



Territorial tensions: Misaligned management and community perspectives on health services for older people in remote rural areas

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ABSTRACT

This paper presents findings from a qualitative study investigating older people's health service provision in remote rural Scotland. Comparing stakeholders' perspectives, contested issues were exposed where community members, service managers and policymakers disagreed. Considering these, led to the proposal that fundamental tensions exist between community and management/policy stakeholders' perspectives and these underlie service change conflicts. While highlighting issues for older people's service design, findings suggest that impacts of the current planning process require to be understood, and aspects need to be changed, before the voice of older people can inform local service policy.

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1. Introduction

In Scotland, remote and rural community-based health care services have been regarded as a bastion of quality service provision. There has been a high ratio of health professionals in relation to population size,¹ with consequent relative ease of access to appointments (Scottish Executive, 2005a) and high public satisfaction (Farmer et al., 2005). Simultaneously, specialised aspects of care can be difficult to access; for example, mental health services (Philo et al., 2003). Internationally, rural service 'modernisation' is urged by a neo-liberal political response to contextual challenges. Policy-makers reassure that services will remain locally accessible and high quality (Scottish Executive, 2005b), but questions remain about how changing services will affect communities.

This paper presents findings from a study of older people in remote parts of the Scottish Highlands. Conducted as part of a 2005–06 European Union Northern Periphery (EU NP) Programme project, Our Life as Elderly (OLE),² explored views of older residents about

health service provision to inform future policy direction. There is little evidence about older Scottish rural community members' views in a context of rising proportions of older people and service change. Our previous work in rural communities highlighted discord between communities and service managers (Farmer et al., 2007); we were interested in stakeholders' views and reasons for similarities and differences between perspectives. An exploratory approach was adopted because the same overall topic was being investigated across the international regions of OLE and we wanted to avoid complicating interview questions for international participants by introducing specific national issues. Here, we present contesting views of community members and planners on key issues raised about service provision for older people in remote rural Scotland. We use these as evidence for suggesting that there are fundamental tensions in squaring managerial concerns with efficiency with the public desire for connected personalised services aligned to rural social conditions.

2. Background

2.1. Rurality and service change

Hugo (2005) describes how 'rural' and 'remote', terms used conjointly, actually have distinct implications. Rurality comprises a set of social living conditions and remoteness is about inaccessibility. Henceforth, we use the term 'rural', but as shorthand to encompass both features of rural social organisation

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¹ The NHS Scotland Information and Statistics Division (ISD) states that numbers of practices in the most rural NHS Boards stayed similar 1998–2005 (Highland 1998: 74 and 2005: 69 practices; Orkney Islands 1998: 15 practices, 2005: 14; Shetland Islands 1998: 10 practices, 2005: 10) [personal communication].

² Our Life as Elderly (OLE) was a European Northern Periphery Programme project, incorporating aspects of research and policy design focussing on older people in northern regions of Finland, Sweden, Norway, the Faroe Islands and the Scottish Highlands.

and inaccessibility to service centres. The Scottish Government defines rurality in terms of population sparsity and distance from service centres. The communities included here are designated 'very remote rural' (Scottish Executive, 2004): areas with settlements of less than 3000 people and a drive time of over 60 min to a settlement of 10,000 or more, they are defined as rural in OECD (2006) population sparsity terms and because their economic activity centres on agriculture and services. They lack infrastructure and their terrain is mountain, hill and moorland. For health care, the study communities experience typical 'rural' challenges of small, widely dispersed clientele, limited human resources, physical, technical and economic barriers to provision (Bryant and Joseph, 2001).

Internationally, rural health services are being reconfigured (British Medical Association, 2005; Humphreys, 2008), representing operational responses to fundamental socio-political forces. Service managers must match policy, context and a budget to provide safe, accessible and sustainable services. Technicalisation of public service work is one issue underpinning change in rural service models. This is manifested in professional role specialisation; for example, the NHS grading system rigidly delineates practice boundaries (Dept. of Health, 2004). Generalism is a poor career choice, with specialism linked positively to patient safety because practitioners are more experienced. Supplying specialist services in rural areas is prohibitive as large numbers of staff would be required (to comply with legal working time directives) and staff see insufficient patient numbers to maintain specialist skills. To counteract negativity about rural employment, working conditions and pay have been addressed for some groups; for example, the 2004 UK general practitioner (GP) contract was partly introduced to stimulate recruitment, releasing GPs from out of hours working requirements and increasing remuneration (Charlton, 2005).

