

# Service Provision and Rural Sustainability: Infrastructure and Innovation

RPLC Webinar  
February 2019

Greg Halseth, Laura Ryser, Sean Markey, Neil Hanlon, and  
Sean Connelly



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Social Sciences and Humanities  
Research Council of Canada

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# Agenda

1. Introduction of panel
2. Introduction to the topic, book
3. Case chapters:
  - I. Pursuing alternative infrastructure arrangements
  - II. Rural health service delivery challenges in New Zealand
  - III. Partnering for health care sustainability in smaller urban centres
4. Discussion



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# Introduction: A Way Out of Policy Incoherence...

- Goal: sustainable and resilient rural communities
- Major shifts in thinking / approach:
  - Economic growth to integrated rural development
  - Sector-based to place-based development



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# Rural Services



# Rural Competitiveness Connection

- Importance of competitiveness to rural development:
  - Human capital
  - Social innovation
  - Quality of infrastructure, etc.
  - Tax rates
- Combine competitiveness with place-based development
- Quality of life for rural residents (attract, retain)
- Service and infrastructure connection to community resilience



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# Challenges of Rural Service Provision

1. Classic rural dynamics of distance, density, human capital
2. 30 years of neoliberalism and market-oriented policy that allows market failures to impact rural and small town communities
3. Crumbling service infrastructure – end of life cycle for investments made following WWII
4. New economy and new resident expectations requiring new suite of service provision

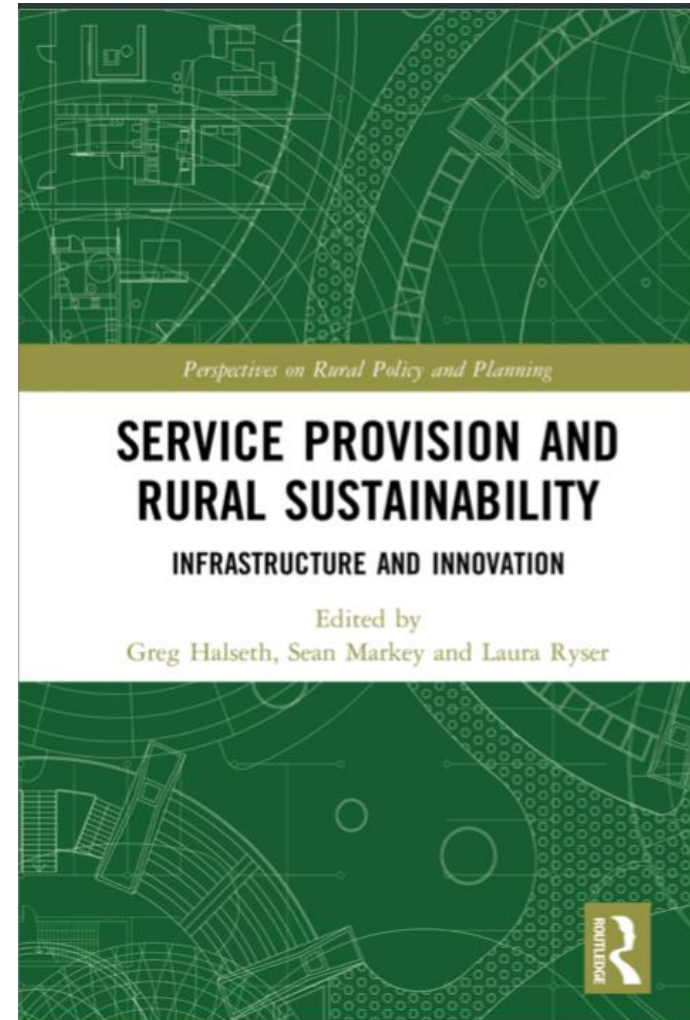


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# Moving Beyond “Reactionary Incoherence”

- Awareness of the problem
- Knowledge of approach, solutions
- Search for and testing of solutions, examples
- 12 chapters – 3 sections (4 OECD States)
  1. Government policies
  2. New service arrangements
  3. New infrastructure arrangements



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# Pursuing Alternative Infrastructure Arrangements to Strengthen Rural Service Provision

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Laura Ryser, Greg Halseth, Sean Markey



