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Service Users' Views on the Restructuring Of Primary and Community Care Services For Older Adults: A Scoping Review

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Abstract

Research on the design, delivery, and restructuring of primary and community care for urban- and rural-dwelling older adults rarely considers the perspectives of service users. This review examined research literature on the restructuring of primary and community care services for older adults, with an emphasis on the views of older adults as service users. Using the scoping review methodology, five databases were searched for research papers ranging from 2005 to 2019. Articles were screened by title, abstract, and full text; and citation tracing was performed. Research articles on the design, delivery, and restructuring of primary and community care services were included. Attention was paid to the views of older adults as service users. Both urban and rural perspectives were considered. Twenty-four articles met the inclusion criteria. At least two individuals read each article and extracted the data. Data were themed using an inductive approach. Four themes were identified: (1) fragmented service delivery, (2) service discrepancies between urban and rural geographies, (3) reliance on informal supports, and (4) tailoring restructuring to meet community needs. There are discrepancies in the provision of healthcare services between rural and urban areas as restructuring rarely considers the perspectives of rural-dwelling older adults as service users. In order for healthcare services to address inequities and enable rural older adults to age in place, policy makers need to seek and act upon the views of both urban- and rural-dwelling older adults.

Keywords: Restructuring, aging, rural, health services, primary care, community care interest

Point de vue des utilisateurs des services sur la restructuration des services de soins primaires et communautaires pour les personnes âgées : Un examen de la portée

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Résumé

La recherche sur la conception, la prestation et la restructuration des soins primaires et communautaires pour les personnes âgées vivant en milieu urbain et rural tient rarement compte des points de vue des utilisateurs des services. Cette revue a examiné la littérature de recherche sur la restructuration des services de soins primaires et communautaires pour les personnes âgées, en mettant l'accent sur les points de vue des personnes âgées en tant qu'utilisateurs de services. À l'aide de la méthodologie d'examen de la portée, cinq bases de données ont été consultées pour des articles de recherche allant de 2005 à 2019. Les articles ont été sélectionnés par titre, résumé et texte intégral ; et le traçage des citations a été effectué. Des articles de recherche sur la conception, la prestation et la restructuration des services de soins primaires et communautaires ont été inclus. Une attention particulière a été accordée aux points de vue des personnes âgées en tant qu'utilisateurs de services. Les perspectives urbaines et rurales ont été prises en compte. Vingt-quatre articles remplissaient les critères d'inclusion. Au moins deux personnes ont lu chaque article et extrait les données. Les données ont été thématisées en utilisant une approche inductive. Quatre thèmes ont été identifiés : (1) la prestation de services fragmentée, (2) les écarts de service entre les zones géographiques urbaines et rurales, (3) la dépendance à l'égard des soutiens informels et (4) l'adaptation de la restructuration pour répondre aux besoins de la communauté. Il existe des écarts dans la prestation de services de santé entre les zones rurales et urbaines, car la restructuration prend rarement en compte les perspectives des personnes âgées vivant en milieu rural en tant qu'utilisateurs de services. Pour que les services de santé corrigent les inégalités et permettent aux personnes âgées des régions rurales de vieillir chez elles, les décideurs doivent solliciter et agir en fonction des points de vue des personnes âgées vivant en milieu urbain et rural.

Mots-clés : Restructuration, vieillissement, milieu rural, services de santé, soins primaires, intérêt pour les soins communautaires

1.0 Introduction

Healthcare systems are responsible for creating optimal conditions that allow service users to easily access healthcare services that they need. However, healthcare systems across the world are challenged with meeting the future primary and community care needs of older adults who are increasing in numbers (World Health Organization, 2021). Many older adults currently require or will require specialized community-based care for chronic health conditions while aging in place and delaying transitions to residential care (Canadian Institute for Health Information, 2017). To drive integrated, seamless, and well-coordinated care for older adults, it is important for primary and community care providers to develop strong relationships with service users. This is a key component of the WHO's "Decade of Healthy Ageing (2021–2030)" plan which calls on health systems to reorient care delivery towards "person-centred integrated care and primary health services responsive to older people" (WHO, 2021, para 18). While this may be achievable in urban settings due to the availability of healthcare resources, rural healthcare providers often face challenges in providing accessible, integrated, and well-coordinated care to older adults (Jensen et al., 2020; Skinner et al., 2021).