Managerialism is the application of management techniques to service provision and pervades contemporary service delivery trends (Clarke et al., 2000). Industrial quality management techniques have influenced UK public service management since the 1980s. Target setting, bureaucratized governance and performance frameworks were developed under the 1990s New Labour administration, depleting health professionals' autonomy (Exworthy et al., 2003; McDonald and Harrison, 2004). Contemporaneously, evidence-based medicine (EBM) affected clinical practice, prescribing technical algorithms for care underpinned by findings from large clinical trials. Algorithmic care and volume targets have become paradigmatic, superseding contextual patient-focused care, placing "matters of efficiency above those of equity and entitlement" (Hanlon and Rosenberg, 1998, p. 559). This mass market approach fails to incorporate differing priorities that steer citizen's healthcare choices, including access to transport or proximity to relatives (Fotaki, 2005).

UK public service provision follows neo-liberalism, a political agenda prescribing withdrawal of the state and encouragement of individual and community responsibility. Scottish government policy states that the National Health Service (NHS) is a 'mutual association' owned by diverse stakeholders (Scottish Government, 2007). Rural health policy seeks 'resilient' communities (NHS Scotland Remote and Rural Steering Group, 2008), suggesting citizens should participate, for example, in self-care and community first responder schemes.

Worldwide, similar approaches to rural healthcare reconfiguration; have often resulted in centralisation (Fraser et al., 2005; Mungall, 2005), outreach rather than in-situ services and citizen involvement. Resistance to reconfiguration is also internationally manifested, resulting in conflict between rural citizens and service managers (ABC News, 2007, 2008; Thomson et al., 2008). Typically, policymakers tell rural residents that they will receive

'the same' quality of services as urban citizens, though they may be accessed through new types of providers and technology (NHS Scotland Remote and Rural Steering Group, 2008). Local people tend to reject this change (Farmer et al., 2007), fearing a locally adapted model provided by 'locals' will be replaced by peripatetic teams of specialists and impersonal tele-services. Citizens associate reconfiguration with threatened community sustainability, perhaps justifiably as research from other countries has highlighted the burden, for rural communities, of dealing with neo-liberal rural service models (Skinner and Rosenberg, 2006; Hanlon et al., 2007).

2.2. Service requirements of older rural people

High proportions of older people living in rural areas aggravates service provision challenges. Older people tend to experience complex long-term conditions demanding ongoing, and intermittently acute, support to ensure stability (Elkan et al., 2001). There is no generally accepted definition of an 'older person'. In the UK, using the state pension age—currently 60 for women and 65 for men,³ is a pragmatic solution. OLE included those aged 55 and over, incorporating a 'pre-retirement' perspective, active and independent and frailer individuals (Scottish Executive, 2007). By 2025, Scotland is projected to have 30% of its population aged over 60, compared with 27.4% for the UK, a figure comparable with Germany, Spain and Italy (Raeside and Khan, 2008). For the Highland Council area where this study was located, mid-2006 population estimates showed 25.3% of the population was of pensionable age (GRO-Scotland, 2007, p. 54). This is projected to increase by 51.3% by 2031, compared with a Scottish increase of 31.2% (GRO-Scotland, 2008). National and regional demographic statistics obscure smaller scale patterns influencing local service delivery. One Highland area, Ross and Cromarty, is projected to see a 149.4% increase in its over 75 population between 2006 and 2031 (Highland Council, 2008).

In the UK, pre or immediate post-retirement migration is common, with relocation to rural Scotland perceived as offering quality of life benefits (Richards and Farmer, 2003). UK rural demographic ageing is predominantly attributable to the out-migration of younger people, ageing of 'local' residents and the in-migration of middle-aged and retired people who then age *in situ* (Commission for Rural Communities, 2004). Older in-migrants may give scant thought to future care needs (Richards and Farmer, 2003), while their relocation can create considerable pressure for service providers because small differences in population needs impact considerably on staffing levels required. Rural health and social care workers have inconsistent workloads: they may be required, for example, to provide intensive palliative care for a period, followed by a time of light workload. This challenges service managers in designing sustainable jobs.

In Scotland, rural areas have the highest proportions of older people,⁴ but little is known about how being older may be different in rural or urban areas. Thewlis (2001) found that older rural people appreciate continuity of place and interdependence. Older people are the largest group in income poverty in rural

³ Between 2010 and 2020 the state pension age for women will increase to 65. The State Pension age for both men and women will increase from 65 to 68 between 2024 and 2046. <<http://thepensionerservice.gov.uk/state-pension/home.asp>>

⁴ In Scotland, for the years 2001–2005, over a quarter of the population in predominantly remote rural local authority areas (Dumfries and Galloway, Western Isles, South Ayrshire, Argyll and Bute and the Scottish Borders) were aged 60 or over but under a fifth of the population in the highly urbanised local authorities (including West Lothian, North Lanarkshire and Edinburgh) were over 60 (GRO-Scotland, 2007).