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**UNBC** UNIVERSITY OF  
NORTHERN BRITISH COLUMBIA

**SFU** ENGAGING THE WORLD



# Study



# Findings

- Funding
- Governance
- Site selection and design
- Human resources
- Equipment and technology



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# Funding I

- Industrial restructuring and closures
  - Challenged requirement for matching funds for provincial / federal infrastructure programs
- Industries reduced community donation programs
- Smaller economies of scale
- Fewer resources



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# Funding II

- Neighbourhood Learning Centres
  - Provincial joint infrastructure initiative to save rural schools
  - But... no long-term certainty to protect assets from future school closure decisions
  - Rural stakeholders building financial reserves to purchase facilities in the event of closures



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Photo credit: NDIT

# Governance I

- Tendering and construction often managed by a school district or local government



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Port Clement Multipurpose Centre

# Governance II



# Site Selection and Design I

Shared  
reception

Multi-purpose  
rooms

Shared  
whiteboard  
walls

Shared Wif-fi

Shared staff  
rooms

Family rooms

Expanded  
storage in  
walls

Shared tele /  
video  
conferencing

Shared  
kitchen

Quiet rooms

Separate  
inside /  
outside access

Shared audio-  
visual  
equipment



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# Site Selection and Design II

- Modifications for regulations / service providers
- Ground floor access to accommodate seniors, young parents, or people with disabilities
- Modifications to enhance energy efficiency
- Helped to make wiser use of limited budget resources



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# Human Resources

- Greater stability and coverage for day-to-day operations
- Shared administrative and financial staff:
  - Supported communication and reporting
  - Worked through grants / procurement processes,
  - Processed applications for property tax breaks
  - Submitted invoices / tax returns
- Human resources expanded after savings from shared staff
- Joint recruitment and training



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# Equipment and Technology I

- Opportunities to share resources, reduce costs, and use shared spaces
  - E.g. equipment, phone and Internet service plans, multi-media infrastructure, and supplies
- Use of opportunities varied
  - Underutilized by more self-contained groups



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# Equipment and Technology II

- Broadband infrastructure remains limited in some parts of rural BC
  - Limits the design and potential of multi-purpose facilities



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Photo credits: Ukees, WCCRS: Ucluelet, BC

# Moving Forward I

- Short-term priorities of governments / boom and bust conditions
  - Not compatible with collaborative arrangements
- Inadequate time to mobilize and engage stakeholders in building relationships and planning
- Funding models support hard infrastructure without resources for planning and operations



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# Moving Forward II

- Need central hub for service / infrastructure models
- Need opportunities to learn about:
  - Ownership and user agreements
  - Design features for multi-purpose spaces
  - Risks and liabilities
  - Protocols to guide development, operations, and maintenance
- Need greater political leadership to shape shared infrastructure and service arrangements
  - Shared services assessment teams or managers



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# Rural health service delivery challenges in an era of neo-liberalism in New Zealand

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National  
**SCIENCE**  
Challenges

**BUILDING BETTER  
HOMES, TOWNS  
AND CITIES**

Ko Ngā wā Kainga hei  
whakamāhorahora

# Outline

- Rural health context in NZ
- Role of health partnerships, community trusts and social infrastructure
- Community health trust model
  - Lawrence
  - Clyde – Dunstan
  - Tapanui
- Uneven development / uneven rural healthcare?