In the Canadian context—where there is a geographically dispersed population that is both aging and becoming more ethnically and racially diverse (Statistics Canada, 2019)—more attention needs to be paid to the specific challenges of rural and remote communities along with their service delivery needs and preferences. Similar to the Canadian population as a whole, 18.3% of residents of British Columbia (BC), a western Canadian province, are 65 years and older (Statistics Canada, 2021). However, due to 16 years of underfunding, privatization, and fragmentation, older adults and their families and communities now must either 'patch together' care or go without (Longhurst, 2017, p. 4). As a result, there is an increased demand for primary and community care services by older adult service users who want to age in place in both urban and rural areas of the province. All six health authorities in the province are responding to these demands by realigning care services to meet the complex, interconnected, and holistic health needs of older adults living in urban and rural settings. Two key patient populations in BC are 'frail elderly' (75 years and older) and rural communities, including First Nations; and this has guided the prioritization of resources and policy and planning efforts by the six health authorities (British Columbia [BC] Ministry of Health, 2014).

A prime example of service realignment efforts is Interior Health (IH)'s development of a new model of health care for older adults in Kamloops and Kelowna—two urban centres in BC's central interior—with complex chronic disease. Known as *repositioning*, this initiative was defined by IH as the restructuring of community services to provide comprehensive and holistic care to adults aged 75 and older, primarily with complex chronic disease. Repositioning refers to the shift of resources within the healthcare system from acute care settings to support independent living at home or in the community, with the goal of reducing hospital visits and residential care admissions (BC Ministry of Health, n.d.). While a local action team developed the repositioning model for both urban- and rural-dwelling older adults, the informal consultations they held were with service providers (clinicians), older adults (service users), and care partners in one urban centre.

In order for repositioning of healthcare services to successfully meet the needs of older service users, healthcare decisions need to be founded in research evidence, clinician expertise, and service user preferences—all of which are the key elements of evidence-informed decision making (Melnyk & Fineout-

Overholt, 2018). Since the views of rural-dwelling older adults did not inform the Local Action Team's repositioning model, our research team conducted a scoping review to inform health professionals and decisions-makers within IH about the findings of previous research on healthcare restructuring and the design and delivery of primary and community care services for older adults in both urban and rural settings.

There has been a great deal of research on models of coordinated care for older adults. *Integrated care* is an approach that facilitates responsive care for older adults by uniting sectors from across healthcare systems (Goldhar et al., 2014). In their international study, Béland and Hollander (2011) describe two models of integrated care: one that requires collaboration across home- and community-based care providers in a single community, and one that is administered by state authorities who organize state-wide services bound by a single budget. Hills et al. (2007) explore the implementation of *multidisciplinary practice* in primary care from the viewpoint of health professionals, revealing that such a change requires a shift in values and power dynamics to facilitate a shared emphasis between all disciplines rather than focusing on physician-directed care. Hall and Reynolds (2014) advocate for the use of c*ollaborative care* in primary care settings, which they have found to be effective when treating clients with mental health conditions.

According to Frank and Wilson (2015), primary care in Canada has evolved to include integrated, shared, and home-based care models, as well as family medicine specialist clinics. Pardasani and Thompson (2012) expand this literature by documenting a multitude of innovative and changing services provided by senior centres across the United States. These services include (a) the provision of information and referrals; (b) health and wellness education; (c) caregiver respite and support; (d) home-bound support services; (e) medical transportation; and (f) recreation, meals, and vocational training. While many healthcare providers are changing their approach to care provision by including team-based models, these changes are often implemented without consulting the target demographic—older adults. Similarly, in reviewing the literature, we did not locate any syntheses or review articles on service users' views on the restructuring (i.e., redesign and delivery) of primary and community care services, particularly from an older adult perspective, thus we undertook a scoping review on this topic. This paper reports on the results of this review.