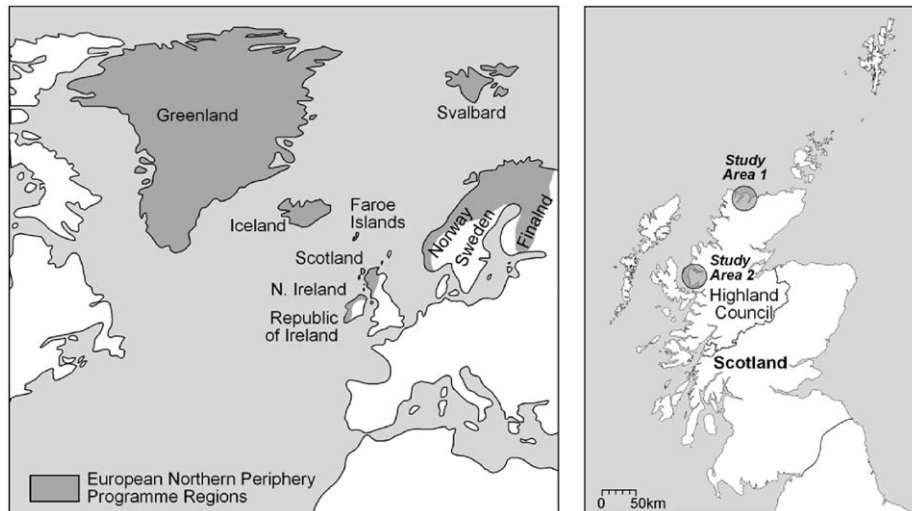


Fig. 1. European Northern Periphery Programme Regions (Interreg IIIB), left, and location of the study region and study areas, right.

Britain (Philip and Gilbert, 2007). Access to public transport is problematical (Wenger, 2001) and over 75s are less likely to own their own cars than younger adults, resulting in difficulty reaching advice, information and key services (Philip et al., 2003). Moving to supported accommodation often requires removal from rural communities (Philip et al., 2003), making it difficult to retain social connections. Conversely, older rural residents are more secure from crime, compared with their urban counterparts (Scottish Executive, 2000a).

Impacts of ageing on service provision are often portrayed apocalyptically. Internationally, public expenditure is two to three times higher for the aged than for the young (Gee, 2002). Older people, especially the very old, are more likely than other age groups to require a complex pattern of inputs from a range of services. A high proportion of older people repeatedly readmitted to hospital suggests insufficient community support (NHS Scotland, 2002). Policy promotes older people living independently at home and urges joined-up working between the caring agencies (Scottish Executive, 2000b). Simultaneously, the delineations between health and social care tasks are quite strictly defined, making joint working complex for workers and those cared-for. Apocalyptic demography has been challenged, with suggestions made that older people are undemanding and resilient. Although older people in Scotland may appear burdensome on the state, receiving if eligible, free home nursing care, personal care or help⁵ as well as free health care, it has been noted that it is a small proportion of older people that are intensive users of expensive specialised services (Wilson et al., 2005). Evans et al. (2001) have noted that new technologies and pharmaceuticals account for much of rising service provision costs. With improved health the “young-old” are active participants in society, taking on caring roles and volunteering (Philip et al., 2003).

2.3. Planning rural services for older people

It is frequently said that older people should have a greater ‘voice’ in service planning as their experiences and priorities can be misunderstood (Joseph Rowantree Foundation, 2004; Age

Concern, 2006). The current rural policy paradigm supports territorial planning, that is a place-based focus for determining service provision, economic planning and development (OECD, 2008). This reflects the interconnectedness of rural life and recognises the uniqueness of diverse rural contexts (Pezzini, 2001; Kitson et al., 2004). There is debate about how territorial planning could happen, with questions raised about the extent to which local people want to participate in community governance (Shortall, 2008). Given the prevalence of older people in rural communities, the lack of research interest in the role of older people in rural territorial planning is surprising.

3. Methodology

3.1. The case study communities

Part of an EU NP Project, this study was located in the Highland Council area. With an expanse of 39,050 km² and a population of 373,000, it is one of the most sparsely populated EU regions (Highlands and Islands Enterprise, 2008).

