Is a global rural and remote health research agenda desirable – or is context supreme?

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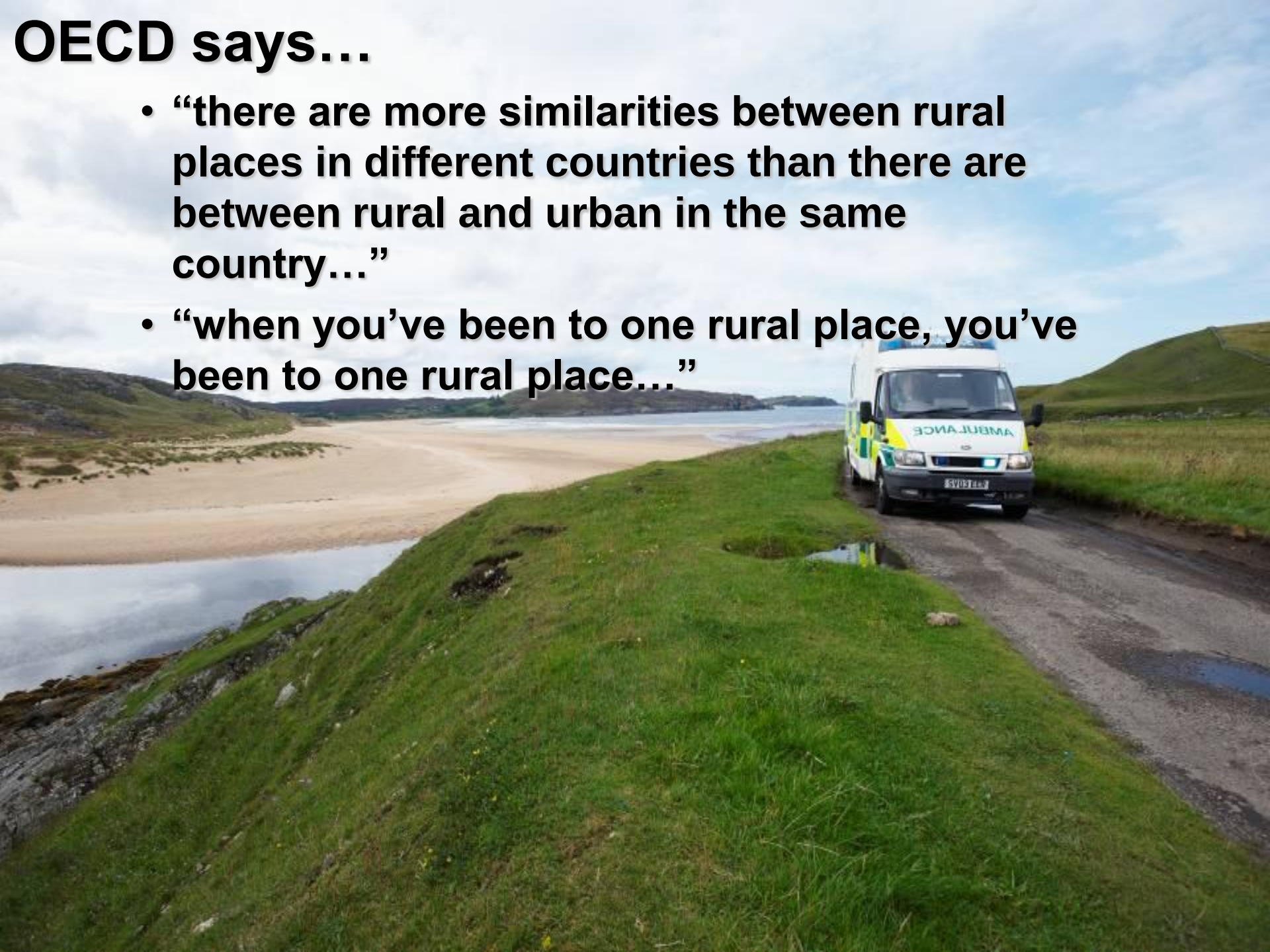
My interest in this comes from…