2.0 Methods

This review used Arksey and O'Malley's (2005) framework for conducting scoping reviews, a framework that is frequently used in health research (Davis et al., 2009; Holly, 2017). Scoping reviews allow researchers to identify current evidence and gaps in research pertaining to a particular subject area and are useful in creating a preliminary synthesis (Grimshaw, 2010). Since there is no available synthesis that includes service users' views on the restructuring of primary and community care services particularly from an older adult perspective, the scoping review was an appropriate synthesis methodology for us to use. Arksey and O'Malley (2005, pp. 22–23) identify five main stages of a scoping review, "(1) Identifying the research question or purpose; (2) Identifying relevant studies; (3) Study selection; (4) Charting the data; and (5) Collating, summarizing and reporting the results." The following sections of this paper follow this scoping review schemata.

2.1 Stages of a Scoping Review

Stage 1: Research question or purpose. The purpose of this scoping review was to examine literature on healthcare restructuring—including the design and delivery—of primary and community care services for older adults with an emphasis on the service user perspective. Scoping reviews are often used to set the stage for future research. As such, this review informed our subsequent research on older adults' views on the 'repositioning' initiative in B.C.'s central interior (Hulko et al., 2020).

Stage 2: Identifying relevant studies. The initial search was conducted in 2016 while the repositioning initiative was unfolding and was limited to articles from the last 10 years (2005–2016); our practice partners were interested in learning about recent primary and community care restructuring initiatives. To identify potential records for this review, five electronic databases were searched: Social Service Abstracts, Social Work Abstracts, Web of Science, Cumulative Index to Nursing and Allied Health Literature (CINAHL), and Medline. Through a brainstorming session, the research team identified a combination of search terms and grouped them under four categories to search the databases. The search categories consisted of action, service, population, and system (see Table 1).

Table 1. *Search Categories and Terms*

Action	**Service**	**Population**	**Systems**
Reposition*	'Health services'	Senior*	Transition
Restructur*	Health services	Old* adult	Trajectories
Realign*	'Community care'	Age*	'Aging in place'
Prioritiz*	Community care	Aging	'Systems of care'
Reprioritiz*	'Primary care'	Elderly	centers
	Primary care	Elder*	'Care coordination"
	Healthcare	Elders	Accessibility
	'Health care'	Frail	'Closer to home'
	Health care	Comorbidity	
	Home care	Old*	
	Homecare	Old* people	
	'Home care'	Ag*	
	Care		
	'Community care access centre'		
	'Senior centre'		

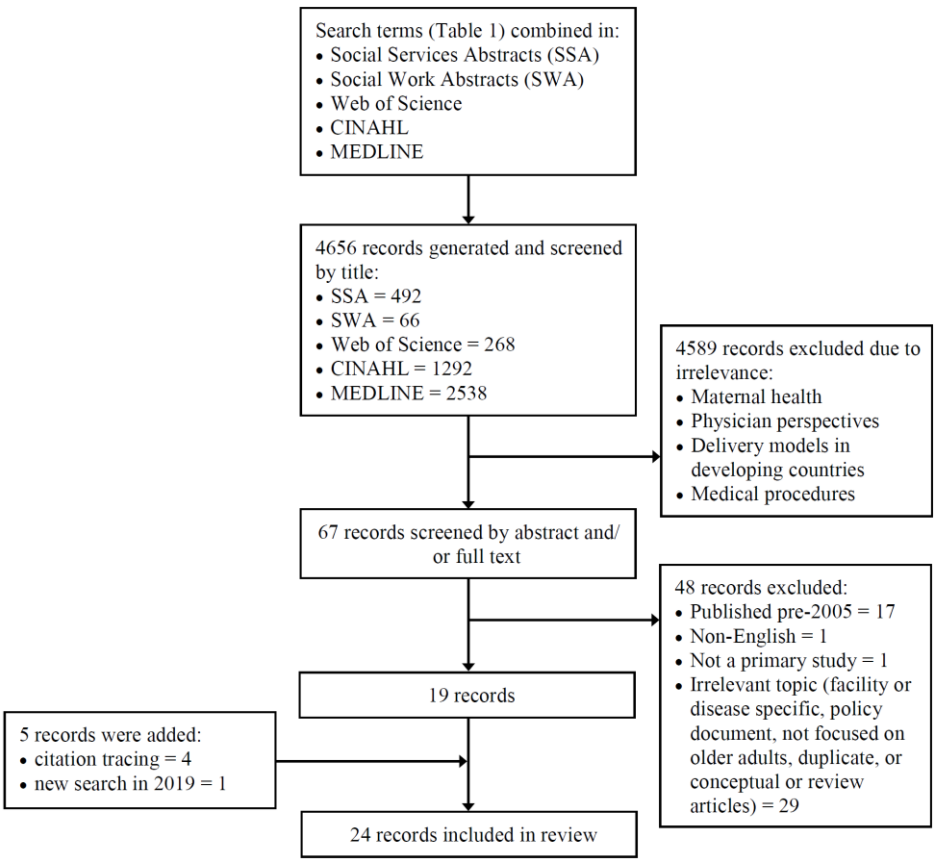
*Table note:The asterix * indicates truncation and allows for both verb (e.g., restructure) and noun (e.g., restructuring) forms*

