

Connected care in a fragmented world: lessons from rural health care

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ABSTRACT

This paper uses the phenomenon of very high satisfaction with remote rural health services in Scotland as a trigger for exploring what consumers want and like in health service utilisation — and why. It draws on the business literature in customer services marketing and economic sociology to illuminate why long-term associations between consumers and providers in health care are important and beneficial. In doing so, it highlights wider lessons about the experience of good health care to be learned from the satisfaction expressed by rural residents and suggests, as health services become increasingly fragmented, the relevance of maintaining a connected experience for patients.

Keywords

continuity of patient care; health care reform; patient care; patient satisfaction; rural health services; Scotland.

INTRODUCTION

In 2002 a national survey was conducted comparing attitudes to health care in rural and urban Scotland.¹ Remarkably, and counter-intuitively given their distance from a choice of services, people living in the most remote areas of Scotland were most satisfied with health services. They were 2.5 times more likely to be very happy with their local GPs and around twice as likely, compared with people in other types of location, to be very satisfied with hospitals. Within several dimensions of the survey, rural residents showed a different perspective on health services compared with their urban counterparts. The national survey research team were intrigued by this finding, which contrasts with findings of low satisfaction with rural health care in other parts of the world. Therefore the potential reasons for this curious Scottish remote rural health phenomenon, were explored with particular regard to the wider implications for healthcare provision.

UK rural residents' expressed satisfaction with health services has been found in studies preceding the 2002 survey.² Reasons have been suggested including stoicism and low expectations, but unsurprisingly given the complex nature of the issue, there is little empirical evidence.

Since the 2002 survey, qualitative studies comparing Scottish rural and urban health care have been conducted, allowing exploration of people's reactions to the healthcare systems they are presented with. Emergent issues are that rural health care is appreciated as being personal and supportive compared with descriptions of apparently 'cold' and less caring urban health services; and the way that people behave in relation to rural health care may be different as a result.

The benefits of continuous patient care have long been promoted by health professionals and the idea is generally regarded as either: accepted — on the basis of personal perception and an extensive literature on patient–doctor relationships; or anachronistic because we live in a modern age where choice is suggested as the prime characteristic of service valued by patients. In this paper it is suggested that, certainly in remoter rural areas of Scotland, health care is more than continuous, it is connected — and that is worthy of

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scrutiny. In this sense, connected care means that patients and health professionals have mutual personal and contextual knowledge that reaches beyond healthcare transactions. Connection implies enhancement of aspects of healthcare provision, and further, implies contributions to social bonding and social capital. Connected care is satisfying for patients because it is knowledge-rich and 'rational', as shown by evidence from social economics and produces an attitudinal contract.

In this paper, customer services marketing and economic sociology literature is drawn on to penetrate the surface of connected care and explain why people like it. This is of interest to health services now because:

- quality and performance measurement continues to have a technical focus to the detriment of valued personal aspects;
- restructuring neo-liberal governments tell us, without much proof, that what is most important to the consumer is choice; and
- future health care has the potential to be so fragmented. There are increasing types of providers, super-specialisation and differentiation of tasks within teams. Simultaneously, policy suggests modern health care should have a local focus³ and moves to supported self-management could provide real opportunities for greater continuity of care, certainly for those with chronic illness.⁴

Contrary to some government statements, consumption of health care is not like buying a car. There is evidence to support this and the importance of connected care.

THE PRODUCTION OF CONSUMER SATISFACTION

It is generally agreed that satisfaction is a difficult concept to 'pin down', but is an important, valid and useful measure of consumers' experience of services. Rust and Oliver⁵ suggest that satisfaction results from evaluation of an overall service experience integrating perceived quality, value and performance. From a healthcare perspective, satisfaction is regarded as a subjective and personal evaluation consisting of assessments of interpersonal manner, technical quality, accessibility and/or convenience, financial arrangements, efficacy and/or outcomes, continuity, physical environment and availability.⁶ However, there has been little exploration of these dimensions and their relative weighting in producing satisfaction.

Level of satisfaction arises from 'expectancy disconfirmation'. That is, prior to consumption, the

consumer expects a certain level and type of experience. After service consumption, a comparison is made between actual experience and prior expectation; the gap represents the level of satisfaction. Assuming consistent service provision, with ongoing consumption of the same service, the gap between expectations and experience may be supposed to diminish because people will grow to know what to expect. Thus, assessments of satisfaction with a service consumed over time should be more secure than those for one-off experiences as they are based on accrued experiences.

