**Chapter 24**

 **COMMUNITY HEALTH PLANNING: RURAL RESPONSES TO CHANGE**

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**Abstract**

Social and economic change and isolation can be catalysts for a variety of health and well-being outcomes, and also for a variety of innovative strategic responses where rural communities and industries take control of their own health and well-being. Rural health can link to particular lifestyles and occupations, to the accessibility of health and well-being infrastructure (doctors, opportunities for physical activity, etc.), the social networks that provide a soft support to communities and individuals, and, as education is a key social determinant of health, to opportunities for education and learning. This chapter introduces health as a key theme for rural planning before focusing on case studies of rural communities and rural industry bodies who have actively collaborated with organisations to drive improvement in health and well-being and support through understanding of their own needs and priorities. It concludes that effective rural health planning should involve strength–based, community health development approaches to build relationships between community members and between community and health services.

# INTRODUCTION

The challenges facing rural communities have been highlighted increasingly in past decades as rural communities seek to adapt to significant social and economic change (Flora et al., 2015). This chapter introduces community health as a key theme for rural planning. It argues that effective community health planning is a process that should be fundamentally underpinned by consultation and involvement of community members in order to balance private verses public interests in the delivery and allocation of health resources. We explore a number of key elements which underpin how rural communities including individuals, groups and key industries can act as drivers of change in enabling strategic and innovative local responses to improving the ‘availability, accessibility and quality of services as a means to improving health status’ (Steen, 2008: 1). Focussed case studies of health planning by rural Australian communities and partner organisations showcase how a strengths-based approach to community health can assist in planning and driving a variety of health and well-being support programs and strategies.

This chapter discusses health planning in the context of Australian rural communities, which differ from those in many other countries, and discusses key factors informing how rural health needs can be addressed. The National Strategic Framework for Rural and Remote Health uses the term ‘rural and remote’ to encompass all areas outside Australia’s major cities (Department of Health, 2011). The Framework is a response to the ‘unique characteristics, needs, strengths and challenges experienced in rural and remote parts of the country’ (Australian Health Ministers’ Advisory Council Rural Health Standing Committee, 2011: 6).

# Background

Rural areas in Australia and around the world have long been known to have poorer health outcomes than metropolitan areas (Beard et al., 2009). Australians living in rural and remote areas tend to die younger, suffer higher levels of injury and disease, and have poorer access to health services (Australian Institute of Health and Welfare, 2017).

An understanding of ‘what is health’ is useful before discussing rural health planning. Society’s understanding of what constitutes good health has evolved over recent decades. In 1948 the World Health Organisation defined health as a ‘state of complete physical, mental and social well-being and not merely the absence of disease or infirmity’ (World Health Organisation 1948). In recent years the perceptions of what health is have evolved beyond viewing health as a fixed state, to health and well-being as influenced by systems and resources that support an individual’s capacity to function in wider society including an ability to adapt to change (Giacaman et al., 2009). Additionally, key WHO directives such as the Ottawa Charter on Health Promotion (1986) have stressed the importance of communities having the opportunity and ability to actively participate in planning for community health and well-being which has led to increasing capacity building and engagement of communities around rural health planning (Kilpatrick, 2009; Hawe et al., 1997).

Conceptualising rural health requires an understanding of how the rural setting influences an individual’s health outcomes. The value of community to health and well-being in rural areas, whilst difficult to quantify, cannot be underestimated, particularly in communities with high levels of connectivity and social cohesion. It is widely recognised that there are a number of social determinants of health, including socioeconomic status, race and ethnicity, gender, sociocultural and psychosocial factors (Dixon and Welch, 2000). Individual and neighbourhood socioeconomic disadvantage, sociocultural factors, and physical and other environmental factors interact to produce health outcomes, for example low population density, often high proportions of Indigenous populations and geographic isolation, are related to limited health services and limited availability of fresh and healthy food choices. On the other hand, fresh air and natural environmental amenity and close knit communities can promote well-being; while limited education and outmigration of young people reduce community income and resilience (Beard et al., 2009). Outmigration, in particular, can be seen to have two major negative effects on health: a reduction in health status as the remaining population is proportionally older, and a reduction in health services as populations fall below the critical mass deemed as needed to support them (Rickards, 2011).