Action referred to search terms relevant to healthcare design such as repositioning, restructuring, or realignment of healthcare services. The *service* search category included community care, primary care, and similar search terms. Since the review aimed to include the perspectives of older adults, search terms relevant to the *population* included seniors, older adults, and aging. We also included search terms describing *systems*, such as care transition, trajectories, aging in place, and care delivery and coordination. In addition to searches in the database, citations of key articles were also examined in 2017 to locate potentially useful articles for the review. This search was repeated in 2019 and yielded one additional article.

Stage 3: Study selection. A total of 4,656 records were generated from the search strategy (492 from Social Service Abstracts, 66 from Social Work Abstracts, 268 from Web of Science, 2,538 from Medline, and 1,292 from CINAHL). Articles were first screened by title. Titles that did not include at least two search terms were excluded. Titles were also excluded because they focused on maternal health, physician perspectives, delivery models in developing countries, or medical procedures. This yielded 67 relevant records and 17 were excluded immediately for having a pre-2005 publication date.

The content of the remaining 50 records was reviewed either by reading their abstracts or full article text. Of these, one was not in English, one was not a primary study, and 29 were irrelevant to the research question. These included articles that were (a) facility or disease specific, (b) exclusively focused on policy, (c) lacked focus on older adults, (d) reported the same study that we had already included, or (e) were conceptual or review articles rather than reports of primary empirical research. To the remaining 19 records, we added an additional four records that we had discovered through citation tracing in 2017. This yielded 23 records. Our new search in 2019 yielded one additional record, resulting in 24 articles to be included in this review (see Figure 1).

Figure 1. Flow diagram of search strategy.



Stage 4: Charting the data. Selected records were read and re-read by at least two members of the research team after which they were summarized and presented in a data extraction table (see Table 2). For each selected record, the reference, purpose of the study, methods used, and major findings were noted. This information provided a thorough description of the existing literature on service users' views on the design and delivery, and the restructuring of healthcare services with a particular focus on the views of older adults.

