Dr. John has gone: assessing health professionals’ contribution to remote rural community sustainability in the UK

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Abstract

Due mainly to increasing difficulties in recruiting and retaining health professionals to work in remote and peripheral areas of Scotland, there is discussion of the need to implement new models of primary health care provision. However, innovative service models may imply a reduction in the number of health professionals who live and work in remote communities. Currently decisions about remodelling service provision are being taken by National Health Service stakeholders, apparently with little consideration of the wider social and economic impacts of change. This paper aims to argue that health professionals contribute to the fabric of rural life in a number of ways and that decisions about health service redesign need to take this into account. As well as fulfilling a wide health and social care role for patients, the authors seek to show that health professionals are important to the social sustainability of rural communities as, due to their unique position, they are often at the heart of networks within and between communities. The wider economic contribution of health services in remote communities is important, but often underplayed. The authors propose that theories of capital, principally the concept of social capital, could help in investigating the wider contribution of health professionals to their local communities. Ultimately, it is proposed that health services, as embodied in nurses, doctors and others, could be highly important to the ongoing livelihood and social infrastructure of fragile remote communities. Since this area is poorly understood, there is a need for prospective primary research and evaluation of service redesign initiatives.

\begin{keyword}
Rural healthcare; Service redesign; Professional roles; Community sustainability; Social capital; Scotland, UK
\end{keyword}

Introduction

Rural areas are suddenly on the UK policy agenda (Department of Environment, Transport & the Regions, 2000). The agricultural industry has been in decline for years and tourism is a fragile replacement. Many rural areas have been experiencing the curious joint effects of out-migration of young people and in-migration of older retired people which has led to an ageing population (Philips, 1999). Accessible rural areas have been colonised by commuters and the decline of local services—the village shop, post office, bank—are...
hastened. In 2001, the effects of UK rural decline also hit urbanites as, for some considerable time, the countryside (their idyllic green and leafy heritage park (Pahl, 1970)) closed to public access due to foot and mouth disease.

In Scotland, the effects of these economic and demographic changes have prompted policymakers to make:

... a commitment to economic, social and environmental development of ... rural communities—even the most remote (Scottish Executive Rural Affairs Department, 2000).

A parallel interest in remote and rural health care has emerged, with policymakers’ attention tracing back to a key Scottish health services review in 1998 (The Scottish Office Department of Health, 1998). This confirmed the views of academics that there was a dearth of remote and rural health care research in the UK (Higgs, 1999). Remote and rural health care research is now developing, particularly in relation to health service concerns about a crisis in recruitment and retention of health professionals to more remote places (Cox, 1997; Remote and Rural Areas Resources Initiative (RARARI) Solutions Group, 2002).¹

Due mainly to the manpower crisis, though partly to the availability of new technologies and desire to rationalise costs, new models of providing primary health care services are being considered, some targeted specifically at remote rural areas. These include: branch surgeries; mobile clinics; peripatetic teams working from a central hub; family health nurses (Proctor, 2000) and nurse practitioners (who would take on some of the roles of general practitioners (GPs)); enhancing the role of paramedics; training local people for a first responder role; NHS24 telephone advice line; telemedicine and telehealth; and health ‘booths’ providing information and an advice link to external health professionals (Scottish National Rural Partnership, 2000; Deaville, 2001; RARARI, 2002).

These ‘solutions’ will sometimes mean radical change in the provision of primary health care services to remote or peripheral communities. They may imply some loss of locally resident health professionals. Further, given the interconnected nature of life in such places, the ripples of decisions about service redesign may have wider and unpredictable effects on social stability. Evidence points to the importance of secure infrastructure in resilient communities (Reimer, 2000). Health care provision is often included among a list of services noted as being fundamental to community life (Cloke, Milbourne, & Thomas, 1994; Hope, Anderson, & Sawyer, 2000), although there is still a lack of evidence regarding what people in different areas consider to be an ‘acceptable level’ of local service provision. Accessible health services are certainly seen as crucial by many local people as highlighted by recent action of communities in the Scottish Highlands mobilised by loss of GP and consultant surgeon services (see, for example: Helmsdale & District GP Action Group, 2001). Rural areas have traditionally been seen as bastions of ‘holistic’, patient-oriented continuing care and studies have shown the adverse effects on utilisation of services (Haynes & Bentham, 1982; Jones et al., 1998), screening uptake (Bentham, Hinton, Haynes, Lovett, & Bestwick, 1995), health outcomes (Launoy, Coutour, Gignoux, Pottier, & Dugulex, 1992; Jones & Bentham, 1995, 1997; Jones, Bentham, & Horwell, 1999; Campbell et al., 2000) and rural patients’ health and quality of life (Baird, Donnelly, Miscampbell, & Wemyss, 2000) of having to travel some distance to access health services. However, perhaps rural patients also sense that more than accessible health services would be lost to their community should some of the new models of service provision be implemented. The presence of many professionals (clergy, police, teachers, local government) living and working in remote communities has already been eroded (Boyle & Halfacree, 1998). The further potential loss of health professionals, leads one to ask—can service infrastructure continue to decline without heavy costs to community wellbeing?