- People are always saying we should learn from other countries
  - Is it a vague excuse?
  - Because concrete, programmatic things don't seem to happen
  - *'while the grass is always greener when seen from a distance…the thorns and burrs contained in those green pastures are not evident from afar.' (*Bjorkman & Altenstetter, 1997).
- (Some) people get quite excited when they think of programme of learning from others
- Australians smirk at Scottish rurality…
  - But we really don't know how similar/different?
- Strength in numbers
  - Tired of saying that rural/remote is different

OECD says…

- **“there are more similarities between rural places in different countries than there are between rural and urban in the same country…”**
- **“when you’ve been to one rural place, you’ve been to one rural place…”**



They aren’t mutually exclusive

- Is a global rural and remote health agenda desirable?
  - Lessons to be learned
  - Transferable ‘innovative’ models
  - Networks & ‘social capital’
  - A mechanism for change
- Is context supreme?
  - We don’t know enough about contextual influence
  - Somehow there is something important here?
    - Or is it just a rehash of all those definitions of rural(!)

The I don't knows…

- **Is it an indulgence?**
- **Is it useful?**
- **Would it be implemented?**
- **Is it research?**
- **Can it be done?**
- **Developing countries & indigenous peoples?**

Remote & rural: categorised & positivistic

- Rural = social/ size of population
- Remote = distance from…
- Typologising by:
  - Geography
  - Topography
  - Social structures/ attitudes
  - Demography
  - Infrastructure
  - History/soc-ec history

Or intangible & constructed

"place, in whatever guise, is like space and time, a social construct.This is the baseline proposition from which I start. The only question that can then be asked is: by what social process(es) is space constructed?" **(Harvey, 2006)**

Place is an exclusionary concept that we use in a globalized world to try to differentiate ourselves from the masses and in order to compete (Harvey, 2006)

"He realized as he watched what had happened in going away. The valley as landscape had been taken, but its work forgotten. The visitor sees beauty, the inhabitant a place where he works and has his friends. Far away, closing his eyes, he had been seeing this valley, but as the visitor sees it, as the guide book sees it." Williams, 1960

Cresswell, T (2004)
Place: a short introduction.
Oxford; Blackwell

International comparative research

Nuffield Trust (2010)

The funding and performance of healthcare systems in the four countries of the UK

Scotland has

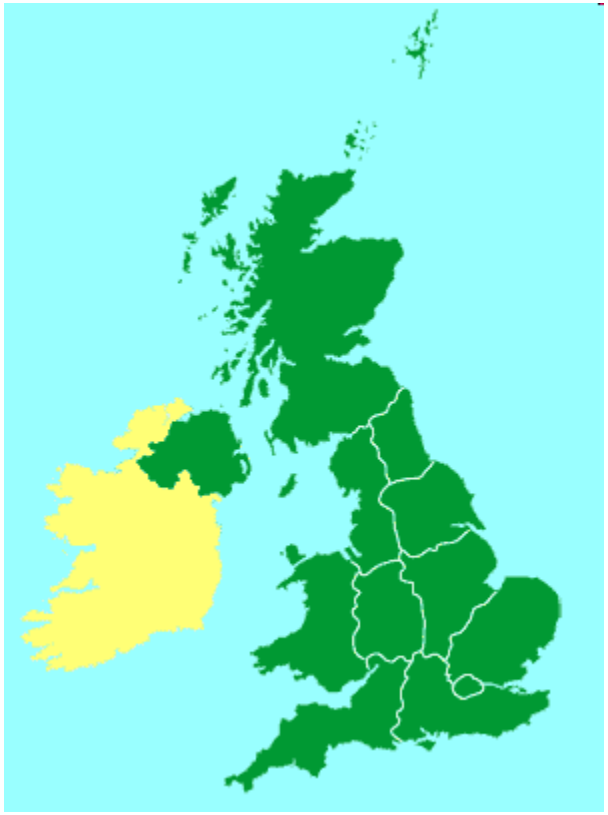
Most doctors and nurses

Highest patient satisfaction

Lowest overall productivity

Lowest productivity per doctor & nurse

Poorest life expectancy



What's going on there?