Pressures on current health care services in Australia have increased the demands on policy makers to implement effective health planning. However, planning is often underpinned by the adoption of both biomedical approaches and economic rationalist models of health care provision which have embedded a deficit way of thinking (Bourke et al., 2010). Such models focus on problems that need ‘fixing’ from an individual health perspective or considers services from an economic rationalist perspective where community members are seen as consumers not citizens. Often a deficit model of rurality is used to justify an economic rationalist approach to rural health policy and planning, most often to the exclusion of rural communities themselves.

This contributes to the stereotyping of rural areas as problematic environments in which to live, work and for which to plan and deliver health services, and tends to downplay provision of preventative health and well-being programs and services. Furthermore, the outcome of biomedical and economic rationalist approaches is a tendency to see all rural areas as the same, and to disregard the local contexts and environments of rural settings which can impact significantly on health determinants and the effectiveness of programs.

Focusing on key strengths is an alternative way to move rural planning in a time of change from ‘problem-describing’ to ‘problem-solving’ paradigms. Such an approach starts from a position of local knowledge and values and engages the community in shaping goals and pathways (Rickards, 2011). Many traditional approaches to community health planning start with a needs analysis or some other way of focusing on the community’s needs (Kretzmann and McKnight, 1993; Mathie and Cunningham, 2003).

A strengths-based approach tends to build relationships between community members, while deficit-based approaches tended to focus more on the relationship between the organisation and community members.

The next section explores approaches to community health planning and capacity building for health including how rural communities can provide a basis to improve what works, promote positive aspects, challenge stereotypes, attract staff, encourage local responsibility for health and develop further strategies to ensure optimal health and well-being (Bourke et al., 2010; White, 2013).

# Community Health Planning: Key Issues and Considerations

Community health planning has been acknowledged as a major field of practice and policy in nations across the world. The ultimate goal of any health planning process is to improve or optimise the health and well-being of a community. The World Health Organisation (2018) defines community health planning as ‘the orderly process of defining community health problems, identifying unmet needs and surveying the resources to meet them’ which also involves establishing priority goals that are realistic, feasible and actionable particularly within the context of rural areas where they may be increasing demands for health services with increasingly limited resources.

While health planning can vary across countries and settings, within developed nations, it is argued that ‘the challenge’ which effective community health planning addresses is making any healthcare system ‘more accountable to the average residents in their communities’ (Steen, 2008: 1) and thus better balancing commercial interests in healthcare delivery with public interests. Traditionally, health planning has tended to be driven and controlled by government bodies with the aim only to identify priority issues. However, the ways in which information has been gathered through health needs assessments and used by governments has been criticised for not only the quality and validity of community consultation, but the ways in which has been used to align with bureaucratic pressures and priorities rather than those of a particular community or area (Jordan et al., 1998; Hancock and Minkler, 1997).

Health service planning in Australia in recent years has seen a significant policy shift in the way in which rural health services are designed and funded. This shift has been characterised by the emergence of Primary Health Networks and support for strategic and less linear based funding approaches. Primary Health Networks are national, government funded policy implementation and service purchasing agencies. Such approaches challenge the traditional methods of service provision, based on identifying a need, funding a service and expecting a casual outcome. This policy shift is driven by the five outcomes and objectives defined within the National Strategic Framework for Rural and Remote Health (Australian Health Ministers’ Advisory Council Rural Health Standing Committee, 2011):

* Improved access to appropriate and comprehensive health care for people living in rural and remote Australia;
* Effective, appropriate and sustainable health care in rural and remote settings;
* Health service design that better meets local consumer and community needs;
* Collaborative health service planning and policy development in rural and remote Australia;
* Strong leadership, governance.