Of course, change is not necessarily wrong. Communities and service provision should not be in stasis, but there are important issues at stake. Evidence to inform decision-making about rural health service redesign is essential. This paper highlights the need to know more about the contribution of health professionals to the sustainability of remote rural communities. We propose that health services, embodied in GPs, nurses and allied health staff, are part of the important underpinning for community and not simply because of their direct (curative, preventive and palliative care) contributions to patient health. Due to their role and status in rural communities, health professionals are often deeply embedded in the social networks that make up the ‘fabric’ of rural life. The existence of dense social networks is said to build social capital, a concept currently popular among policymakers and social scientists in helping to explain communities’ ability to adapt to change (Putnam, 1993a). We briefly consider how theories of capital might provide a useful framework for examining the contribution of health professional to remote communities. This paper brings together evidence from existing literature and seeks to

¹The crisis has arisen for different and complex reasons, including: general lack of medical and nursing staff, increased specialisation of clinical workforce, feminisation of medical model of working, comparison with perceived urban ‘9 to 5’, poor mobility for career moves out of remote/rural work.
make a case for research on the wider role of health professionals in remote communities. There is little evaluation of the social impacts of different models of health service provision. We argue there is a need to generate knowledge before personnel are lost or replaced by alternatives and before change is wrought that might affect the viability of some remote communities.

Remote and peripheral communities

The diversity and fluidity of rural areas is widely accepted (Halfacree, 1993). While a multitude of definitions and typologies of rurality exist (Hoggart, Buller, & Black, 1995), it is probably impossible to identify a definition that encompasses the many facets relevant to primary care across the UK (Farmer, Iversen, & Baird, 2001) and, indeed, researchers have been advised to use a definition that best suits their area of enquiry (Rousseau, 1995). Therefore, this paper does not tie itself to a quantitative or factorial characterisation, but instead broadly characterises the types of remote or peripheral locations envisaged.

Research on migration in several countries has shown that accessible and attractive rural areas have actually experienced a renaissance in population growth in recent years (Boyle & Halfacree, 1998). This has been variously attributed to greater car ownership, willingness to travel over longer distances to work and failure to develop attractive inner city living environments (Hugo & Smailes, 1985; University of Aberdeen & University of Cardiff, 2001). Many rural areas adjacent to towns and cities have thus experienced ‘rurbanisation’ effects (European Society for Rural Sociology, 2001) which have changed the nature of communities. Change tends to be characterised by mutually reinforcing effects; chiefly, travel over longer distances to access products and services and decline in local amenities (Joseph & Chalmers, 1995). Service decline impacts most on indigenous, poorer and elderly people as it is experienced as a loss (White, Guy, & Higgs, 1997). The result, reported by long-standing rural residents, is deteriorating community cohesion and identity.

While sharing these wider rural problems of local service decline, the types of areas envisaged in this paper are yet more challenged as they are characterised by relatively greater inaccessibility to urban centres and sparser infrastructure. These are the more remote areas of Scotland, including the Highlands and Islands, Argyll, Dumfriesshire and Galloway which contain areas of high peripherality, lack transport and communications infrastructure and do not readily attract medical or nursing staff. They generally have few economic opportunities and are highly dependent on service industry employment. These areas:

... at the edge of a communication system...away from the core or controlling centre of the economy... (Goodall, 1987).

A study considering health care for UK island communities noted that remote islands, in particular, experience a ‘penalty’ in service provision (Gould & Moon, 2000). This occurs through multiple effects: having to provide a certain standard of service to meet statutory and professional requirements although population numbers may be low; the need to cater for fluctuating population of temporary residents; high proportions of elderly patients; costs of transporting goods; and the need to pay incentives to recruit and retain health professionals.

The Scottish Highlands and Islands area extends over 39,050 km² and is described as one of the last unspoilt areas of Europe, a fifth of the land being classed as National Scenic Area and almost all of it as Less-Favoured Area for agriculture (Highlands & Islands Enterprise, 2001).

The area is one of most sparsely populated in the European Union (EU), with a population density of 9.5 people per square kilometre compared with Scottish average of 65.5 and EU average of 116 people per square kilometre in 1998. This places the region on a par with northern parts of Finland and Sweden. Thirty per cent of the population live on more than 90 inhabited islands including those forming the Orkney and Shetlands Islands to the north and the Inner and Outer Hebrides (Western Isles) to the west (Highlands & Islands Enterprise, 2001).

While more accessible areas within the Highlands are flourishing, the population of island and remote areas is declining and ageing. The population of the Western Isles has fallen by five per cent since 1991 (Highlands & Islands Enterprise, 2001).