CONSUMING SERVICES

Consumption of health services is a peculiar business. Unless a product or intervention is received, there may be no tangible evidence that a service has been given; for example, if advice is provided by a health professional to a patient. Further, the consumer is an integral part of the service that is produced. The quality of the output is dependent on the relationship between the consumer and producer and their exchange of information.

Gronroos⁷ has suggested that services comprise technical and interpersonal dimensions. The technical aspect is the 'core' service — it could be clinical expertise or an intervention. The interpersonal aspect concerns service delivery and includes cognitive features (for example, appropriateness and amount of information given) and affective features (for example, perception that problems are listened to, and showing interest and understanding). Thus, the interpersonal enhances a service by providing appropriate information, that is appropriately communicated.

A further peculiarity of consuming health services is that it involves the consumer, to a large extent, in believing that health professionals' diagnoses are accurate and that they may require attention. Health services are regarded as 'high credence' services in marketing terms as often the consumer may not actually know if a service is needed and has to

How this fits in

In contrast with other parts of the world, UK rural patient satisfaction has been good. Stoicism and low expectations are suggested causes. Connected, continuing care may actually underpin rural satisfaction. Healthcare reform could cause fragmentation, but should aspire to connectivity.

place their trust in a health professional's opinion.⁸ Further, until the recent advent of tools like league tables and health information on the internet, consumers had few means of assessing the technical quality of health services prior to consumption and had to take professional advice.⁹ Even now, credible sources of technical information for consumers are limited, and, prior to receiving a clear diagnosis, it is difficult for patients to determine what information to seek.

Thus, interpersonal communication between health professionals and patients is hugely important in health services. In a study by Brown and Swartz,¹⁰ communication with the doctor emerged as the most important factor affecting client evaluations of service. Mittal and Lassar¹¹ compared consumption of health care with car repairs. They found interpersonal aspects were more influential in consumer's evaluations of health care, while technical aspects were emphasised in assessing car repairs.

OPTIMISING COMMUNICATION

Customer services literature suggests that the quality of interpersonal exchange is heightened where transactions between consumer and producer have developed over time. Enhanced mutual knowledge, empathy and trust result from lasting customer relationships.¹² Further, at some point in enduring associations between consumers and producers, interactions become 'embedded'; that is, they move from being isolated and episodic to becoming part of an ongoing social narrative with the potential for synergous connections outside the core reason for interacting. Within embedded associations, repeated interactions lead to the emergence of tacit negotiated 'rules of engagement'. These are grounded, again tacitly, in a desire to maintain ongoing social relations because these have 'economic' benefits for participants. These benefits can be explained as economically 'rational' because they reduce costs of exchange, but they also bring added social benefits. The principal economic benefit is that the 'costs' of finding new information are minimised because participants have a history. When interacting within an embedded relationship, information:

*'... is cheap ... richer, more detailed and known to be accurate Individuals with whom one has a continuing relation have an economic motivation to be trustworthy and ... continuing relations often become overlaid with social content that carries strong expectations of trust and abstention from opportunism.'*¹³

Uzzi¹⁴ studied the nature of transactions within a New York business community and found a number of time-saving and economic benefits emerging from enduring relationships within a business network of customers and producers. As mutual knowledge developed over time, participants were able to quickly direct new contracts to appropriate providers without wasting time in researching information providers and their capacity.

Other studies found mutual commitment, loyalty, cooperative action, mutually altruistic behaviour, joint problem-solving, service customisation and increased confidence emerging from long-term associations between consumers and producers.¹⁵ These are aspects that, in addition to easing and enhancing exchange, contribute to overall positive emotional affect. The contribution of embedded associations to social capital (a way of conceptualising the intangible resources inherent in community, shared values and trust that we draw upon in daily life)¹⁶ and the benefits of this to the wider community, have also been explored.¹⁷

It is interesting that, although some researchers note social benefits emerging from embedded associations, others have emphasised that bonds between consumers and producers may be strong without being overly close or emotional. This is important if considering embedded associations in health care because we are told that most modern consumers want partnership and equivalent status in relationships with health professionals. Bonds can be built on the basis of an information-sharing and emotionally reinforcing association rather than dependence or patriarchy.¹⁸