Two communities were selected as case studies with the potential to highlight views related to inaccessibility to service centres and staffing challenges (see Fig. 1). These met pragmatic criteria in that, firstly, they were remote rural sites and, secondly, project partners – Highland Community Care Forum (HCCF) – had workers located in the villages who could assist us with identifying study participants and participating in data collection. Case study Site 1, a community of approximately 400 people, is on the north coast. Case study Site 2 is on the north-west coast and has approximately 900 inhabitants. Their settlement structure is one of dispersed cottages and coastal strip housing, often linked to ‘crofts’.⁶ In 2005, Site 1 had 29.9% of the population aged over 65 and Site 2 had 24%, compared with Highland and UK proportions of 16.7% and 16%. Both sites have a community general practice providing 24/7 cover. Both are within 70 miles of a Rural District General Hospital and have day care facilities. Site 2 has nursing home facilities.

⁵ Personal care is intimate care, including washing and toileting. Nursing care requires the skills of a trained health professional. Domestic help includes chores around the house and shopping.

⁶ Crofting is a system of landholding unique to the Highlands and Islands of Scotland. <<http://www.crofterscommission.org.uk/What-is-Crofting.asp>> It involves a small agricultural land holding (commonly around 5 ha), normally held in tenancy and perhaps with associated buildings.

Citizens	Health & social care practitioners	Service managers & politicians
Older people wanted to remain as independent as possible for as long as possible. Wanted services to be delivered in a way that increased independence.	Health professionals described a population of older people who were independent and undemanding of the services available.	Older people should be living independently at home for as long as possible so money needs to be directed out of care homes and into the community. Funding to cover change is limited.
It is likely that people have to move out of their community if they need to live in a care home. People wanted to have access to a small care home locally in order to stay in their community.	Health professionals talked about how important it was for older people to stay in their communities. There were times when this was not possible, especially for people with dementia.	Small care homes are very expensive per person. Innovative solutions and sheltered housing are needed. Goal should be most gain for most people. Small remote care homes don't provide nursing care anyway.
Meals on wheels service had deteriorated since reorganisation. Would like meals on wheels organised as it was previously – cooked locally and delivered by local volunteers.	Staff believed that it was a mistake to change the way that meals on wheels were delivered to people in remote and rural areas.	The need for a meal is a separate thing to the need for social interaction. Social interaction can be obtained in other ways. Old scheme failed on quality; was difficult to staff and inconsistent in coverage.
People very pleased that local GPs have decided to continue to offer 24 hour care. Would like this to continue.	GPs and nurses also wanted GPs to continue to offer 24-hour care.	Can understand why people would like this because it gives continuity and trust. But it will not last and will go as GPs retire. Other practitioners should be developed to do some of the tasks.
Healthcare services were described as excellent. People wanted to maintain the quality of their local healthcare services.	Health professionals talked about the commitment of the staff to meeting the needs of older people. They described how important it was for them to provide good quality care and gave examples of how they worked well together across different agencies and disciplines. They identified difficulties with health and social services working well together at management level.	People need to understand that the way health services are being provided is changing.
Unhappy with home carers carrying out personal care such as washing or dressing. Would like nursing assistants to carry out such personal care.	Some nurses said that it was difficult for patients to accept that the role of the home carer had changed.	Part of this is just what they are called – perhaps they should be home health workers. It's not nursing care. People are reticent because they are used to health professionals in intimate situations, but not these new workers.
Very satisfied with nursing service. Would like to have one general worker (a nurse) who would do all that was needed in one visit.	Health professionals described working together with social services to attempt to reduce the number of visits to patients. They supported the idea of a general worker.	Yes nurses are excellent and the service is changing to make the most of their skills, but bring in other practitioners to do non-nursing tasks. Completely support the idea of a generic 'assistant'.

Fig. 2. Summary matrix of stakeholder views.

3.2. Data collection methods

OLE involved five participant EU NP regions investigating older people's views about health services. Each participant region, other than ours in the Scottish Highlands, included local government representatives. Our university-led Scottish team was challenged by EU partners to involve service managers and policymakers so that findings could influence policy. We did this by engaging managers and policymakers in discussing findings from interviews with older people. With ethical committee approval, an exploratory qualitative research design was adopted. Interview data were gathered from older people, focusing on opinions about health services. These data were used to derive themes about services that were then discussed with service providers, service managers and policymakers. This approach allowed stakeholders to respond to older people's viewpoints in a non-confrontational situation. Differing perspectives on service provision were revealed which, in turn, allowed us to consider underlying tensions.