Average gross weekly earnings for males and females in 1999 were lower in the Highlands and Islands compared with a Scottish average (male: £377.40 (Highlands and Islands) £406.00 (Scotland); female: £276.50 (Highlands and Islands) £297.70 (Scotland)). Highest employment is within service sector jobs (as shown in Fig. 1). Employment in public administration, education and health accounted for 39% of jobs on the Western Isles in 1997. Women occupied 74.9% of these jobs, many working part-time. There are high rates of long-term unemployment in island and remote areas, particularly among older age groups. The cost of living is higher than in more accessible parts of Scotland, with average prices for a range of goods being 9.8% higher, in winter 2000/01, than in the North-East Scotland city of Aberdeen. At that time, the price of petrol on the island of Islay, Argyll was 18.4% higher than in Aberdeen (Highlands & Islands Enterprise, 2001).
Recent research in rural Scotland has shown that residents think activities for teenagers, facilities for sport and leisure and local service decline need to be addressed (Hope et al., 2000). The need for differing policy for remote areas is highlighted by Highlands and Islands Council’s desire for major investment in roads development in contrast to national transport policy where emphasis is on boosting public transport use (University of Aberdeen & University of Cardiff, 2001).

The role(s) of health professionals

Given the situation in remote and peripheral Scotland, it is not surprising that studies of work in these areas show primary health care professionals dealing with patients presenting diverse health and social problems (Iversen, Farmer, & Hannaford, 2000). In other areas, these might be dealt with by a range of services and professionals. A district nurse in a study of Argyll, Scotland provided a flavour of her multi-faceted work:

There is a complete lack of services around here. I end up doing everything...rurality causes problems. I have to drop off medicine to people because there’s no pharmacy. I have to arrange carers. We just have to cobble everything together... (Farmer et al., 2002)

Cox and Mungall (1998) outline the wide-ranging tasks for UK rural health professionals and there is evidence confirming a similar picture for primary health care in remote areas in North America (Larson & Hart, 2000) and Australia (Wilks, Barnes, Paul, Wood, & Jones, 1997).

In remote areas of Scotland, nurses have combined roles including elements of community nursing, health visiting and midwifery. Findings about district nursing activity in remote areas of Scotland reveal different types of patient contact for district nurses (Lauder, Reynolds, Reilly, & Angus, 2001; Farmer et al., 2002). These might include intensive activities focused on particular sick or elderly people, often involving several
visits each day to provide health and social care and support to patients and relatives. One Hebridean nurse reflected her emphasis on keeping sick or elderly people ‘on the island’:

I’m a great believer in keeping patients in their own homes here because if you send them away from here you’re taking them away from what they’re used to. (Farmer et al., 2002)

While there is increasing evidence of the multiple facets of nursing in remote areas, coupled with findings about gaps in social (Harrop, 2000) and voluntary care provision (Craig & Manthorpe, 2000; Milligan, 2000), there is still a lack of explicit acknowledgement by senior health service management that social and wider ‘caring’ responsibilities are a valid part of the nurse’s job. This implies that a range of ‘social care’ tasks currently undertaken, may be undervalued (Audit Commission, 1992; Lauder et al., 2001). Because the wider role is difficult to record and undertaken implicitly, nurses may be left in a vulnerable position when their workload and productivity are audited.

General practice, regardless of where it is conducted, should take into account patients’ social and cultural contexts. In remote rural areas, where there may be no choice of GP, and poorer access to secondary care, social services and other support networks, the holistic nature of primary care is particularly important. In urban settings, continuity of care, a core value of UK general practice, is being eroded (Guthrie & Wyke, 2000). This relates to organisational changes, such as the move towards larger practices and the establishment of out-of-hours co-operatives. In remote rural areas, which often have small practices and little scope for sharing on-call, continuity remains (Cox, 1997). These organisational differences mean that rural general practitioners are likely to be more intensively involved with the health and social needs of their patients compared with their urban counterparts.

In addition to a responsive role in health and social care, it has been suggested that health professionals in remote areas can use their rich knowledge of community and patients proactively to protect and sustain health. A Scottish study found that rural district nurses became aware of a wide range of family and individual health problems at an early stage and from sources other than formal channels (Lauder et al., 2001). The researchers identified the concept of ‘community embeddedness’ as a central feature of the work of district nurses in rural areas. Embeddedness refers to nurses’ degree of integration with place and people in the community in which they practice. The research concluded:

The theme of community embeddedness suggests that rural nurses have a unique position within their community. This enables them to gain early insights into evolving human problems in the context of family systems and the dysfunctional person’s position within that community. This community-family perspective has both a practical and a symbolic element…[rural nurses]… are seen as central to a healthy and vigorous sense of community, in a very similar way to the local primary school. (Lauder et al., 2001)

As this last point suggests, the presence of health professionals may bring yet another category of benefits to communities. Indeed, we are proposing that health professionals may have a key role within the social structure of fragile remote and peripheral places. This role emerges from their situation and status in the community which legitimates them to be richly integrated in formal and informal social, as well as organisational, networks.