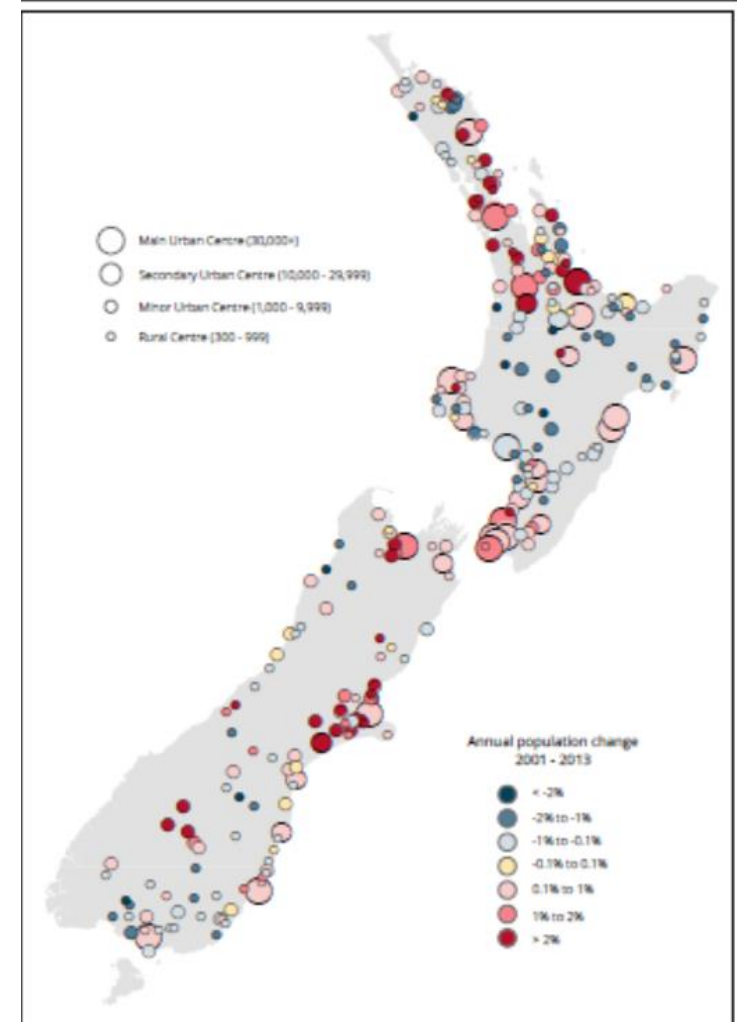
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# Rural health context

- Declining rural populations / rising healthcare costs / government austerity
  - Local communities rely on own resources and capacity to preserve services
- Health outcomes defined by location?
- Rural health / wellbeing / community development linkages



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# Rural health context

- Decentralized rural health care up to 1960s
- State control 1960s-1990s
- Neoliberal restructuring
  - Switch to population-based model (prioritizes greater centralization)
  - Otago region 7 → 3 hospitals
- Community filling gap with rationalization and withdrawal of state support



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# Health partnerships, community trusts and social infrastructure

- > Community mobilization around preservation of services
  - > Health services
  - > Professional jobs
  - > Community development
  - > Attract new residents / maintain existing residents
- > Social capital, social infrastructure
  - > Sense of identity
  - > Social relationships, trust
  - > Solidarity
- > From protest to co-provision



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# Co-production / co-delivery of health services – community health trust model

- CHT model
  - Local leadership and innovation
  - Lobby external support
  - Local capability
  - Local professionals
  - Voluntary and financial support, commitment, networking
  - State support
  - Broad accountability and legitimacy
- Benefits – greater community control, improved access to services, empowerment
- Challenges – large administrative burden, significant financial impact, polarization in community over focus of trust activities