Traditionally poor & deprived – subsidised by UK govt

Socialist/welfarist/communitarian ethos

Lack of robust middle class (docs & lawyers are the middle class – lack of governing class = power)

Many remote and rural areas (lack economies of scale/ politically sensitive to deplete rural)

Big cities with significant soc-ec problems

'Quality' judged by people in interpersonal terms

Strong interconnections – relationship based services

Scott Greer's analysis of UK health systems

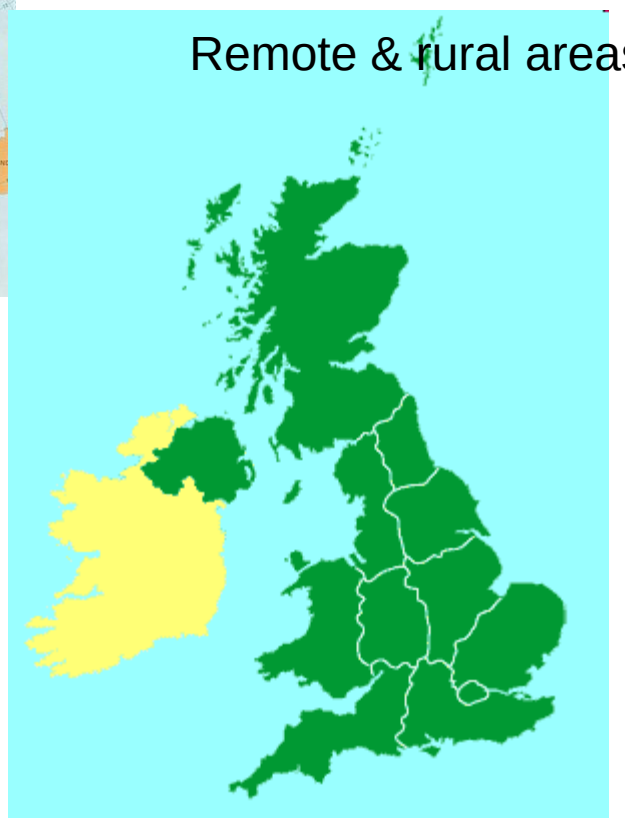
- England = markets
  - Managerial/ mixed economy/ thinktanks
- Wales = localism
  - Public health/ needs analysis/ green/ people involvement
- Scotland = professionalism
  - Medical profession drive and influence policy
  - Home of SIGN guidelines, etc
- N. Ireland = permissive managerialism
  - mix

O4O: older people for older people

- **Looked at how older people in peripheral areas could do more service provision for themselves**
- **‘social enterprise’ & volunteering key themes**
- **Scotland, Sweden, Finland, N Ireland, Greenland**

- Where do people go when they're old?