Table 2. *Summary of Selected Records*

Authors and Year	Purpose	Methods	Findings
Allan et al., 2007	Investigate rural health service provision and identify needs (expressed, felt, normative, comparative) of rural residents.	Case study of two rural small towns in Australia; GIS mapping, document analysis, four SS interviews with policymakers and eight focus groups with 128 community members at community group meetings (e.g., Rotary, mothers, school staff, health, and welfare workers).	Children and 'elderly' people felt to have greatest need for health services, mental health services identified as inadequate and ineffective and more GPs needed, transport felt to be a need for some groups (youth) at some times, high information needs for those with chronic conditions and reluctance to seek assistance, illness a drain on financial and emotional resources (related to travel to urban centre). Comparison showed one town more positive about their health services (more resources–services except for aging services (men's shed in the other) and close to gov't and the needs of the towns varied (e.g., childcare).
Aronson, 2006	Examine the cumulative effects of homecare rationing on older women in Ontario.	Longitudinal qualitative study with 27 older women in receipt of home care services; semi-structured interviews twice a year and notes of phone conversations and field observations.	All experienced "resource-driven withdrawals or dilutions of service" and often inconsistency and lack of skill in service providers. Coping strategies included practical accommodations, engagement of other peoples' help, and self-reflective adjustments. Themes were voicing complaints or criticism, muting complaints (due to hopelessness, due to shame and pride, due to concern for others), and accommodating to perceived shortcomings in care.
Averill, 2012	Analyze health disparities and strengths in relation to aging, rurality, a "depressed economy" and scarce health resources amongst older adults in the southwestern United States.	Critical ethnography and community-based participatory research (CBPR), including 64 multiracial participants (12 men, 52 women) from three rural communities. Used individual and group interviews, ethnographic processes (field notes, reflective journaling, participant observation, photography, and archival review).	Study participants identified that attention and action is required for sustained access to prescriptions, transportation solutions for older adults in isolated communities, insufficient access to specialty and primary care, inadequate infrastructure and coordination of services, lack of assisted living and in-home care, and challenges with culture, language, and economics.

Bascu et al., 2014	Examine rural older adults' perspectives on healthy aging in place.	CBPR approach to collect data. Semi-structured interviews with 40 rural adults (24 women, 16 men) in Saskatchewan in 2011.	Participants viewed aging from a holistic perspective with emphasis on physical and psychosocial aspects. Five main themes: maintaining social interaction (familial, friendship), keeping active, feelings of independence (self-sufficiency), optimistic outlook, and cognitive engagement (staying sharp). Policy makers and researchers must involve older adults when planning rural healthy aging in place interventions.
Bascu et al., 2014	Explore interventions that support rural older adults to stay at home.	CBPR approach to collect data. Semi-structured follow-up interviews with 36 rural adults (22 women, 14 men) in Saskatchewan.	Certain policy interventions can facilitate aging in rural areas: improved consistency in home care, accessible built environments, increased public transportation, thorough provision of health service information, improved Meals on Wheels accessibility, and options for social well-being in housing.
Bernoth et al., 2012	Explore experiences of carers of older adults who have been forced to pursue aged care in a residential facility away from their rural community in New South Wales, Australia.	Secondary data analysis of qualitative data collected in a phenomenological study that made use of 21 in-depth interviews.	Three themes: in exile (challenges with distance, unavailability of local residential aged care, being forced to leave community), brokenness (social disconnection, separated spouses), and the battle with the system designed to meet its own needs (cost). Inaccessible aged care services result in isolation, loneliness, and loss amongst rural older adults and their family and community.
Davenport et al., 2005	Identify the perceptions and understandings of service providers in Atlantic Canada about seniors services as part of larger study of service-rich and service-poor communities across Canada.	Case studies of four communities (two medium-sized cities and two semi-rural, one low income and one middle class) in Atlantic Canada; 31 key informant interviews; larger (national) study also made use of secondary data analysis.	Atlantic communities face similar challenges in service provision to seniors, including broad systemic challenges (long waiting lists, no family doctors), lack of housing and care options (two extremes of in-home or nursing home), lack of integration and coordination of services (e.g., home care), and discrepancy between rural and urban geographies (fewer services and practitioners in rural areas and transportation is an issue).
de Stampa et al., 2014	Evaluate the effect on hospital admissions of the COPA model (CO-ordination Personnes Agées–integrated primary care) for older adults who are frail and community-dwelling in Paris, France	Intervention study: data collected on hospitalizations (unplanned, planned, overall) and assessment of IADLs, ADLs, cognitive status and mental health through pre-test post-test with an experimental (n=105) and a control group (n=323); logistic regression. Intervention group had a two-person team of case manager and primary care physician (with support of geriatrician as needed for in-home needs assessment).	Risk of hospital admission, depression, and dyspnea (shortness of breath) was lower in intervention group, however there was no significant reduction in total hospitalizations. Integrated care model improves patient trajectories.