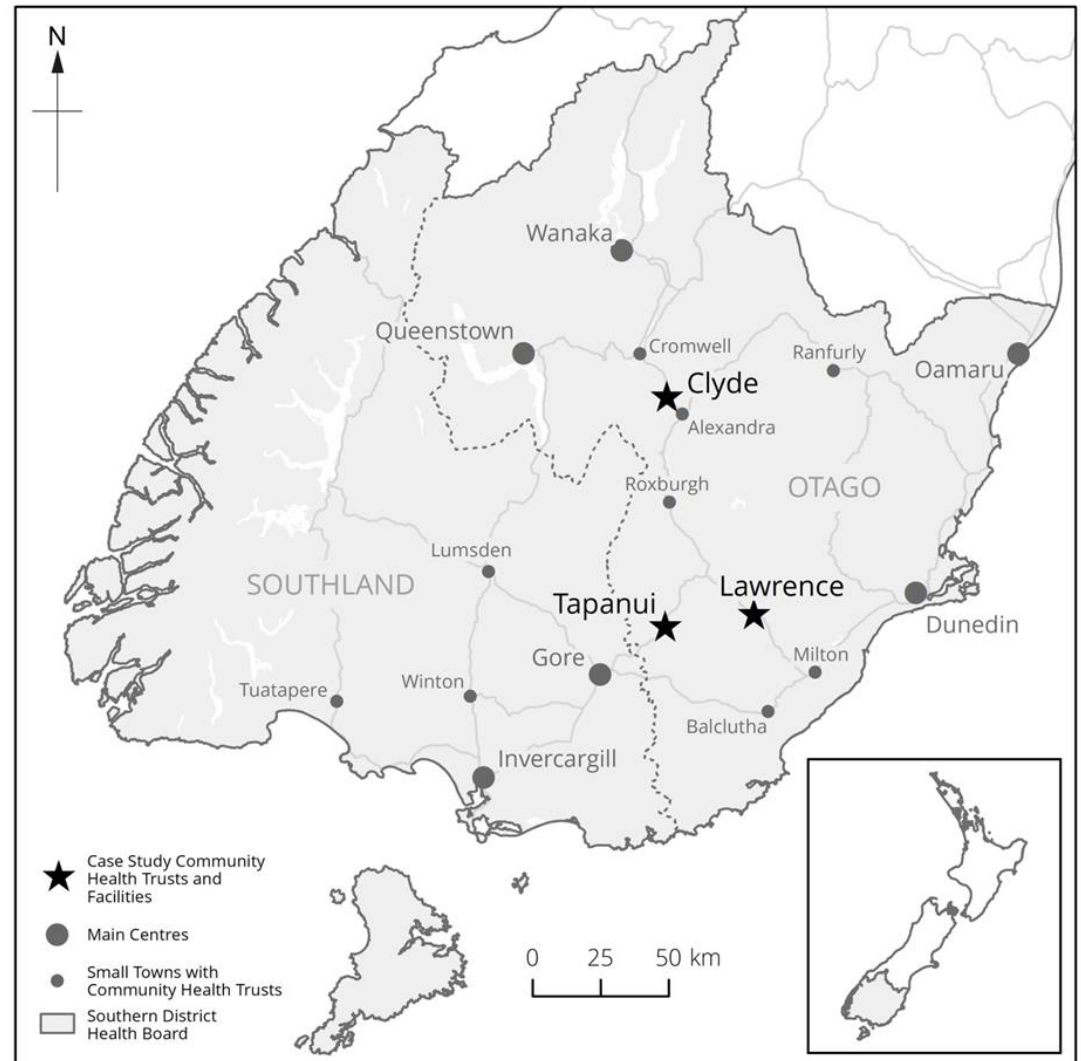


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# Co-production / co-delivery of health services – community health trust model

- Lawrence
- Clyde – Dunstan
- Tapanui



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# Lawrence



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# Tuapeka CHT



- First CHT in 1992 – direct community take over of state hospital – facilitated by service agreement that provides state subsidy per bed
- Pre-existing community groups that galvanized support (\$1 for hospital / \$1M for upgrade)
- 17 rest home beds, five DHB subsidised hospital beds, general practitioner services (which also nets a state subsidy), community nursing, and meals on wheels in the community
- Purchased pharmacy
- 23 local jobs (\$0.7M local salaries)



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# Uneven development / uneven rural healthcare?

- The importance of community capacity, social cohesion, and social capital in responding to the needs of communities undergoing transition
- Reliance on community fundraising, voluntarism, and a redefinition of health facilities / services
  - Innovation and success where capacity exists
- Pop-based funding model has negatively impacted rural areas
  - Devolution of management and responsibility of health care to rural communities in the context of reduced state financial input.
- Urban bias implicit in this scenario serves to reinforce geographically uneven development which is the spatial hallmark of neoliberalism



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# Partnering for health care sustainability in smaller urban centres: Why and how a health authority chose to ‘go upstream’

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Martha MacLeod (School of Nursing, UNBC)

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David Snadden (Faculty of Medicine, UBC)



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# Introduction

- Rural and small town challenges
  - Smaller populations, geographical remoteness
  - Poorer health outcomes, more complex care needs
- Calls for primary health care development, but persistent barriers to reform
- Exploring the case of health care reform efforts in northern British Columbia, Canada
  - How and why a rural health authority chose to “go upstream”



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# Northern Health's service area



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Source: Kyle Kusch, 2018

# Case study: Northern Health's reform approach

- A 'structured community engagement approach' to achieve sustainable, integrated, community-centred health systems
  - (1) Foundations of community collaboration (2002-05)
  - (2) Adaptive strategy (2006-09)
  - (3) Upstream engagements (2010 to present)