Denmark



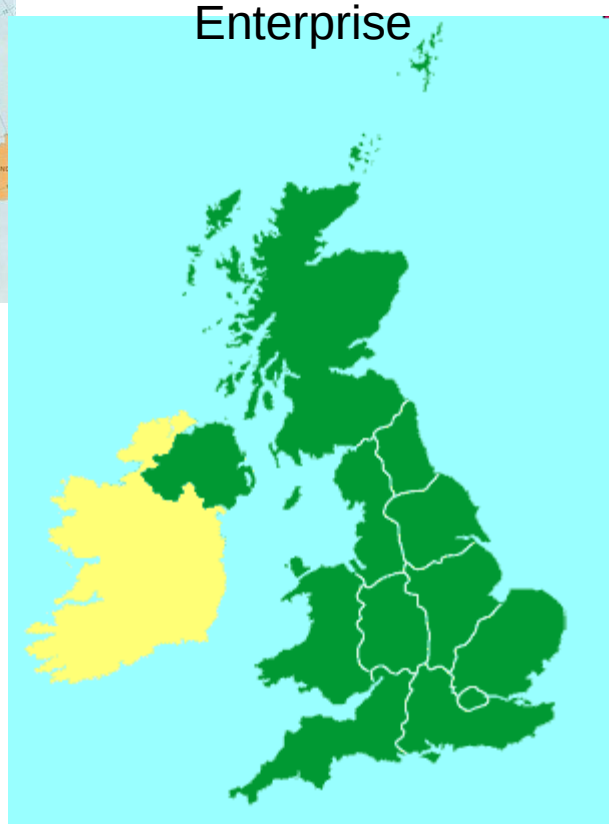
Remote & rural areas

Towns and cities

- Equivalence of terms -> political ideology

Volunteering?
Enterprise?