There is some evidence supporting this proposition, although none emerging from direct empirical study of health professionals’ contribution to social aspects of community. Cutchin (Cutchin et al., 1994; Cutchin, 1997a,b) studied the relationship between physician retention and ‘place integration’ in rural America. Intriguingly, he found that rural doctors who made a commitment to staying in a location, actively sought out roles in community associations and networks. Over time, rural doctors’ integration in the local social fabric, made quitting their job a less likely or attractive option. As the researcher concluded:

…by interacting through time with the emergent and ongoing problems posed by place, physicians become woven into the fabric of place. (Cutchin, 1997b)

Those who were not integrated tended to leave rural places. The overall theme emerging from Cutchin’s studies was that, if communities desired to retain doctors and nurses, they should make efforts to include them in local activities. These findings infer that health professionals who stay in rural areas over a number of years are likely to be well integrated socially.

Further evidence of health professionals’ roles in social structure is provided by Scottish research. An investigation of life in the Highlands and Islands described local district nurses and teachers acting as ‘mediators’ for their communities in negotiations with external bureaucrats (Shucksmith, Chapman, & Clark, 1996). These ‘boundary spanners’ (Anderson, 2000) were seen to be legitimised by the community to make such ‘vertical linkages’, while also enjoying ‘horizontal linkages’ through wide social contact with local people (O’Brien, Raedeke, & Hassinger, 1998). A study in rural Grampian, Scotland revealed that GPs were sometimes called upon to help in organising local events and arbitrate in disputes among neighbours; findings that
infer a role in community ‘leadership’ (Iversen et al., 2000).

While this evidence exists, we do not wish to suggest that health professionals hold a unique position regarding social integration and community leadership. Indeed, other service professionals, ‘entrepreneurial incomers’ (Anderson, 2000) and others may be similarly placed. However, it seems their position as respected cosmopolitan members of the local community must locate health professionals as key points of (apparently) ‘neutral’ advice and participation.

Empirical evidence about primary health care in remote areas of Scotland is only beginning to emerge, but data so far suggest the importance of carefully examining existing models of service provision before changes are considered (Farmer et al., 2002). Current provision may already represent efficient and effective models of supplying seamless health and social care for communities, simultaneously bridging gaps in access, and sparing demand on secondary care and centralised social services. Also, and of perhaps key importance to the ongoing life of fragile remote communities, they may be providing a crucial contribution to social infrastructure. It is interesting to note that in countries such as Australia where the problems of recruitment and retention of rural health professionals have been recognised for many years, there is still a policy of employing doctors and nurses locally, where possible (National Rural Health Policy Forum, 1999). Attention to the value of rural health professionals is evident at a number of levels including the establishment of several Australian university departments of rural health, a rural medical school, a range of incentives to rural working and support for health professionals’ families. It seems the presence of rural nurses and GPs is perceived as being intrinsically valuable as a sign of confident and sustainable rural communities (Bryant & Strasser, 1999). On a political level this is a sign of the value of the Australian rural vote.

To summarise, this initial consideration of health professionals’ roles suggests there is evidence of social contributions to community that extend beyond designated health service responsibilities. In considering health service redesign, it is important to appreciate and understand the full value of health professionals to community sustainability.

Life for health professionals working in remote areas

Studies of health professionals who continue to live and work in remote rural areas indicate that they and their families appreciate aspects such as ‘clean air’, beautiful scenery and a secure environment for bringing up children. Professional aspects such as variety of work and the chance to practise continuing holistic care are also reported to be important (Hamilton, Gillies, Ross, & Sullivan, 1997).

However, professional life in remote areas can be less than idyllic. A common view expressed is ‘it’s like living in a goldfish bowl’. It can be difficult to attain family privacy and appropriate employment for health professionals’ spouses (Hays, 1999). More than this, isolated populations can tend to engender feelings that the local doctor or nurse is ‘owned’ by the community (Rosenthal & Campbell-Heider, 2001). As Scottish researchers found:

Many district nurses took the view that locals regarded them as their own property and not someone doing a job for 37.75 hours a week. (Lauder et al., 2001)

In turn, health professionals may feel they are ‘oblighed’ to help out at all times:

District nurses embedded in the community reported feeling a commitment towards their community, which went beyond their professional remit. (Lauder et al., 2001)

Far from being a source of job satisfaction, health professionals’ status can act as a barrier to ‘normal’ life as it is perhaps difficult to integrate as an ‘ordinary person’. Since there are undoubted pressures inherent in working as a health professional in remote and peripheral areas, it is perhaps worth asking why some health professionals do actually stay? Do some professionals obtain more benefit from life in these communities than others? While Cutchin’s work, previously discussed, reveals how health professionals become ‘entangled’ in community networks, it is also likely to be true that some are more inclined to life and work in rural communities due to a variety of personal and professional traits and preferences.

Accomplishing community

In seeking to understand health professionals’ proposed social contribution, it is first necessary to review some findings about what is meant by ‘community’ and how people accomplish it (Scott, Park, & Cocklin, 2000).

Shortall (1994) defines community in terms of people “… living in the same geographical area and frequently feeling a sense of ‘community spirit’”. It has been suggested, when considering health policy, that the term ‘locale’ is most useful as it describes the ‘space used as a setting for routinised interaction’ (Moon, 1990). Having examined many definitions of ‘community’, Hillery (1955) defined a typology based on:

- ...
the process of identity building (Entrikin, 1999) which has place. Place and people are actively involved in this combine to build the social structures with which local place like the elements of a landscape. These elements shaping identity and sense of place, laying down public services and the churches) have effects on life (Philo & Parr, 2000). Cloke and Jones (2001) discuss indeed, Casey (1993) highlights the power of place to: isolation (Rousseau, 1995).

