



Care interrupted: Poverty, in-migration, and primary care in rural resource towns



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ABSTRACT

Internationally, rural people have poorer health outcomes relative to their urban counterparts, and primary care providers face particular challenges in rural and remote regions. Drawing on ethnographic fieldnotes and 14 open-ended qualitative interviews with care providers and chronic pain patients in two remote resource communities in Northern Ontario, Canada, this article examines the challenges involved in providing and receiving primary care for complex chronic conditions in these communities. Both towns struggle with high unemployment in the aftermath of industry closure, and are characterized by an abundance of affordable housing. Many of the challenges that care providers face and that patients experience are well-documented in Canadian and international literature on rural and remote health, and health care in resource towns (e.g. lack of specialized care, difficulty with recruitment and retention of care providers, heavy workload for existing care providers). However, our study also documents the recent in-migration of low-income, largely working-age people with complex chronic conditions who are drawn to the region by the low cost of housing. We discuss the ways in which the needs of these in-migrants compound existing challenges to rural primary care provision. To our knowledge, our study is the first to document both this migration trend, and the implications of this for primary care. In the interest of patient health and care provider well-being, existing health and social services will likely need to be expanded to meet the needs of these in-migrants.

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1. Introduction

Globally, rural-dwelling people are in poorer health relative to their urban counterparts (International Labour Office, 2015; Kondro, 2006; Strasser, 2003). For example, a review of rural healthcare in Canada, Australia, and the USA found that rural residents are generally older, access healthcare less frequently, have more chronic conditions, and self-report poorer health relative to their urban counterparts (Bushy, 2002). Furthermore, across North America, rural-dwellers have greater morbidity, shorter life-expectancies, higher infant mortality rates (Canadian Institute for Health Information, 2006; Meit et al., 2014; Williams, 2012), and higher prevalence of chronic pain (Hoffman et al., 2002; Tripp, VanDenKerkhof, & McAllister, 2006).

These poor health-related outcomes are inseparable from the health care delivery challenges that rural and remote communities face. These include escalating age-related healthcare needs (Bushy, 2002; Hanlon and Halseth, 2005; Joseph and Cloutier-Fisher, 2005), the logistical barriers to providing services to dispersed populations, and a lack of specialized care (Pong, 2008; Sibley and Weiner, 2011; Strasser, 2003). Moreover, evidence from various countries indicates that rural areas struggle with the recruitment, retention, and education of health care providers (Andrews et al., 2005; Burnham et al., 2010; Bushy, 2002; Pong, 2008). Reasons for these staffing issues include isolation and lack of privacy (Bushy, 2002; Wakerman et al., 2012; Williams, 2012), and insufficient resources relative to demand for care (Hunsberger et al., 2009; Paliadelis et al., 2012). In tandem with the advancing age and escalating complexity of rural patients, this is concerning given the treatment of complex chronic conditions is most effective through multidisciplinary team-based care. For example, a recent evaluation of a multidisciplinary chronic pain management program in rural Canada found clinically and statistically significant improvements in patient pain when a team-based approach was

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implemented (Burnham et al., 2010).

These combined challenges of care provider retention, population aging, and strained health services are characteristic of health care provision in what are variously referred to as “resource towns,” “resource communities,” “instant towns,” and “company towns” (see Carson and Carson, 2014; Carson et al., 2016; Gjertsen et al., 2015; Hanlon and Halseth, 2005; Jauhiainen, 2009; Mitchell and O’Neill, 2016; Skinner and Hanlon, 2016; Gjertsen et al., 2015; Skinner and Hanlon, 2016; Winterton and Warburton, 2015). Scattered across remote parts of nations with significant natural resource extraction sectors, such as Australia, Canada, Finland, and Norway, these towns were typically established rapidly, usually during the 20th Century, through industrial investments in the resource extraction sector and were designed to meet the needs of young workers and their families (Jauhiainen, 2009; Leach and Winson, 1999; Ryser and Halseth, 2013). These communities are highly vulnerable to “boom and bust” patterns of economic development, especially when they are dependent on a single resource industry (Bray and Thomson, 1996; Bray and Thomson, 1996; Mawhiney and Pitblado, 1999; Mitchell & O’Neill, 2016). These vulnerabilities have amplified in recent decades, with increasing liberalization of the natural resource market (Leach and Winson, 1999).

Accordingly, a body of research documents transformation in these communities following the concurrent downsizing of the resource extraction sector and the social welfare system since the 1980s (see Bray and Thomson, 1996; Carson and Carson, 2014; Mawhiney and Pitblado, 1999; Randall and Ironside, 1996; Skinner and Hanlon, 2016). This work shows that in many such towns, young people have left to find work elsewhere, leaving behind a greying population with complex age-related health and social care needs. Not only do these towns often lack specialized health and social services, care providers also face additional hurdles because existing services and infrastructure were not designed to meet the needs of the elderly (Hanlon and Halseth, 2005; Pong et al., 1999).