Ferris et al., 2016	Determine if environmental factors can predict unmet needs in home- and community-based services (HCBS) amongst older adults in Philadelphia.	Cross-sectional analysis of the southeastern Pennsylvania Household Health Survey.	Environmental predictors of unmet needs in HCBS included lack of access to healthy foods, poor housing quality, and feeling unsafe in neighbourhoods. Those who experienced these environmental factors (food, housing) experienced depression, poor health, increased problems with instrumental activities of daily living (IADL) and were often racialized individuals.
Grimmer et al., 2015	Explore and synthesize the experiences and perspective of older people planning for and experiencing ageing in place in Australia.	42 community-dwelling older adults connected to aged care service provider (23 1st stage and 19 2nd stage). Two focus groups and 40 SS individual interviews (phone or in-home) in total. Qualitative thematic analysis.	Main factors to successfully age in place are adaptability, independence and resilience information, finance, transport, physical and mental activity health, practical assistance, company, and safety. Older adults need responsive, integrated, and accessible primary health and community services to age in place.
Hanlon & Halseth, 2005	Examine the context of ageing in rural and remote locations and identify imminent challenges for healthcare service providers.	Case studies of three Northern BC communities: Kitimat, Mackenzie, and Fort Nelson. Secondary data analysis (BC statistics) and document analysis (BC policy documents).	Northern local health areas (LHAs) are aging faster than other areas of B.C. Resource frontier communities were designed for young families and do not have many services for older populations (those aging in place). Broader social and community-based services such as urban planning, housing, and transportation should be examined for older adults. Rural and remote northern communities have unique needs and issues associated with physician availability and unmet care needs.
Hanlon et al., 2007	Examine the experiences and impressions of volunteers and formal sector providers of providing services for older adults and people with disabilities in a remote urban centre in BC. Part of larger–national ‘service-rich and service-poor’ study.	21 key informant interviews with service providers; data analyzed using grounded theory methods.	Retrenchment of government services was key theme. The provincial government's cuts to funding was seen to be shortsighted and to result in gaps and rationing of services. Contemporary volunteer activity is currently experiencing: (a) an emphasis on efficiency–competition, (b) pressure to become larger organizations, and (c) erosion of flexibility and personalization.

Hanlon et al., 2014	Explore the role voluntary sector leaders play in transforming resource communities into more liveable places that support the needs of older adults.	Case study design that examines the conditions and experiences of voluntary sector leadership in two resource communities in Northern BC. 30 semi-structured interviews were held with local community informants (15 from each community) who were aged 50 or older (15 males, 15 females).	Two themes: (1) older adults had close interrelationships and voluntarism was viewed as a social activity, while community development was seen as a collective exercise; and (2) local voluntary efforts contributed to an age friendly community through various initiatives (e.g., social activities).
Herron & Skinner, 2013	Explore the importance and implications of emotions related to negotiation of care relationships, expectations, and responsibilities.	Case study of rural aging involving in-depth and semi-structured interviews and focus groups with 30 older adults and 14 unpaid family carers in Peterborough, Ontario.	At an interpersonal level, experiences and expectations for care are informed by perceived positive or negative emotions. In families, negative emotions (guilt, resentment, and frustration) prevent discussion of care consequences. At a household level, participants wanted supportive services (respite for carers, residential care for older adults), which suggests there should be an increased focus on care alternatives and opportunities for care in rural communities. At the community level, limited options to age independently in the home reinforced older adults' will to remain independent and at home longer, while increasing hesitance in requesting home support.
Lafortune et al., 2015	Understand the experiences of community-based primary healthcare users, caregivers, and service providers in several care settings.	Qualitative consultation with seven focus groups (four with service providers, three with clients and family caregivers) and one interview with a caregiver. Total participants = 48 (20 service providers and 28 clients and family caregivers)	Barriers to community based primary healthcare were deficient system integration and restricted access to services. Facilitators were self-management resources, successful collaborative practice, and family and person focused care. Improvements to system could be achieved through increasing and integrating care teams; supporting system navigation; and developing standardized assessments, care pathways, and information systems.