Discussions of rural community see their identity emerging from a combination of historical, relationship and spatial elements (Jones, 1995). ‘Institutions’ (including public services and the churches) have effects on shaping identity and sense of place, laying down “sediments” of action that serve to shape the norms of life (Philo & Parr, 2000). Cloke and Jones (2001) discuss the “taskscapes” that meld together jobs, people and place like the elements of a landscape. These elements combine to build the social structures with which local people identify to give them a sense of belonging to a place. Place and people are actively involved in this process of identity building (Entrikin, 1999) which has significant emotional effects (Cloke & Jones, 2001). Indeed, Casey (1993) highlights the power of place to:

...direct and stabilize us, to memorialize and identify us, to tell us who and what we are in terms of where we are...

Findings from ethnographic studies of rural locations are salutary in warning that beneath the apparent fixed and bounded territory. rural communities are still often portrayed as the last strongholds of ‘traditional society’, characterised by ecological friendliness, self-sufficiency, spirituality of life and exchange based on trust and kinship (Pawar, 2001). Exemplified by strong family or neighbourhood ties, as in Tonnie’s (1887) notion of ‘gemeinschaft’, they are held to be imbued with qualities of solidarity and reciprocity, where something of high value is obtainable: “...a sense of belonging to a face-to-face group” (Crichton, 1964). In Sack’s (1997) terms they are communities where life is “thick”, enriched by closely bound networks interacting in relative isolation (Rousseau, 1995).

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In this paper we are interested in health professional’s contribution to each of these aspects of community. Although the myth of the rural idyll has been firmly dispelled (Cloke & Thrift, 1994), rural communities are still often portrayed as the last strongholds of ‘traditional society’, characterised by ecological friendliness, self-sufficiency, spirituality of life and exchange based on trust and kinship (Pawar, 2001). Exemplified by strong family or neighbourhood ties, as in Tonnie’s (1887) notion of ‘gemeinschaft’, they are held to be imbued with qualities of solidarity and reciprocity, where something of high value is obtainable: “...a sense of belonging to a face-to-face group” (Crichton, 1964). In Sack’s (1997) terms they are communities where life is “thick”, enriched by closely bound networks interacting in relative isolation (Rousseau, 1995).

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Findings from ethnographic studies of rural locations are salutary in warning that beneath the apparent interconnectedness of ‘communities of place’, there lies a diversity of ‘communities of interest’ (Bell & Newby, 1971). Philo (1992) has highlighted the importance of considering the often-excluded “others” of rural communities (that is, non-middle-class, white, male perspectives (Murdoch & Pratt, 1997)). A study of the Mangakahia valley in New Zealand revealed three key social groupings (affluent incomers, traditional farming families and poorer Maoris returning from cities), each with a different perspective on societal change (Scott et al., 2000). In the Orkney islands of Scotland, Forsythe (1980) revealed a number of communities of interest affected differently by migration effects: former out-migrant returners, service professionals, ‘urban refugees’ and ‘natives’. Research in rural Grampian, Scotland revealed health professionals’ perceptions of a number of different patient groups, with differing service needs and demands: commuters, women at home with children, older people, families with socio-economic difficulties, incomers and rural people who had been born and brought up in the area (Iversen et al., 2000). The Cattell (2001) description of ‘membership groups’ in London communities highlights that such groups can appear distinct, but are generally inter-linked through patterns of membership.

These ideas about community suggest factors that could be important in examining health professionals’ contribution to social structure. They raise questions of: whether health services as ‘institutions’ might represent part of a geographical focus for ‘community of place’?; whether health professionals are a vital part of the network of social interactions that bind together disparate ‘communities of interest’?; or whether the presence of health professionals is important in maintaining community identity and values? The local presence of health professionals might have varying importance and relevance for different ‘communities of interest’.

According to a study by Shucksmith et al. (1996), there are three essentials of community: school, church, and a medical practice. (At the time of that study, only 56% of the Scottish Highland population had access to a GP within five miles). Later research revealed that the “core services” for a community were thought to be: shop, primary school, GP and community hall (Hope et al., 2000). These statements about essential or core elements require serious consideration. Are they really saying that, without these institutions, community is threatened?; or is a spatial concept of ‘community of place’ focused on central infrastructure being implied? If so, it is important to develop understanding of how key services affect the social and cultural fabric such that they bind together communities, enhancing quality of life and nurturing a sense of identity. If, in the future, fewer services are provided in situ, lost through societal change, service redesign or inability to recruit staff, might make a community lose its sustainability or begin to disintegrate?