While the importance of community health planning is argued internationally (Manaf and Juni, 2017), there is a paucity of information on best practice in health planning for rural areas, particularly in the context of social change, economic and new technologies for health service delivery. Recent developments have seen the emergence of community development approaches that work at the grassroots, engage and empower local residents encourage participation in processes that build on strengths and address weaknesses (Johns et al., 2007).

White (2013) examined key issues and best practice for rural health population planning and delivery within published literature and found that there were six key elements that should be considered by those responsible for the development of policies and strategies in rural communities. Many of these areas are concerned with identifying and understanding the local contexts of health including defining rural communities, identifying local assets and challenges, multiple levels of community support and understanding social determinants of health which considers a ‘full range of factors that influence and contribute’ (White, 2013: 34) to a community’s health and well-being. These findings are consistent with our own research and practice which has identified that viewing communities themselves as authentic partners is essential in any process of community health planning (Auckland et al., 2007; Johns et al., 2007; Kilpatrick and Auckland, 2009; Whelan et al., 2009). We have identified the following five attributes as key components of evidence based community health planning:

* An integrated and holistic approach to community health based on social determinants of health;
* A strengths-based approach which builds capacity within communities to address community priorities;
* Partnerships and coalitions based on engagement and shared aims and visions;
* A strong commitment to community consultation and engagement, through strategic approaches such as community health needs assessments or health improvement projects;
* An understanding of research and evaluation, and the collection of valid information from a variety of areas which best provide informed views on community priorities.

# Planning in Practice: Case Studies from Rural Australia

This section provides three focussed case studies developed by rural Australian communities and partner organisations which showcase how a strengths-based approach to community health can assist in planning and driving a variety of health and well-being support programs and strategies.

## Case study 1: Planning for the health and well-being of fishing families

The Australian wild-catch fishing industry, through its producer-led state-based associations, identified a need to address industry economic losses incurred through poor health and well-being of fishers’ who are dispersed along rural coastal areas of Australia (King et al., 2015). This economic motivation contrasts with traditional social, often equity focussed, motivation for planning Australian rural health services. Three industry funded research projects saw researchers working with fishing communities and associations to develop programs and tools to improve fisher health (Fisheries Research and Development Corporation, 2017; Kilpatrick et al., 2012; King, et al., 2015).

Alongside the disease and health risk factors experienced by Australian rural populations, fishers are at particular risk of certain kinds of illnesses (for example, skin and diet-related), as well as injury (fatality rates are more than double those in the agricultural sector). While both women and men are at risk, 87% of fishers are male, a factor placing them at greater risk of suicide. Insecurity of fishing quotas and licences drives chronic livelihood insecurity, resulting in reports of stress, depression and suicide (King et al., 2015).

The first project worked with both farming and fishing communities. It found farming industry associations, unlike their fishing counterparts, were proactive in working with local and national health services to develop health and well-being programs that matched farmers’ needs. Using credibility of industry events as ‘soft entry points’ to health checks, mental well-being and other programs was key to farmer uptake (Kilpatrick, et al., 2012). In the second project, three fishing communities worked with the researchers and local health services to develop health and well-being plans and health toolkits of useful information and contacts for each of the fishing communities, and prioritise soft entry points (King, et al., 2015). This project identified women as key players in the fishing industry (Kilpatrick et al., 2015). Their knowledge of, and credibility within, fishing businesses makes them valuable sources of information about health issues facing the industry and effective strategies to address them. A key finding was women’s expertise should be applied in conjunction with industry associations and health providers to achieve better health outcomes (Kilpatrick et al., 2015). The final project adapted the Sustainable Farm FamiliesTM program for the fishing industry and collected detailed self-reported health data from 872 commercial fishers (over 20% response rate), to be used in planning health services.