Volunteering
Enterprise



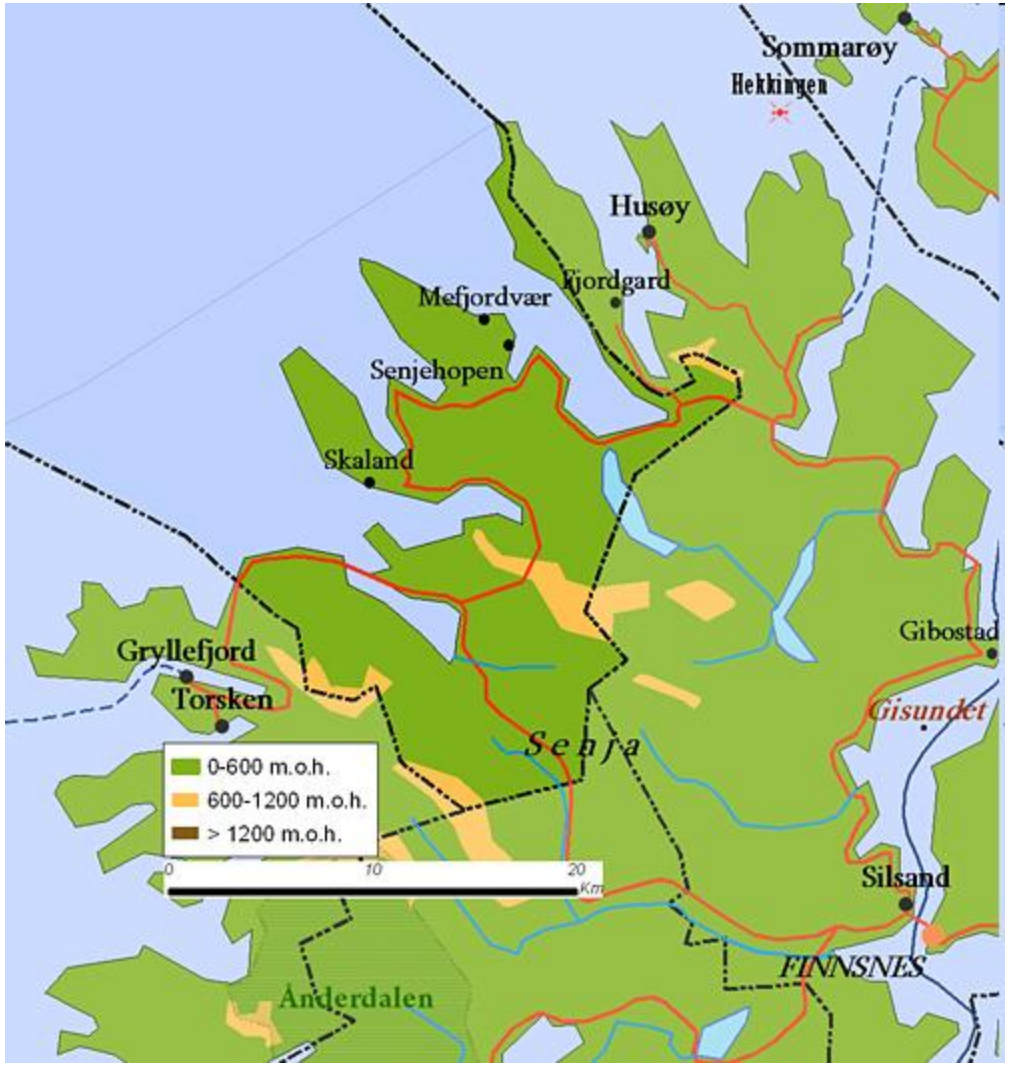
Volunteering
Enterprise

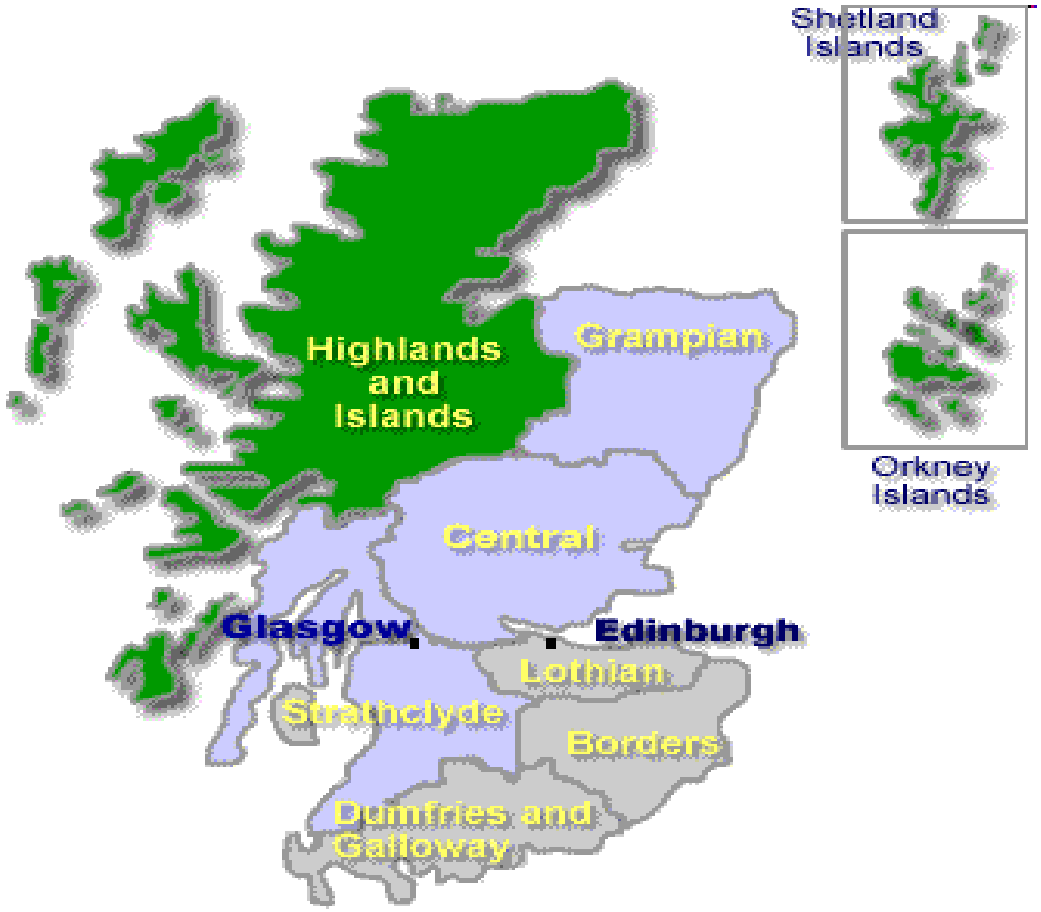
What am I proposing we look at? Models…

"Model…is defined as '…specific configuration of the vision of [type of healthcare]*, the resources, organisational structure, and practices. Each configuration is conceptually distinct and empirically observable at a given time and in a defined context."* Lamarche et al, 2003

Models as 'ideal types'

- Senja, Norway docs
  - Hub & outreach
  - Recruitment problems
  - Community approach





Highland Diabetes care

-primary care
-teleconsults
-good? Or bad?