This is clearly a bleak scenario whose existence can currently only be sustained through amalgamating hints of evidence. A New Zealand study revealed that the combined problems of ageing population and service depletion make life ‘tough’ for older people who choose to remain living in rural communities (Joseph & Chalmers, 1995). Younger people tended to move out to areas where services were accessible. Bryant and Strasser (1999) suggest that people need to feel ‘secure’ that they will be able to access the necessary level of...
health care, should a serious situation arise. People will not move to, or remain in, a community where they cannot receive health care in an emergency. It is perhaps mostly from these feelings of insecurity that anger about local health services decline arise, even although some studies (for example of rural hospital closures in Canada (Liu, Hader, Brossart, White, & Lewis, 2001)) have shown little impact on actual health. Clearly, there is a need for further information about how deteriorating access to local primary health care services might affect longer-term community viability.

Discussion has so far focused on 'communities of place'. There are, as noted earlier, other constructions of community. Massey (1994), for example, argues that place is not static or authentic, but resides in social interaction. Thus, predicting the decline of remote communities through service depletion is both unrealistically romantic, regarding place; and an over-reaction, regarding community decline. Massey (1994) describes community as residing where social interactions knit together. These 'hubs' may, indeed should, change over time. Further, due to the existence of different 'communities of interest', everyone has a different sense of place and community.

Following this line of argument, there would be little point in worrying about the effects of service decline on existing remote communities because societal change and adaptation are inevitable. Alternative constructions of community and identity will emerge around places and social systems. There are other societal forces, such as access to information and communications technologies, which are reconstructing the concept of community. Counter-migration back into remote and rural areas by entrepreneurial incomers and those seeking improved quality of life are engendering economic and social revival in some places (Anderson, 2000). Given the distances over which affluent people will commute or consume, it could be that a sense of community will be formed over wider geographical areas. Within such scenarios, although traditional community infrastructure changes and new patterns of health service provision emerge, the concept of community is still sustainable.

**Community sustainability**

Within a considerable literature on sustainability, Bryden (1994) highlights the need for rural communities to have:

...the capacity to regenerate socially and economically...the capacity to reproduce...and evolve economically, socially, culturally and ecologically.

Sustainability is a concept notoriously difficult to define, but Bryden’s description seems to encapsulate the notion envisaged in this paper. That is, we are interested in health professionals’ contribution to a community’s capacity to evolve and be a vibrant place to live, in the face of societal change.

Traditionally, discussion of community sustainability has emphasised the economic dimension, and it is only fairly recently that environmental, social and cultural aspects have become recognised as important (Rivlin, 1993). The Brundtland Commission on Environment and Development has urged work on measures of sustainability that emphasise the relationship between economic, environmental and social conditions (World Commission on Environment and Development, 1987). As yet, though, the relationship between factors and how they work to engender community sustainability is still poorly understood (Reed, 1999).

There is a developing discussion about the importance of social aspects in sustainability (Smailes, 1995). Social sustainability is said to depend on elements of “likelihood, social participation, justice, equity” (Scott et al., 2000) and sense of place (Stedman, 1999). Research involving Canadian forestry communities (Nadeau, Shindler, & Kakoyannis, 1999) has identified a set of concepts that are important in enriching understanding of social sustainability, as follows:

- **Community stability**: is proposed as a measure of the prosperity, adaptability and cohesiveness of people in an area and their positive reaction to change (Society of American Foresters, 1989).
- **Community capacity**: is the characterisation of a community’s ability to face changing economic, social and political circumstances.
- **Community wellbeing**: focuses on the degree of match between local community resources and the social, cultural and psychological needs of people living locally.
- **Community resiliency**: is concerned with the capacity of people and institutions to adapt to change over a long period of time.

These concepts are all underpinned by notions that infrastructural and social resources are required for communities to adapt successfully to change. We argue that local primary health care provision simultaneously contributes service infrastructure and ‘social capital’ (discussed later). The concepts listed above present a useful framework for analysing these inputs and considering the mechanisms by which they help communities to function and cope with change.

**Health professionals and community sustainability**

We need to begin to understand the role of health professionals in sustaining remote and rural
communities, particularly in light of what has already been lost to social structure through increasing centralisation. Research has revealed the significance of services that have already declined: the social role of resident clergy (Francis & Lankshear, 1992); the problems (real or perceived) with rural crime due to lack of police presence (Morris, 2001); the role of post offices, banks and village shops as ‘social hubs’ (The Countryside Agency, 2001); rural schools’ relevance in helping in-migrant parents to integrate and as a meeting place for parents from all social groups (Joint Unit for Research on the Urban Environment and the Department of Educational Enquiry, 1981; Witten, McCleanor, Kearns, & Ramasubramanian, 2001).

The current focus on access to health services in remote areas has revealed a surprising lack of understanding of the value of health services to communities. Some studies have noted the physical importance of the GP surgery as a meeting place (Farmer & Kennedy, 2001), but there has been little research into the nature of health professionals’ contribution to wider social wellbeing. The significance of health professionals to specific ‘communities of interest’ within localities is also poorly understood, for example, the importance of visits from the district nurse for the social inclusion of people with mobility problems.