Firstly, semi-structured face-to-face interviews were held with 12 men and 11 women: age range 55–87 (median 64, mean 67), evenly split between the two study communities. Participants were recruited with the assistance of the HCCF. To include different views, our sample included varying socio-economic background, lengths of time lived locally and levels of community involvement. Participants were approached by researchers once initial consent was obtained by HCCF workers. Interviews lasted for about 1 h and were conducted in people's homes. A topic guide covered experiences of local health services, individual's wants regarding key attributes of future services, the role of technology and the role of family and the community in supporting older people.

Issues raised by participants were consistent within and between case study sites. The most frequently repeated themes emergent from the interviews with older people were used to form a topic guide for a second phase of interviewing; this time, with health and social care practitioners. In these, participants were asked questions in the format: 'The older people we spoke with thought X, what do you think about that?'. Interviews lasted between 40–60 min. Practitioners were identified by contacting general practices and requesting that a GP, a nurse, a home care worker and a healthcare assistant be nominated. The residential care home manager at Site 2 was also interviewed. This made a total of nine phase 2 (service practitioner) interviewees: two GPs, two community nurses, two home care workers, two home care assistants and one residential care home manager. A further iteration of interviewing (phase 3) involved a similar process with service managers and politicians. These comprised the Heads and Deputy Heads of Departments providing health and social care services for older people in Highland (four interviewees), three local authority councillors and three local Members of the Scottish Parliament (MSPs) (representing Scottish Nationalist Party (SNP), Green Party and Labour Party) with a stated interest in older people's services. All persons who were approached consented to be interviewed.

Interviews were recorded and transcribed verbatim. Data analysis followed 'framework analysis' (Ritchie and Spencer, 1994), adapted to accommodate our iterative approach. The transcripts from interviews with older people were read independently by three researchers and a thematic coding schedule was developed based upon issues raised consistently by respondents (for example change to 'meals-on-wheels' service and high satisfaction with GPs). Data were coded, using NU*DIST software for management. Data were scrutinised for similar and divergent perspectives, but there was strong convergence of themes amongst the transcripts. Interview data from service providers,

service managers and policymakers were then compared against themes raised by older people. Relationships between older peoples' and other stakeholders' responses were then explored. A summary 'matrix' (see Fig. 2), encapsulating responses of stakeholder groups, was circulated to participants for verification.

3.3. Findings

The interview guide for older people asked about health services, but responses ranged across topics including formal social care, informal helping, housing, transport and meals provision, apparently indicating perceived interconnection of many aspects of community life and wellbeing. Here, we report the most consistent emergent issues about services from interviews with older people and juxtapose these with the reactions of health and social care providers, managers and politicians to highlight where there were differing perspectives. Issues are grouped into three broad themes: where older people should live; the way that services should be provided; and who should care and help.

3.4. Where should older people live?

Reflecting other studies, older people emphasised the importance of living independently in their own homes if possible (Cloutier-Fisher and Joseph, 2000; Harrefors et al., 2009). Health professionals confirmed that older local residents *and* more recent incomers were fiercely independent and largely undemanding of services. If needs necessitated moving, most interviewees emphasised the importance of staying in their community. Some raised the importance of the view from their window and being near friends (alive and dead). Reflecting on how older people needing extended care have to leave their community and go to live at considerable distance, in a variety of different residential facilities, interviewees said that once older residents leave, others accept they will not return. Removal was described as depressing for the older person and for their friends and relatives who become separated by distance. It was suggested that important social, cultural and historical assets were lost to communities when a long-term local resident had to leave to live in a care home.

"... where somebody got to that stage when they had to go into care. They went to Invergordon or somewhere like that ... The day they went in there was the last day they would see their village that they loved" (Male aged 60)

Interviewees wanted small local residential care facilities so that, even when very infirm, older people could remain in their community. Health professionals recognised the significance for older people of staying locally, but noted times when the level of care required meant this was impossible (e.g. for those needing dementia nursing care).