The fishing industry example highlights the power of planning for rural health using a geo-occupational lens to engage community and better target not only evidence-based needs of various groups within rural populations, but also take account of gender and behaviour norms and preferences for service access. Embedding responsibility for health in industry organisations fosters sustainability.

## Case study 2: Planning for healthy and resilient communities (HaRC)

The Centre for Rural Health in Tasmania has collaborated with Rural Alive and Well Inc (RAW) to identify community based service interventions that enhance community resilience and build the capacity of rural Tasmanian communities to react to challenging life experiences as individuals, families and whole communities. Rural Alive and Well Inc is a not-for-profit organisation that has a primary goal of helping individuals, families and the community through mental health issues with a focus on suicide prevention. The underpinning rationale for RAW’s grassroots approach is the acknowledgement that the relationship between people, place and health is fundamental to the success of health interventions within rural and remote communities.

Rural communities are often characterised, as being resilient in the way in which they draw on their underlying social capital to deal with life challenging events however, in areas that experience greater social isolation, the social capital may not be adequate to cope with the adversity. The design and delivery of the HaRC program focuses on the concepts of community strength, preparedness and resilience within the context of enhancing both individual and collective well-being within those communities. The program is underpinned by an understanding that rural people construct ‘community’ both as people relating to each other in a shared locality, and the extent to which people relate to each other in cooperative, sharing, supportive, caring, and trusting ways.

HaRC program staff focused on firstly understanding the community’s level of readiness in the design of engagement processes and interventions. Through the adoption of different measures across multiple dimensions including a sense of community, desire for the program, capacity to manage and develop the program, commitment to program goals and outcomes as well as a commitment to collaborate with program staff to achieve program goals, the program staff were able to match community interventions to the community’s level of readiness.

Pivotal to this approach has been the program’s ability to recruit ‘field workers’ considered to have broad skillsets described as a ‘specialist-generalist’. Program staff are flexible and responsive to community needs, which included them being a single point of contact, providing care coordination, assisting the community to become self-reliant, while clearly outlining their role with clients and maintaining boundaries.

The goal of the HaRC Program is the development of twenty ‘community owned’ suicide prevention strategies over a three-year period commencing 2016. The evaluation identified pre and post program measures to help assess the program’s performance using indicators of the effective implementation of rural community health programs. Findings from the evaluation have been used to refine programming and planning, including the assessment of new sites and delivery of services.

## Case Study 3: Planning for whole of municipality/community health and well-being

Within Australia and elsewhere, health planning including strategic responses to whole of municipality (local government area) health and well-being issues including service provision, infrastructure and resource allocation has increasingly moved from being the remit of **only** federal or state governments and their administration to other levels of government such as municipal local governments or regionalauthorities.

Increasingly health and well-being plans for regions**,** municipalities and communities underpinned by community consultation have become accepted practice in Australia - particularly in rural areas. This case study focusses on one municipal area within the state of Tasmania to demonstrate how effective health and well-being planning was undertaken in partnership with the University of Tasmania and other stakeholders.

The West Tamar municipality has a population of approximately twenty thousand people spread across 690 square kilometres and includes both rural and regional townships and communities**,** some with significant socio-economic disadvantage. Over 18 months, the municipal government worked with the local university to conduct a whole of community health needs assessment which would inform a number of strategic areas for the authority including sports and recreation planning, youth and positive ageing strategies, infrastructure allocation and cross sectoral collaborations and partnerships.

Led by a steering group of municipal staff, university researchers, community representatives and other local stakeholders including industry, business and health professionals**,** the West Tamar Community Health and Wellbeing Project consulted with more than five thousand residents of the municipality to identify, understand and prioritise the health and well-being issues facing the whole municipality at that time and for the next three to five years. This was achieved using a variety of information collecting methods including community forums, focus groups, interviews with stakeholders within and outside the community, a whole of community survey, youth surveys and analysis of existing policies, documents and other relevant information which could inform planning for the future and for expected changes in population such as ageing and new housing development.