The economic contribution of health service employment to remote communities has also been underplayed. Roberts (2002) described the increasingly important part played by the state funding of public sector activity in remote communities as the traditional economic base (fishing and textiles in the case of the Western Isles) declines. The key contribution of the public sector in local people’s employment has already been shown (see Fig. 1). Around 17,000 jobs are directly provided by the health care sector in the Scottish Highlands and Islands compared with around 8,000 in education and 12,000 in local government.² A recent US study highlighted that 15–20% of local employment was generated by direct health care posts and jobs created in servicing the health care community (Doeksen & Schott, 2002). A glance at the local directory on the Hebridean island of Tiree demonstrates little industrial activity and surprisingly little tourism-related development. Yet the island supports a population of around 750 people, many of whom obtain full or part-time employment from services such as transport, education and health care. It could be that service sector employment is making a key contribution to some younger families’ decisions to remain living and working in the community. With such a complex interdependent network of jobs and people, decline in the health service sector would have impacts on both direct health service employment and on associated posts.

Further, both US and Scottish studies have highlighted the important economic effect of local public service infrastructure in attracting tourists and retirees to locate in rural areas (Roberts, 2002; Doeksen & Schott, 2002). These are important groups in terms of their propensity to consume within local communities.

We argue that assessing the social and economic contribution of health professionals to community sustainability is worthwhile and timely. Examination of different types of remote communities (i.e. those that have traditionally had poor health service infrastructure, those that have recently lost services and those where service provision is still vigorous) could assist in detecting the contribution of health professionals. This strategy could prove useful in developing knowledge of who fulfills the proposed extended social role of health professionals, as well as their professional role, when they are gone. Such studies could reveal whether communities with and without accessible working health professionals exhibit different patterns of social interconnections. And, if infrastructural changes occur in communities, whether, and at what pace, society adapts.

Health professionals and capital

A growing body of work by sociologists, political scientists and others could provide a potential theoretical framework for understanding and analysing the resources necessary for community sustainability. This envisages the generation and spending of ‘capital’ (resources) within a number of key areas, including: material, cultural, symbolic and social. Consideration of health professionals’ role in relation to capital could be important in understanding their contribution to community. The possible relevance of theories of capital is discussed briefly here.

Social capital

The concept of social capital is currently prevalent in policy and academic circles (Baron, Field, & Schuller, 2000; Cote & Healy, 2001; Atterton, 2001) and it is therefore particularly relevant in examining issues pertinent to public services design. It is additionally apposite in the examination of remote communities which are thought to be more ‘traditional’ and therefore might be assumed to have greater potential to generate social capital. Like sustainability, social capital is an ill-defined concept. Although it is generally agreed that high levels of formal and informal social interaction benefit society, it is unclear whether this amounts to ‘social capital’. A lack of empirical evidence means that mechanisms, indicators and tools for measurement of social capital, are poorly developed (Baron et al., 2000).

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²Figures supplied by Highlands and Islands Enterprise (2002).
Social capital is said to form out of repeated social interaction between individuals and groups which develops trust, reciprocity and norms of behaviour (Coleman, 1994). The amount of capital built depends on the quality and quantity of interactions (Falk & Kilpatrick, 2000). A recent study of social capital within a rural community described resources as emerging through exchange of ‘knowledge resources’ and ‘identity resources’; that is, frequent allusions to shared knowledge, history and vision for the future served to enhance and embed social relations (Falk & Kilpatrick, 2000). Since it is proposed that health professionals in remote communities have a high level of interaction within their local community (horizontal linkages) and externally (vertical linkages), they are likely to be important contributors to building social capital.

There is some debate as to whether social capital can only reside with groups (Lochner, Kawachi, & Kennedy, 1999), having developed out of interaction; or whether individuals can hold ‘slices’ of social capital that are dependent on their place and status in social groups (Bourdieu, 1986). Adherence depends on different interpretations of the concept of social capital (Siiskiinen, 2000). Use of the word ‘capital’ would imply that the idea of social capital is premised on rational economic ‘exchange theory’. Bourdieu’s (1986) interpretation certainly holds that no accumulation of capital is disinterested and thus social capital would be built as a source of personal power. However, in viewing social capital as a by-product of social activities, other interpretations imply that it could have developed out of altruistic actions (Putnam, 1993b).

A disturbing element of social capital is its potential use to maintain status in the social hierarchy (Hawe & Shiell, 2000). Shucksmith (2000) notes the discord inherent within the concept of social capital which:

...can be a source of cohesion, but also of conflict as those who are excluded from the group in which the capital resides will not benefit... .

He provides an illustrative example from his own work, which found that European Union LEADER programme funds tended to be granted to those well-networked local ‘notables’ who already dominated rural development rather than to less experienced applicants. Massey (1991) confirms this notion of ‘power geometry’, conspicuous in rural areas. It might be argued that health professionals, simply through their position in the social hierarchy, exclude others from meaningful social roles; although again, there is no evidence on this issue.