Service managers noted that older people's desire to live independently aligned with policy promoting 'active ageing' and self-reliant living (Scottish Executive, 2007). Managers interpreted expressions of a desire for independence to mean that older people agreed with their policy of focusing on home care and disinvesting in rural residential care; however, community members still wanted local residential care for those who could no longer cope at home. Managers noted that supporting frail people at home was complicated by poor private housing conditions in the remoter Highlands,⁷ but aspired to develop

⁷ Research by Scottish Homes, Communities Scotland and the Commission for Rural Communities has identified a high proportion of private housing below tolerable standard in remote rural areas.

housing with integral social and e-monitoring support. Service managers and councillors thought that more of those currently in residential care could be living at home, suggesting older people were sometimes placed in residential care to meet their distant relatives' desires to know they were 'secure', rather than from need. In 2001, the number of people, per 1000 population, aged 65 and over in residential care in Scotland was 17, while in Highland Council area it was 23 (Scottish Executive, 2001).

Considering small local care facilities, two MSPs (SNP and Labour) and all councillors and service managers stated that these were unsustainably expensive at per person costs around four times more expensive than in larger facilities (in 2006, the average gross weekly cost of a local authority care home place in Highland council area was £612, compared with an average of £512 for Scotland) (Scottish Government, 2004). Due to sporadic client throughput, care facilities were said to operate below capacity and staff recruitment was difficult. Supported housing was promoted as the most feasible option. Service managers stated that their goal, in allocating resources, was achieving the most gain for the most people:

"The problem is that residential care, especially in remote and rural areas where the numbers of beds are low, it is extremely expensive ... We have closed ... residential beds because they were costing almost £2000 a week per person... If we are given the money, we will not be spending it on two or three beds in a remote area..." Councillor 2

"You have got to decide on—do you disadvantage that very small group of people who may have to travel a bit further so that you can continue to maintain the people in that community so they don't have to move... that is the very difficult decision that councillors have to make..." Councillor 1

At the time of the study, Highland Council's policy was to focus on home care ironically, with a political leadership reorientation in 2007, older people's care policy has changed and Highland Council is now developing some rural residential care facilities.

3.5. How should services be provided?

'Meals-on-wheels' provision (the delivery of meals to people who find it difficult to prepare a meal at home) was raised frequently by older interviewees as an example of what they *did not* want to, but feared would, happen to services in the future. In the rural Highlands, food used to be cooked locally and delivered by volunteers. In 2004 a Highland Council policy decision was taken (also by other Scottish local authorities) to replace the 'meals-on-wheels' service with frozen meals, produced and delivered monthly or fortnightly by staff of a private company. Meal provision moved from being a visiting voluntary service to one consisting of providing a freezer, a microwave oven and a fortnightly delivery of a frozen meal supply.

Interviewees liked food being cooked and delivered by volunteers, locally. They suggested that the meals are, in a sense, incidental—it is what they and the service around them represent that is critical. This is, having someone local visit regularly with whom 'news' and chat can be exchanged, a connection providing social contact to those whose mobility is restricted. Interviewees thought that the way meals are now provided was impersonal and symbolic of society's lack of value of older people.

"... a few times I did meals on wheels myself. When you went round to some of the old people's houses you had a job getting away ... You would have a dozen meals still to deliver and they were wanting to sit and have a wee blether because they were quite isolated" (Male aged 72)

Health and social care professionals said the new meal provision model neglected elements of social support and day-to-day surveillance. Service managers had a different view and were supported by most of the local councillors, one of whom said:

"I think there are two things there. The need for a meal and the need to meet people. The two are not the same... If a care plan is saying that Mrs. MacKay needs a meal, she needs a meal seven days a week—not once a week when it can come from the school kitchen or something like that... If all she needs is social contact, then you need to build that into the care plan..." Councillor 1

Service managers thought service users underestimated the challenge of providing meals across the Highlands. Change was required because the old scheme did not meet health and safety requirements: delivering consistently hot meals in a rural area at lunchtime was difficult. Some people got their meals early and reheated them; others received meals in the afternoon when they had got cold and reheated them. Some of the food prepared was of poor nutritional quality ('pink custard' and 'like school meals') and it was difficult to recruit volunteers in some areas meaning that regional coverage was inconsistent. Local councillors thought a good meals-on-wheels service was ideal, but overly challenging to provide.

Technology is increasingly proposed as part of the solution to home care for older people. Interviewees accepted that technology would increasingly feature in future care, but they feared impersonal, technical, solutions being implemented as the whole, rather than part of, the service.

"I think it (technology) has its place as long as we do not lose the actual face-to-face contact as well. It is not a replacement ... certainly it is not an alternative to the real thing" (Female aged 60)

Interacting with health and care workers was regarded as socially and emotionally beneficial. Interviewees stressed the value, in isolated settings, of maintaining personal and social connections. Many houses were second homes and, in winter, there might be few people living close by to talk to or to 'keep an eye' on neighbours.