The benefits of continuity of provider in health care have been widely rehearsed, although generally without theoretical reference points.¹⁹ There has been debate over whether the same professional must be involved or whether ongoing care from a team is sufficient. Few connections have been made with the wider customer services literature that explains why interpersonal communication is so important in healthcare service provision and with economic sociology literature that explains how knowledge and other benefits within consumer interactions are optimised. However, on the latter point, researchers have made the connection between extending medical history into biographical knowledge about the patient — and the capacity to provide enhanced care.^{20,21}

CONNECTED CARE

In rural Scotland, and particularly in remote areas, associations between consumer and producer in health care go beyond even the embedded — they are connected. That is, health professionals and

patients live in proximity with shared contextual, family and health service knowledge. To a large extent this is because healthcare provision is concentrated in the hands of a small team so visits to the general practice or small local hospital will expose patients repeatedly to the same healthcare personnel. In addition, it is accepted that isolation from specialised health services, pharmacy, accident and emergency services and a range of social, counselling and voluntary agencies means that patients may seek out rural health professionals for advice or assistance with issues that, in an urban area, would be the province of a specific service. Thus, there are heightened opportunities for mutual exchange of information and acquisition of knowledge within a relatively small pool of healthcare consumers and producers.

In addition, rural healthcare consumers and their health professionals often live in the same community and are known to each other personally as well as professionally. This provides opportunities for gaining further knowledge about the family, social and work circumstances of participants.

Economic sociologists dichotomise models of social living into 'ideal types' — situations of extreme that may not exist, but serve to provide a clear description. Thus, Polanyi *et al*²² contrast reciprocal models of living, where transactions are based on mutual obligation, with market-based society, where contractual relationships exist between exchangers. Similarly Giddens²³ contrasts pre-modern communities emphasising 'trust in persons' with modern society emphasising 'trust in systems'.

Much of remote and rural Scotland still demonstrates features of traditional community living, underpinned by social interaction between well-known individuals.²⁴ Recent comparative studies in Scottish rural health care show differential patterns in expected behaviour between rural residents and their urban counterparts. For example, a study of patients' decision making in primary care showed that rural patients, particularly those of smaller, more remote general practices, tended to consider before calling how their doctor could perceive them and their desire for an appointment.²⁵ This study revealed evidence of an implicit attitudinal contract among rural patients 'not to bother the doctor'. Sturmberg²⁶ noted the existence of 'a contract involving attitudes' within continuous primary health care based on stability of relationship, good communication and the mutual goal of health improvement. Other studies have suggested a 'contractual' relationship binding health professionals to their communities. A study of change in small rural maternity units highlighted

that midwives perceived pressure from the community for them to resist change.²⁷ In another setting, community nurses perceived pressure from local people for them to keep sick older people in the community when they actually required more specialised care from an acute centralised unit.²⁸ The role of connections between personal knowledge and health care in rural areas has been noted by other researchers with outcomes noted as including customisation of care and more in-depth advice.²⁹

ALTERNATIVE REASONS FOR RURAL SATISFACTION

Thus far, the argument has been pursued that rural residents' high levels of satisfaction with health services derives from their likelihood of enjoying the highest 'connections' with their health professionals, resulting in heightened mutual knowledge, minimised economic costs of transactions and an attitudinal contract. It is important, however, to briefly review some of the other potential reasons for, or at least contributing to, rural consumer satisfaction. Some rural researchers have suggested that rural residents start with low expectations.³⁰ However, surveys (including those by Hope *et al*² and Shucksmith *et al*²⁴ quoted earlier in this paper) have shown that while rural residents are satisfied with services such as education and health, they are highly dissatisfied with some other facilities; for example, activities for children and teenagers. Such findings discount the theory of low expectations. They similarly refute suggestions of a 'halo effect' arising from rural residents' appreciation of their living environment and that satisfaction is proclaimed as a gesture of rural difference.

Watt³¹ suggested that expressions of rural satisfaction may reflect a considered appreciation of actual service provision. Scotland's rural residents have reasonable access to primary healthcare services and some have good access to excellent community hospital facilities. In 2003, 94% of Scotland's rural residents could reach a GP within 15 minutes.³² Until recently this access was largely available round the clock, 7 days a week, but has now mostly been replaced by NHS 24 (triaging telephone helpline) and an unscheduled care service out of office hours. Compared with patients of large urban general practices, rural residents find it easier to gain an appointment with a doctor of their choice. Compared with other countries, GPs are fairly evenly distributed across urban and rural Scotland,^{33,34} thus there is no troublesome rural-urban divide in equity of access. Additionally, doctors in some Scottish rural areas have traditionally tended to have smaller list sizes compared with their urban counterparts.