Social capital is argued by some to be a key element in community viability and whether or not it develops to become a coherent and enduring concept, there is wide support for the relevance of strong social infrastructure to community wellbeing. Evidence indicates that health professionals are well placed to contribute to social infrastructure and, therefore, the relevance of social capital to an underlying theory for health care provision in remote communities should be considered. It is important also to reflect on those who stand to gain and lose from health professionals’ role in producing social capital when assessing the effects of their loss to communities. Again, it might be that different ‘communities of interest’ might be affected in varying ways.

Symbolic and cultural capital

Since we are hypothesising that health professionals play a role in community sustainability and that they are important contributors to social capital, it is now pertinent to ask—to what extent does this role reside with the job or with the individual? One school of thought argues that it is charismatic individuals who energise community or group achievement (Wilkinson, 1991). A study of the Scottish Highlands and Islands noted that:

... in the scattered communities, the doctors were revered for their commitment to the community and their accessibility...personal involvement with the community, integrity and conscientious visiting habits...[They were]...viewed as key local personalities. (Shucksmith et al., 1996)

Only two of the features present in that statement, ‘visiting’ and ‘accessibility’, might be construed as related to doctors’ health care role. Indeed the emphasis is on their value as individual personalities.

Contrary to this position, theories of capital would see power residing in the cultural and symbolic resources inherent in the professional role (Bhaskar, 1979). Bourdieu’s writing on social theory implies that health professionals are seen as respected ‘leaders’ by their communities both because of the cultural capital they hold (derived from educational and professional qualifications) and their symbolic capital or power (Swartz, 1997). Symbolic capital is that which is accrued through exercising their professional status. Health professionals and their patients might be viewed as being involved in a cyclical process of developing this capital. Put simply, because it is perceived by the community as important to have a local doctor, the person in that role can gain symbolic power within the community. Bourdieu’s philosophy suggests that such arrangements would be typical within traditional societies, where:

...individuals and groups draw on a variety of cultural, social and symbolic resources in order to maintain and enhance the social order (Swartz, 1997).
While the relevance of this theory within the context of contemporary (i.e. non-traditional) Western societies might be considered doubtful, there is some evidence from research in remote rural Scotland suggesting its validity. The Ennew (1980) ethnographic study of life on a Hebridean island and previously mentioned work by Shucksmith et al. (1996) noted that service professionals such as doctors, nurses and teachers were ‘expected’ to undertake tasks such as negotiating with those external to the community. Forsythe’s (1980) study of an Orkney island showed that cosmopolitan incomers tended to become community leaders and were ‘expected’ to provide employment, while the attitudinal norms of indigenous people forced them to be more reticent and passive.

This choice between charismatic personality or symbolic role being most important in ascribing health professionals’ identity in the community implies a dichotomy. Inevitably, the situation is probably more complex than this. Indeed, it seems likely that aspects of personality and role are inter-twined. It may even be that only certain types of personality respond to the social responsibilities attendant with working in remote communities.

Conclusions

This paper has attempted to develop the argument that health professionals, working and residing locally, make a valuable contribution to the social structure of remote communities, in addition to health care, social care and economic contributions. It seeks to stimulate consideration of the extent to which primary health care services are necessary to the infrastructure required to sustain communities into the future. It suggests that consideration of theories of capital, and particularly the concept of social capital, might be pertinent in understanding the extended role of health professionals in remote places. At the same time, it acknowledges that society thrives on change and communities might form around different models. New ‘communities of place’ and ‘communities of interest’ might have different patterns of leadership and perspectives on social activity and identity. New models of health care provision, with fewer local health professionals, might actually empower those traditionally excluded from participation in social infrastructure by prevailing hegemonies.

At root, we are urging for greater understanding of the roles of health care professionals in remote communities before new models of primary health care provision are introduced which might have unforeseen effects on social and economic structure. Currently, it seems, decisions about service redesign are being considered solely by health service stakeholders. Yet health service decisions regarding fragile communities may affect their sustainability and are relevant to all in society. A holistic approach to service redesign needs to be taken, informed by evidence about the potential impacts of change. At the very least, any new health care models implemented should be evaluated by assessing social and economic, as well as health care, effects. Moreover, decisions about health service remodelling should ideally be seen as part of a wider debate about the future sustainability of remote communities. As a society, do we value these communities? Do we want to keep them? Are they important to our cultural and historical heritage? What do they contribute to the future we envisage for our country? If they are valued, we need to invest in supporting them. This is a debate relevant to all in society, rural and urban dwellers alike. Government policies may need to reorient so that they are not simply addressing economic issues such as compensation for agricultural decline and small business start-ups. (Only so many pottery shops are needed in the Hebrides!) A substantial proportion of current full and part-time employment in remote communities is based around service and utility jobs. If society decided it wanted to invest in retaining remote communities, then steps to maintain service infrastructure could be taken. Careful reflection on policies and their outcomes in countries with a record of considering the rural agenda (for example, Canada, Sweden, Norway and Australia) would be instructive in highlighting the relationship between government support for services and rural community vibrancy. This paper does not seek to romanticise the role of health professionals in rural areas nor does it advocate an anti-change ‘museum strategy’ to service provision. It merely proposes that we need to explore health professionals’ roles in remote rural areas so evidence can be generated to inform strategic investment decisions about future health care provision.

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