Service managers and politicians thought that technology would increasingly support living in rural areas. Health professionals agreed that technology was part of future health-care, but reiterated the social and surveillance aspects of personal interaction, as well as the therapeutic aspects. A visit to an older person's home has added value that could be overlooked if replacing the apparent health or care intervention with a phone call or a monitoring device. Health professionals, in particular, have legitimised access to private homes that few others enjoy.

3.6. Who should provide care and help?

Changes have occurred recently in the provision and terminology of care in the UK. Home carers now conduct 'personal care' tasks such as washing and toileting, with domestic carers designated to assist with household tasks. Older interviewees expressed unease at home carers carrying out intimate aspects of care. They thought that 'nursing assistants' should undertake these tasks. Several suggested that one generic worker, combining social and health care, but "from a nursing background", was a sensible, multi-functional, solution. There was frustration with

the current division of labour:

“...you seem to have different carers for different jobs ... the carer just does certain things and she is not allowed to do anything else. Sometimes you don't need them to do a lot and other times you need them to do things that you cannot do yourself. There seems to be a rule that they are only doing one thing...” (Male aged 60)

Health and social care professionals reported that they were working to reduce multiple professional and carer visits. Most of the service managers and politicians thought that those with nursing skills should not conduct the tasks of home (social) carers; rather, they should be deployed on specific nursing profession tasks. Some expressed the dilemma about an efficient model of care:

“...I have heard of nurses in remote communities going in and giving people baths because there is no-one to do it. Is that the most efficient use of a trained nurses' time? In some respects you can argue, yes, because while you are doing that, you are doing an assessment... but if that person actually does not have any nursing needs other than a bath, then is it appropriate? If that person is having that nurse spending an hour at their house doing everything that they need, then who is carrying out the nursing needs of the person down the road?” Service Manager 4

In spite of provisions of their contract, GPs in the two study communities had opted to continue 24/7 cover. Older people appreciated this and they and local health professionals wanted 24/7 cover to continue. GPs and nurses discussed how working collaboratively with colleagues from other agencies was key to providing services that looked joined-up to their recipients. They stated that, although services often did not integrate well at the management level, they could ‘*make things work locally*’.

Politicians and service managers appreciated the benefits of GP out-of-hours cover, but said local people would have to become more self-reliant. They suggested that GP cover was unsustainable and that continuous care will disappear as older health professionals retire. It was acknowledged that services are often worked out ‘on the ground’ because of confusion between different managers and, despite a perception of collaborative relationships at strategic level management, co-operation disintegrated when budgets were involved.

4. Discussion

We set out to explore issues for rural older people that would inform future policymaking around service provision. In doing so, we revealed service areas that were contested between rural communities and managers and policymakers. Looking across these, we identified some recurring tensions that appeared to underlie disagreements. We present these here and suggest that these may be fundamental to understanding the gap between current methods of planning and managing to actually implement new service provision models. If older people's voices are to be meaningfully incorporated into planning and developing new rural services, these require to be acknowledged as legitimate and addressed.

4.1. Tensions in management approach: divided vs. connected

There is a tension between the way that community members interact with services and the ways that services are planned and managed. Community members' discussions crisscrossed between health services, social care, transport, meals and housing,

showing an interconnected understanding of these topics. They appreciated the ‘added value’ aspects of services: visits by health and care professionals were noted as having a social interaction dimension, for example. In contrast, policymakers and managers saw needs as silo-ed technical inputs; for example, a councillor said meals are ‘about nutrition’ and social interaction is a different input.

The challenges caused by the divisionist tendencies of technicalisation and managerialism are revealed, with managers struggling to provide delineated specialist functions (nursing, nutrition, social care, social interaction inputs) in a context where citizens see interconnection, where services have previously been provided connectedly and where local health and social care professionals say they still endeavour to join-up services ‘on the ground’. Given difficulties, including recruiting specialists and maintaining their skills, divided service provision appears inappropriate for our study communities. Combining service inputs could cut costs and provide sustainable ‘portfolio’ jobs in rural areas.

4.2. Tensions in solution size: regional vs. local

Community members and local service providers described how provision ‘on the ground’ occurred through combining different local service providers and neighbours. Thus, organisation of provision is negotiated and embedded within the local social context (Granovetter, 1985), manoeuvring around European and national structures. Some aspects are so monolithic that they cannot be adapted for local preferences (e.g. the new model for meal provision), but other national agreements are adaptable, notably 24/7 cover by GPs. The situation exemplifies suggestions of Malpas (2003) who argues there has been a move in service provision planning from a place/context focus to an abstract, ‘spatial’, efficiency orientation.