Northern Periphery telehealth Project

-Swapping technology applications

-Teledialysis

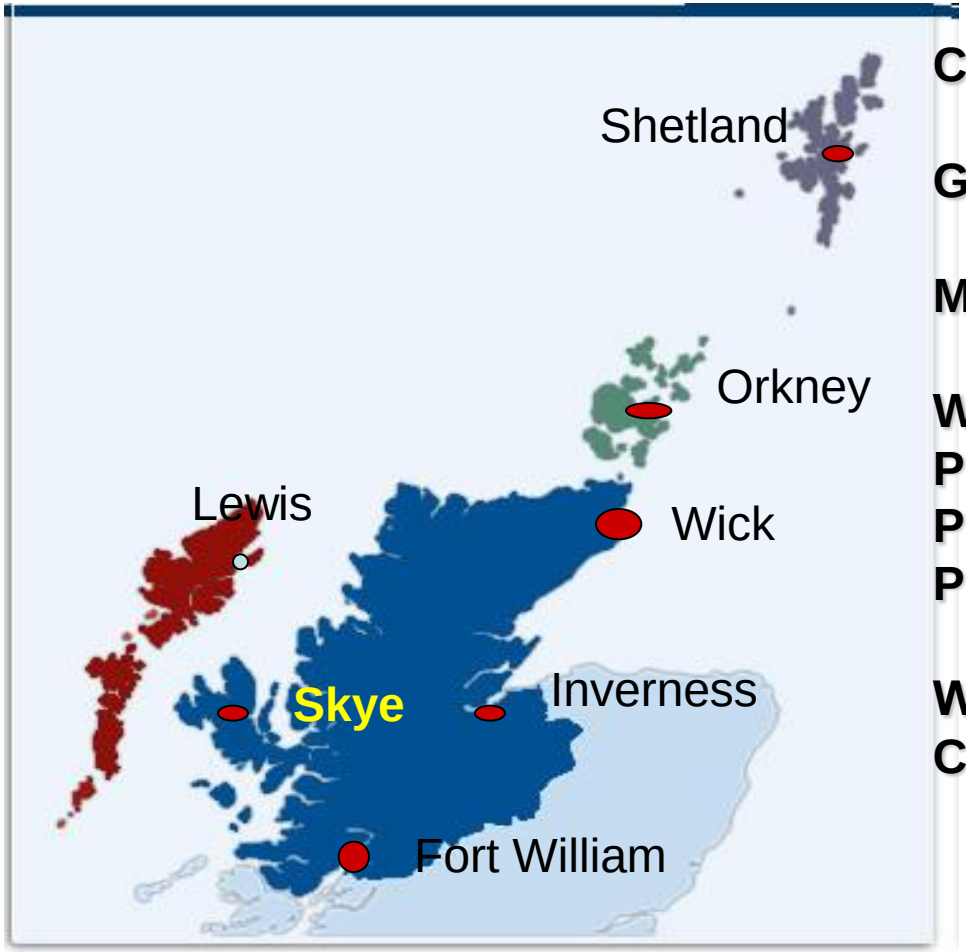
-Speech therapy

-Remote self-monitoring

Problematical models for Scotland

- Maternity
- Aged care
- Unscheduled care

Maternity Care



Consultant led model

GP led model

Midwifery model

Why?
Public pressure
Political lack of bravery
Policy that promotes home birth!

What's happening elsewhere?
Can it help us to sort ourselves out?