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# (1) Foundations of community-based collaboration

- Federal Government's *Primary Health Care Transition Fund*
- Northern Health's (2003a) *Improving our Health, Improving our System ....*
- ... (2003b) *Community Collaborative Project* (implemented in 7 sites)



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## (2) An adaptive strategy

- Committing to move beyond the pilot stage
- Formalization of *Care North* – partnership between physicians and Northern Health (but what of communities?)
- Guided by a vision of “[a] health care system founded in primary care and community” (NH, 2008, p.10)
- Centre-piece of Northern Health’s *Strategic Plan, 2009-2015*



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## (2) An adaptive strategy

- (I) Six 'change leader' community sites chosen for first wave of reforms
  - Implementation Committee members recruited (program managers, health professionals, municipal leaders)
- (II) Analysis and priority setting at each site
  - Implementation Committees meet regularly
- (III) Detailed plans for health service realignments and healthy community initiatives at each site



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# (3) Upstream engagements

- **Healthy Community Partnerships**
  - Established in all six 'change leader' sites by end of 2010
  - Eleven established by end of 2011
- Emerging sense of health care agency among municipal leaders



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# Discussion

- Key factors in success of NH's approach
  - Persistence
  - Opportunism
  - Organizational stability
- Missteps and setbacks along the way
- But strong partnerships have emerged, including municipal leaders as agents of health care change



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# Conclusion

- Transferable lessons
  - Value of a place-based focus
  - Moving health care reform beyond health professionals & administrators
  - Some degree of central direction necessary (information, resources)
  - Value of adaptive strategy and collective learning
  - Whole systems change is complex, slow



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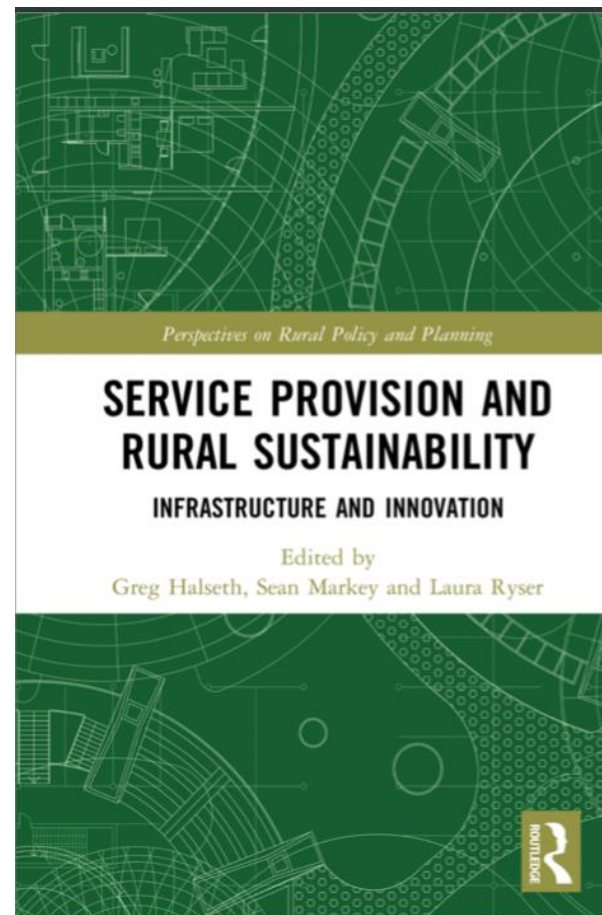


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# Closing Discussion: Central Argument

- We need a more entrepreneurial approach to local service delivery and infrastructure provision by local organizations and local governments
- Not to be confused with market-oriented solutions advocated by neoliberalism – i.e. senior government abandonment to the market



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# Closing Discussion: Policy Recommendations

## **Rural Service and Infrastructure Delivery:**

1. Place-based and highly context sensitive
2. Regionally coordinated (but not regionalized)
3. Co-constructed with rural communities, local governments and senior governments

## **Rural Policy Oriented Towards Pragmatic Innovation**

Rural proofing; scale-up pilot programs; local governments as conveners; re-scale financial resources and jurisdiction; pragmatic accounting and monitoring; life-cycle approach to human capacity; synchronize infrastructure investments; value-added regionalism; integrated senior government policy



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