how power is at the heart of prevailing health disparities between rural and metropolitan-based Australians (6).

Conceptualising power in rural health

This paper draws on the works of Foucault (7), where bodies of knowledge (e.g. rural health research) sustain the effects of power (the research published) and in turn, power produces

knowledge (e.g. what is funded). In this way, particular knowledges prioritised and promoted as the most important in understanding the field construct a version of rural health that undermines its purpose – to improve the health experiences and outcomes of residents living outside of metropolitan areas.

Drawing on the works of Foucault, power is understood as a productive force (8). Rather than being 'possessed' by certain people, power moves through all people's actions and attitudes in everyday life (7). Through this movement, power creates knowledge and the language used to describe and talk about a topic (discourse) (9), influencing what people think and say within a field. Some knowledge and ways of thinking and talking about a particular topic are more dominant than others (10). Moving through discourse, power guides people within a particular context to think and act in certain ways, privileging some knowledges (e.g. Western science) over other knowledges (e.g. Aboriginal knowledge) (8, 11). This means that people's ideas and actions related to a particular topic (e.g. rural health) are structured by the discourses used to describe and talk about it (8, 11).

Adopting this particular understanding of power in rural health allows those working in the field to critically reflect on how their thoughts and actions are influenced by particular bodies of knowledge. In this paper, we use three hypothetical scenarios, each a summation of a real case or conglomeration of several case studies. The scenarios are analysed to examine the effects of power in three areas of rural health: (i) privileging deficit knowledge of rural health workforce, (ii) dominant portrayals of generalism and (iii) a dominant discourse of inferiority about rural communities. It is suggested that making the movement of power visible enables advocates to effect a change in the way power operates and re-position the field of rural health.

Privileging deficit knowledge of rural health workforce

Scenario: Nurses at Ruraltown's rural health service complain to their manager about their workload; the suggestion is that these workloads are higher than the workloads of their metropolitan counterparts, putting rural nurses in danger of burnout. Some nurses have left the service, returning to city locations for work, and like many rural health services, *Ruraltown Health* is struggling to recruit staff. The manager takes the complaints of nurses seriously and conducts an audit of nurse hours and compares these data to data from a larger, city-based hospital. Surprisingly, the findings indicate that the nurses at *Ruraltown Health* do not have significantly higher workloads than those in the city-based service. However, what

is greater in the rurally-based service (compared to the city-based service) is the nurses' autonomy and scope of practice – these rurally-based nurses', sometimes on their own, staff an Urgent Care Centre and provide post-surgical care with no local surgeon, work which in a different context, would be shared across a team with medical support 24/7.

The knowledge that is most often prioritised and promoted about rural health is that rurally-based health professionals have higher workloads than their metropolitan counterparts and are thus, more likely to experience burnout (5). As this knowledge is more common, the recruitment and retention of health professionals, who are essential to 'advancing health' (12), remain key challenges in rural areas. What is often ignored in these dominant discourses is the advantages of working in rural as opposed to metropolitan settings. For example, extended scopes of practice often afforded to rurally-based health professionals enable the development of skills and expertise that would be difficult to achieve in metropolitan areas (13). While common in rural practice, the opportunities to develop broader competencies is not promoted or prioritised in dominant rural health discourses. Further, knowledge pertaining to differences in workforce supply between rural and metropolitan areas is presented in a particular way; dominant discourse centres on the 'shortages' of health professionals in rural rather than inequitable workforce distribution. Thus, certain knowledges (e.g. rural health services are understaffed) are prioritised over others (e.g. health professionals in rural can extend their scope of practice). While neither are incorrect, privileging knowledges that portray rural health as lacking in comparison to its metropolitan counterpart serves to reinforce an image of rural practice that undermines staff recruitment and retention (e.g. there is a shortage of health professionals in rural rather than there are advantages to working in rural and remote).

The privileging and particular framing of knowledges that highlight rural health's deficits has allowed advocates to draw political attention and attract financial investment to the field (14). However, it has also reproduced many of the key challenges in rural health today. The recruitment and retention of health professionals in rural areas is undermined by the dominant construction of rural practice as involving long hours and focus on what is lacking compared to metropolitan-based practice. Privileging what is deficient undermines alternative knowledges of expanded scope, increased autonomy and diverse patients. Yet it is these alternative understandings that may attract a potential workforce.