Health in Canadian resource towns is shaped by both universal health coverage (funded jointly by provincial and federal governments, but administered at a provincial level [see Forget, 2002; Marchildon and Hutchison, 2016]), and, since the 1980s, by changes to health and social service provision premised on market-based models of efficiency which have resulted in a downscaling of community services in rural areas (Halseth and Ryser, 2006; Hanlon & Halseth). Notably, restructuring and downscaling of national employment insurance programs has heavily impacted many resource-dependent communities (Leach and Winson, 1999).

This article focuses on the challenges involved in providing primary care for complex chronic conditions in two rural resource towns called White Falls and Arrelstown (both pseudonyms), with emphasis on how these challenges are compounded by the recent in-migration of low-income, primarily working-age people who are attracted to the region by the affordability of housing in the aftermath of industry closure. Both towns are in northern Ontario, Canada.

Our data constitutes a sub-set of data collected as part of an ongoing Institutional Ethnography (Smith, 1987, 2005, 2006) of chronic pain care coordination in family medicine across Ontario (Webster et al., 2015). In keeping with the pragmatic and analytical approach of our larger study, chronic pain care was our entry point and thematic focus, and the experiences and perceptions of local healthcare providers – all of whom cared for chronic pain patients, but none in a specialized, pain-focused capacity – were the “standpoint” (Smith, 2002) from which our investigation began. However, we soon found that the challenges of providing chronic pain care in rural areas were entwined with broader economic,

social, and medical issues. Accordingly, our findings speak to wider issues of rural care coordination, especially as pertains to depressed resource towns.

White Falls and Arrelstown have populations of approximately 2000 people apiece, in both cases a substantial reduction from their economic heydays. When roads are clear of snow, the nearest small city is between four and 6 h’ drive away. Both towns developed in the 20th Century as mining and logging towns, and both struggle with very high rates of unemployment following the downsizing of local industry. Roughly half of White Falls’ population are Indigenous, while Arrelstown’s population consists almost exclusively of white Canadians. With significant out-migration of job-seekers, both towns are characterized by wide availability of housing for rent or purchase at low cost. In hopes of revitalizing the local economy, Arrelstown’s municipal government is currently promoting the affordability of local housing as an incentive to attractive active and outdoorsy retirees to the area. However, a modest body of research suggests that while some resource towns have attempted to attract retirees, these initiatives have rarely taken sufficient account of the new demands and challenges this might entail for health and social services (Cloutier et al., 2015; Carson and Carson, 2014; Davis and Bartlett, 2008; Hanlon and Halseth, 2005).

2. Methods

This paper draws on 14 interviews with primary care providers (10), a Clinical Director (1), a municipal policymaker (1), and patients (3) in White Falls and Arrelstown, supplemented with ethnographic fieldnotes (Emerson et al., 2011). These interviews and fieldnotes were collected over two separate visits to northern Ontario made by KR, in April 2015 and June 2016 respectively. Seven care providers were interviewed during the first visit, and, in keeping with the principles of community-based research (Flicker et al., 2008), preliminary findings and analysis were presented to these care providers for feedback prior to the second round.

The first round of interviews was structured around an interview guide that is also used for a larger, ongoing institutional ethnographic (IE) study called COPE (see Webster et al., 2015), within which this study is nested. COPE focuses on the management and coordination of care for complex chronic conditions, especially pain, across the province of Ontario. As is typical of ethnographic research, the interview guide is intended to be open-ended, allowing the interviewer flexibility to adapt the questions as appropriate (Spradley, 2016), and in keeping with IE research also has a particular focus on work practices. Topics covered include scope of practice, description of work, definitions of and experience treating complex patients, experiences providing chronic pain care, and challenges encountered in daily work. Cognisant that health outcomes and care coordination are usually poorer in rural areas, particular attention was devoted to probing the ways in which rurality shaped care practices.

In keeping with the iterative nature of most qualitative research, preliminary analysis of this material was concurrent with data collection (Srivastava and Hopwood, 2009). Data were coded and were identified within and across the interviews (LeCompte and Schensul, 1999). This involved the following, often concurrent, process: 1) de-briefing between the two investigators following observations and interviews; 2) generating initial codes from the data; 3) categorizing codes into initial themes; 4) identifying the key themes related to the research questions; 5) identifying relevant literature and theories to help explain our evolving analysis; and 6) ongoing engagement in reflexivity and confirmation of themes during larger team meetings which involved an interdisciplinary team of researchers.

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