4.3. Tensions in resource allocation philosophy: utilitarianism vs. community-centred

In this study, service managers and policymakers displayed a utilitarian philosophy of resource allocation, stating that resources should be allocated to provide the most satisfaction for the most people. Community members, conversely, were focused on how local people could stay in their communities and did not suggest issues of how resources might be shared across the region. While councillors expressed concern over the unsustainable cost of small local facilities, they neglected inequitable access to residential care facilities across the vast Highland region. The question might be asked: why should an older person in Inverness (the Highland ‘capital’, population 45,000), for example, be able to move to residential care within their community, yet someone from North-west Sutherland (3–4 h drive from Inverness) be unable to do so? Both places are on the Scottish mainland and share the same local authority and NHS Board. Hanlon et al. (2007) highlight the ‘particular tyranny of numbers’ associated with service centralisation that disadvantages rural communities. Contemporary policy loosely addresses equity, suggesting equivalent outcome should be expected, rather than equivalent service experience (NHS Scotland Remote and Rural Steering Group, 2008). It is somewhat ambiguous what this actually means, but presumably that citizens in different places may obtain their services through different providers or via a different patient journey, but they should emerge equally ‘well’; for example, in a remote area it might be better to airlift an injured person rather than send an ambulance.

4.4. Tensions in knowledge: management experts vs. community experts

A further tension lay in communities' 'we want what we have' perspective and service managers' reconfiguration preferences. In this study, locals liked what they had known because they perceived it to work for them. Simultaneously, as in the case of meals on wheels, managers and councillors illustrated why traditional solutions no longer worked due to regulation or legislation imperatives, such as failing to meet health and safety standards. Managers also showed that they access comparative information (for example, the costs of provision of different types of care) when considering options. Thus, there is incongruence between the type of knowledge steering citizens' decision-making and the type that service managers and politicians use. Incompatibility between lay contextual knowledge and 'expert facts' has been highlighted as a source of discord in service provider public engagement (Healy, 2008).

What does our analysis suggest for engaging older people's voice in rural service policymaking? Advocates for territorial planning might view community members' bricolage tactics in constructing services locally to fit their needs as evidence for instituting place-based governance. Had local (sub-local government unit) governance been in place, communities could have designed their own local solutions to service delivery challenges. Solutions to providing a meals service might have resulted in diverse solutions such as developing a social enterprise or establishing a lunch club. On the other hand, we found paternalistic attitudes to service provision among older people and local service providers (expressed in, for example, desire for 24/7 on-call GPs and personal care from nurses), suggesting work would be required to persuade people about more participative models of governance and service delivery.

Regarding our study methods, interviews with older people provided rich data on wants for services in settings where service delivery systems are pushed to their limits. Using this data to elicit views of other stakeholders was beneficial as it: (a) focused questioning on the 'real' issues as seen by older people; and (b) served to inform and engage stakeholders in discussing older people's views as well as eliciting *their* views. The findings, based on two (in many ways, relatively homogeneous) locations with accessible residential care and a 24/7 local general practice may not typify all of rural Scotland. Other communities, with different service accessibility, may have divergent opinions. While lacking urban comparator sites, we suggest that aspects of our findings are distinctly 'rural/remote' and would not be manifest in 'urban/accessible' settings. In cities, providing service specialisation is efficient because populations are large and co-located. Service users are more likely to be able to access transport alternatives to reach service options. They are less likely to know their providers or be used to negotiating provision with them. Far from service alternatives, rural residents may be more tenacious in holding on to their existing services, seeing change as threatening the very viability of their community's future.

5. Conclusion

In this paper we suggest tensions that result from a misfit between the way communities live and the ideology and methods driving management and policy-making. If the voices of local people are to truly be incorporated in service design, then the first step is to acknowledge that rural citizens have a distinct and legitimate perspective that aligns with their desire for quality of life in sustainable communities. Place-based policy might help produce appropriate services and fewer disputes between

managers and community members, by allowing an arena for information exchange, discussion and building relationships between stakeholders and for identifying local priorities. Pilots of different ways that rural community members, and in particular the array of rural older people's voices, could be incorporated in local service planning and governance (including budget-holding), would be an interesting next step. Incorporating rural community voices should contribute to creative solutions as local people respond to their own challenges with contextually-achievable solutions. Taking more ambitious steps in local governance would show the degree to which 'mutuality' in service planning and provision is realisable, its effects and whether 'better' services emerge from formal local governance.

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