Dominant portrayals of generalism

Scenario: The new cohort of medical students at Metro University started three weeks ago. One of the early readings has included a short overview of rural health; it talked about 'bush doctors' (15) and the generalist type of work they do, mostly with ageing patients. On rounds, several hospital specialists (16) have made subtle side comments about the ineptitude of rural GPs; it is implied that these doctors did not have the competence or drive to go further in medicine. It's clear that rurally-based doctors are lower on the hierarchy. Much of the advice received from friends and other students support this; generalist practice is low paid, boring and less skilful (17).

Students and professionals may hear and experience different messages to the ones portrayed in the above fictionalised scenario. However, research indicates that the most dominant message received by students is that becoming a generalist is not a 'wise' choice (6). When training, the majority of students learn that specialisation is the pathway to accruing higher status, income and respect (15). In contrast, generalism is associated with boring, monotonous practice that is poorly paid, less clinically skilful and unsophisticated (15, 18-20). Such messages do not assign value to the distinct work of generalists (16, 17). Alternative knowledges, including that generalists (just like 'specialists') have specific skillsets and must become expert in managing the complex interplay between the social and health, are marginalised (3, 6).

These dominant messages about generalism inform the thinking of many students and professionals and the career-related decisions they make (6). It is in such contexts that Hafferty (21) argued "one of the great challenges facing medical educators lies in being willing and able to step back and assess just what messages are being created by and within the very structures they have developed and are responsible for". For rural health, this is a particularly important challenge; the majority of rural practice is generalist (16) yet dominant portrayals of generalism contribute to the low rank of rural health in the health hierarchy.

A dominant discourse of inferiority about rural communities

Scenario: Susan has just completed her nursing degree and is making plans for the year ahead. One of the friends she made while studying comes from a small rural town. Susan occasionally heard other people refer to this friend as a 'country bumpkin'. When Susan mentions going rural for her first year out, questions are asked: what would she do for fun?;

who would she hang out with?; who would she relate to?; will her work be in aged care? Susan begins to doubt whether going rural is the right decision.

There is a dominant perception in Australia that rural communities are somehow 'backward' and inferior in comparison to their metropolitan counterparts (22). City life is popularly constructed as diverse, progressive and exciting, implicating its residents as the same. In contrast, rural life is dominantly portrayed as boring and people living rurally are represented as a homogenous group of older, slightly backward White people (6, 23). These constructions inform health professionals' (and others') thoughts and decisions in relation to rural communities, rural life and rural practice (6).

By representing rurally-based patients as a homogenous group, dominant discourses about rural Australian communities support the notion that rural practice is monotonous. Highlighting the considerable human diversity in rural communities, including First Nation Australians from multiple nation groups, people with a broad range of abilities as well as an increasing number of people with diverse national, cultural, gender and sexual identities would paint a picture of rural communities as heterogeneous and rural practice as diverse and progressively challenging (6). Yet these realities are largely ignored.

Conclusion

There are persisting health disparities between rural and metropolitan populations in Australia. Rural health's key challenges in responding to these disparities include the recruitment and retention of quality health professionals and the related sponsorship of health care systems designed specifically for rural contexts. However, dominant discourses are playing a critical role in maintaining such challenges and thus, health disparities. The privileging of deficit knowledges of rural health is preventing the development and uptake of alternative conceptualisations of rural health that may more readily promote the field to a potential workforce. The dominant ways in which generalism is constructed and understood undermine the distinctive value of and skill involved in generalists work. This further dissuades health professionals from a rural career. Dominant portrayals of rural communities and what they suggest about the nature of rural practice also discourage health professionals from coming rural. Thus, power relations currently reproduce particular knowledges of rural health and marginalise other knowledges. This promotion of particular knowledge, a production of power according to Foucault (7) is at the heart of the field's key challenges.

In order to disrupt these power relations, the privileging of deficit discourses needs to cease. Those working in rural health specifically, but also those responsible for training health professionals more broadly, need to promote other realities about rural health. Those deciding to practice rurally need to be able to make decisions based on the advantages as well as the deficits of rural practice. Those working in (rural) health need to reflect this reality in how we think and talk about the field, the research that is conducted and the education that is provided to students and health professionals.

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