More specialised services are much less available to rural residents. While a 2002 survey suggested that around 86% could reach a hospital within 30 minutes, on exploration this statistic conceals the 40% of rural residents, and the almost 70% of very remote rural people, that could not reach general surgery inpatient services within 30 minutes.³⁵

While reasonable access to basic health services may be reflected in rural residents' levels of satisfaction, it is questionable why their perceptions should be so different to those of their urban counterparts who, after all, have greater access to a range of health, social, voluntary, counselling and private services generally within shorter travelling distances.

CONNECTED CARE MAY NOT SUIT ALL

The *raison d'être* of this article has been to suggest that connected care is liked by consumers and produces benefits. In the UK today it is most likely to be found in more remote rural areas — although this is eroding — and that is why this group expressed such high satisfaction with health services when surveyed in 2002.

But, connected care may not be wholly beneficial. Participants in embedded consumer–producer associations may reach incorrect conclusions or experience communication difficulties because of socioeconomic differences, incorrect interpretation of information or fear of others' perceptions and reactions. Not all relationships will be favourable and in rural areas there may be difficulty reaching an alternative provider. There may be difficulties for health professionals and patients arising from the suggested 'attitudinal contracts', which could deter a necessary patient consultation or prove an emotional burden for health professionals. Recently, Chew-Graham *et al*³⁶ noted difficulties in ongoing relationships because doctors were reluctant to encourage patients to change unhealthy behaviours for fear of affecting future interactions. Issues such as non-compliance, unpleasant medical information or difficult diagnoses could be problematic to discuss where health professional and patient are very well known to each other.³⁷ Business literature also suggests difficulties in connected service provision; some consumers can experience better treatment than others and some may feel trapped in relationships because of loyalty. Embedded associations can pressurise people to conform to behavioural norms, acting as a barrier to innovation and questioning.³⁸

These possible difficulties for some must be balanced against the weightier evidence suggesting substantial benefits from high mutual knowledge between health professionals and patients.

CONCLUSION

This paper proposes that a 'connected care' association between health professionals and patients is valuable to patients and in the wider potential benefits produced. Given the history of writing about the importance of continuity of health care this paper is perhaps not suggesting anything radical or that most health professionals could not agree with. However, it moves beyond that literature by drawing on customer services and economic sociology literature to provide a wider theoretical and empirical base plus explanations for some of the phenomena observed in patient–doctor relationships. It is hard to prove that connected health care in rural Scotland accounts for high levels of satisfaction, but a body of evidence could be interpreted as pointing in that direction and there is much less to refute the contention.

Rural health care is changing and if the 2002 survey was conducted today, findings could be different. As a result of the new UK GMS contract, many rural GPs have opted out of out-of-hours care, perhaps only marginally reducing their interactions with patients, but with substantial symbolic implications. Scottish health policy is seeking to grapple with the demands of providing remote and rural health care and contains an implicit tension between what can and should be provided locally, and what must be provided more centrally due to human resources pressures of many types. There is tremendous potential that the traditional model of rural GPs in many settlements will be replaced by outreach services, nurse practitioners, physician assistants and larger, more centrally-located extended primary care services staffed by a range of practitioners with special interests. Empowerment of local people through community initiatives and supported self-care is mooted. All of these initiatives represent opportunities for remote and rural health care, but there is potential for fragmentation of connected care. The Scottish NHS has looked critically at the past, but perhaps only from a managerial and clinical perspective and not fully from that of the patient looking for satisfying healthcare experiences.

There are good aspects of the current model that it is important to retain, while discarding that which is bad or unsustainable. The customer services literature drawn on here was designed mainly to inform commercial business — and it is perhaps salutary to briefly consider how the matter of customer relationships have been handled there. Banks are a good case in point, like health care they are 'high credence' services as faith is required in the integrity of financial services. Here, two main

approaches have been taken to customer relationship management — databases used to target particular services at individuals based on profiles generated, and personal bankers. Research has shown these strategies to be variable in their success. Consumers have a fairly cynical perspective on the targeted marketing produced through database strategies and personal bankers find it difficult to establish meaningful relationships with the large numbers of clients they are allocated.³⁹ The conclusion: it is very hard for large organisations to have connections with individual customers. Evidence continues to point to the value of connected associations between producers and consumers, particularly for high credence services; it would be innovatory and exemplary if the NHS could make this part of a clear strategic vision — and do it better than business.

Competing interests

The author has stated that there are none.

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