- **Primary Care**

rural ↓ remote

  - **discrete services (e.g.walk-in/walk-out)**
  - **Integrated services (multi-purpose)**
  - **Comprehensive PHC services (e.g. Aboriginal controlled community health services)**
  - **Outreach services (e.g. hub and spoke models)**
    - **Humphreys & Wakerman, 2009**

- **Unscheduled care**

Accessible rural ↓ Island

  - **Community CPR, 1st responders, retained driver & ambulance service, generic support worker**
  - **Community CPR, 1st responders, retained driver, community practitioner, extended community practitioner**

- NHS Scotland Emergency & urgent response to remote and rural communities, 2009

Structure, process & outcomes

"despite…numerous innovative models of service delivery, few have been evaluated in terms of their impact on health outcomes…"

Humphreys & Wakerman, 2009

Structure, process & outcomes

Structure

Material resources: facilities, equipment

Human resources: no., type, qualifications of staff

Organisational characteristics: structures, functions, methods of paying etc

Process

Activities that constitute healthcare e.g. diagnosis, treatment, rehab, prevention, self-care

Outcomes

Changes in individuals & populations attributable to health care

Health status, knowledge, behaviour, satisfaction

Donabedian A (2003) An introduction to quality assurance in health care. Oxford University Press.

Outputs: new ideas, models, networks?

BUT… Finding the models is just the start…
then there is the process of
IMPLEMENTATION!!!!

Is there also a role for international comparative approach there?
Change by devious means?
Ehm… I mean by engagement, networks…

Conceptual (contextual?) framework

- *'the critical task in lesson drawing is to identify the contingencies that affect whether one program can be transferred from one place or time to another'.* Rose (1993: 118)

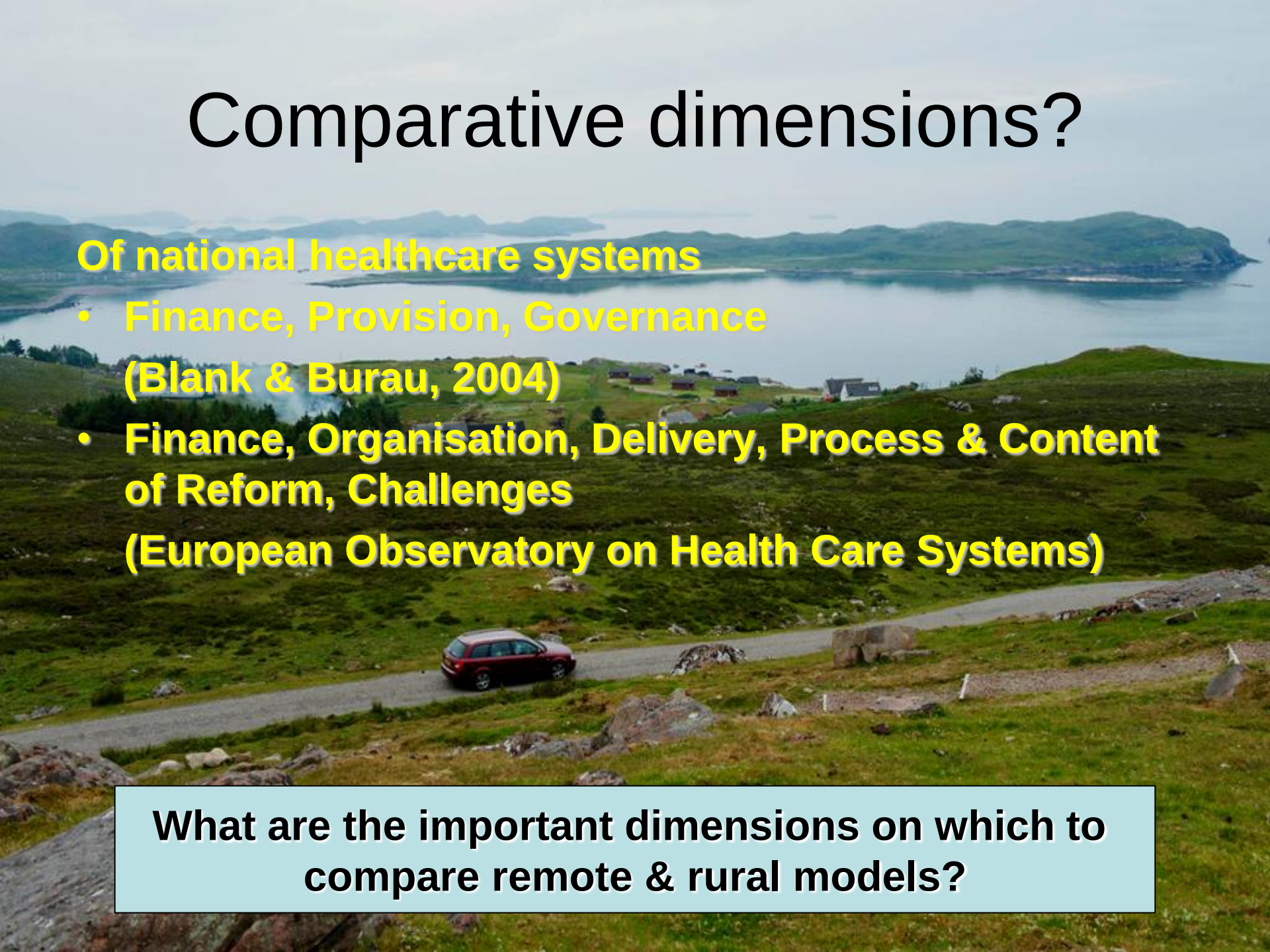
- *'health care policy is shaped by the national context…[and]…an understanding of that context is a necessary condition for drawing any transnational conclusions about the exportability (or otherwise) of any lessons learned. Before transplanting any policies, we have to make sure that there is institutional compatibility between donor and recipient ' (Klein, 1997)*