Informed by a social determinants of health model, the project took an integrated approach to sustainable planning for the health and well-being of the West Tamar. It considered six key areas through which health and well-being planning for the municipality would be guided and prioritised including (a) Services and Resources (b) Partnerships and Collaborations (c) Information, Facilitation and Support (d) Inclusion, Engagement and Participation and (e) Infrastructure, Environment and Safety.

The project also incorporated a strong capacity building element to how it was conducted, in that university researchers worked with community members and municipal staff to develop understanding, skills and knowledge in the areas of research and collection of information. Community members were immediately involved where determined to be effective; for example, in the distribution of surveys to other members of the community and in the validation of findings from other data collection methods such as community forums. Community participation was based on the project team’s strong view that in any community only those who live and inhabit community spaces can truly understand the experiences, priorities, traditions, needs, issues, barriers and enablers that exist there (Whelan et al., 2009; Langwell, 2009).

## Key messages from case studies

The three case studies illustrate how a strengths-based approach works with community and health services to identify assets and community characteristics which can positively contribute to health and well-being outcomes. Place is a key resource contributing to community strength and resilience, even in the context of a rural industry community such as in the fishing case study.

Both the West Tamar and HaRC case studies drew heavily on the importance of adopting an integrated and holistic approach to community health based on social determinants of health, particularly the value of social connectivity and support systems in HaRC. Community engagement and evidence gathering was evident in the fishing case study where the industry associations facilitated the engagement of a significant proportion of wild catch fishers nationally in a detailed self-reporting of health status. In the HaRC study, data was collected about community readiness though engaging with the community. In the West Tamar, more than six months was dedicated to community consultation and the gathering of evidence to inform the community health plan including the allocation of resources into the future.

A partnership between industry and researchers over three projects built evidence to refine health planning for fishers. Significantly, the HaRC project participants identified the need for stronger collaborations and partnerships both between service providers and between community and service providers. In West Tamar, the municipal local government understood that they alone could not assess capacity to meet or successfully address or the health and well-being priorities and needs of their municipality, and that intersectoral and interagency partnerships, including those with health providers and industry were essential to the sustainability of the plan.

Understanding community health and well-being needs, assets, challenges and priorities was evident in the fishing and HaRC case studies, but was at the heart of the West Tamar case study. Regardless of context, the community should be a vested partner in the process of health planning and if done effectively can not only reflect public interest and experience but can direct agencies to areas where rural health and well-being issues can best be addressed, improved or approached. Understanding rural place and health needs facilitates alignment between health programs and community, and helps incorporate community resources into health care (Kilpatrick, 2009). Rural communities, health services and other community organisations need skills in working together to develop effective partnerships that transfer some power from health systems.

Monitoring and evaluation must be embedded in planning. In the HaRC program, research indicated that there needed to be more structuring, monitoring and evaluation and as part of program planning. Evaluation and review was also built into the West Tamar project, and is an integral part of any cycle of health planning or strategic response.

# Implications for rural health planning

This chapter moves our understanding of rural health planning from a desktop and external activity towards an activity which includes the characteristics which underpin how healthy communities can be created, strengthened and understood. We outline a number of elements which underpin our work with rural communities, particularly taking a strengths-based community development approach that embraces the importance of the knowledge of communities themselves and builds partnerships to achieve an integrated and holistic approach to community health based on social determinants of health.

Strength–based, community health development approaches to rural health planning build relationships between community members and between community and health services. This planning approach provides a basis to improve service delivery for the local context, promote positive aspects, challenge stereotypes, help attract and retain staff, encourage local responsibility for health and develop further strategies to ensure optimal health and well-being. A strengths-based approach is effective because it takes account of local rural context, including geo-spatial, occupational and other demographic contexts. The five key attributes listed above are essential for successful and effective health and well-being service planning, and crucial for planning for healthy communities.

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