- *"Categorization of countries into more and less similar groups requires a considered and empirically informed process which is referred to as a framework for international comparisons of health systems" McPake and Mills (2000)*

That is….

- Can we get an idea of whether the model would transfer… with similar outcomes?
- E.g. how similar are, for example:
  - Australia, Canada, Greenland
    - Globally peripheral
    - Vast unpopulated areas
    - Extreme population dispersal
    - Indigenous people
    - ‘Frontier (self-reliant) attitudes’
    - Solutions: transport? Infrastructure?

Comparative dimensions?



Of national healthcare systems

- **Finance, Provision, Governance**

  (Blank & Burau, 2004)
- **Finance, Organisation, Delivery, Process & Content of Reform, Challenges**

  (European Observatory on Health Care Systems)

What are the important dimensions on which to compare remote & rural models?

Rurally: these things are the same?

Hays

-Poorer health status
-Staff professionally isolated
-Medical families are socially isolated
-Health professionals' are part of the community
-Staff require broader knowledge and skills.

Bourke et al

-health differentials
-access
-confidentiality
-Cultural safety
-Team practice

OECD

-out-migration & ageing
-lower educational attainment
-lower average labour productivity
-low levels of public services

Remote/rural health comparative dimensions?

Physical geographical
Distance, terrain, weather, transport type, infrastructure

Social interaction with rural geography
People, way of life, history, expectations, attitudes

Policies of service provision
Rural? Local? Territorial? Silo-ed?

Politics & operation of health system
Roles of health professions, symbolism, power, tribalism

But how measure/typologise?

Issues

- Rural and national?
- Rural and rural?
- Northern European/ Western rural?
  - Developing world? Indigenous peoples?
- Equivalence of terms
- ‘Measuring’ the ‘soft’
- Measuring the ‘hard’: availability & equivalence of data
- Might be of interest, but would it actually be implemented?

- Challenges are now seen world-wide
- Centres for rural health research
- More in common with other rural than with urban areas in their own country! ?

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