Lehmann & Halíková, 2015	Explore contextual factors that affect formal social care services provided to older adults with declining self-sufficiency.	A multiple correspondence analysis and a multidimensional scaling were used to analyze both quantitative and qualitative data from two sources: (a) Eurostat, and (b) the Housing and Home Care for the Elderly and Vulnerable People and Local Partnership Strategies in Central European Cities (HELPS).	Three types of social care systems exist in central Europe: (a) rudimental (basic model that includes a home-based service and one source of institutional care); (b) intermediate (basic model + alternative housing and care to fill gaps in home care and institutional care); and (c) advanced (high rate of care coverage for older adults over 65 years of age + wide variety of housing and care integration). Economic indicators, age structure of population, and unemployment rates affect diversity and availability of social care services.
Longo et al., 2012	Define a method for collecting and analyzing data on primary and community care (PCC) services; and report data on expenditure and activity indicators of PCC.	Quantitative data were collected to compile a list of 303 activity indicators of PCC services within 13 Italian Local Health Authorities (LHA).	56% of financial resources were allocated to PCC. LHAs mainly focused their activities on key services (hospital admissions, pharmaceuticals, specialists, GPs, and admissions to residential care), while marginally serving the growing range of citizens' needs (aging care, disability, rehabilitation, hospice, mental health, prevention, and public health screening).
Menec et al., 2015	Determine the state of age-friendliness in rural communities and whether age-friendliness is influenced by community characteristics.	Survey administered to 56 rural communities (1,373 individuals) in Manitoba, Canada, to measure the different domains of age-friendliness (social and physical environments, transportation, housing, opportunities for community involvement, local supports and health services, and communication and information).	In communities with more older adults (> 65 years), participants reported higher levels of age-friendliness, while low ratings of age-friendliness were reported in rural communities in close proximity to urban centres and those in the north of the province.
Reckrey et al., 2015	Assess how a team-based approach to providing home-based primary care affects clinical outcomes, cost efficacy, and service user and provider acceptance.	Feasibility study; compared team-based (physician, nurse practitioner, social worker, administrative assistant) model (n=347 patients, mean age = 81) with usual care (physician-led) model (n=1074 patients, mean age = 80).	No statistically significant differences in clinical outcomes (mean hospitalization, hospital admission, and readmission rates). Care satisfaction remained high regardless of care delivery approach (team or usual care).

Ryser & Halseth, 2011	Explore the informal supports used by low-income (<$20,000) female older adults living alone.	Of the 805 household surveys that were mailed out to older adults living in Fort St. John in BC, 277 were completed. Of these, 62 were identified as low-income senior women living alone. Findings pertained to this group of participants.	Participants mainly relied on family for support. Informal supports identified were children, grandchildren, cousins, stepfamilies, siblings, nieces, and nephews. The likelihood of these participants drawing on their support networks is greater than that of other groups who completed the survey. Diversification of formal and informal supports would be beneficial as small family networks easily become overwhelmed.
Sharman et al., 2008	Explore the implications that health system restructuring has on employees of BC's home support system with consideration to continuity of care.	Qualitative study using 10 semi-structured focus groups and three individual interviews with home support workers and clients in Greater Vancouver area.	Restructuring resulted in fewer full-time workers and more part-time–casual workers, making it harder for service users to develop trusting relationships with service providers. Restructuring also reduced assistance for non-personal care tasks (e.g., cleaning, shopping, meal preparation). Overall restructuring was found to undermine quality and disrupt continuity of care.
Skinner et al., 2008	Examine the concept of community and its role within the provision of in-home and community care for older adults.	Using a grounded theory approach, data from 55 in-depth interviews were analyzed. Participants included senior administrators from government offices, health and social care institutions, voluntary sector organizations, and community groups. The study focused on nine rural small towns across Canada.	The belief that communities are able to compensate for a lack of services for older adults, neglects to take into account the coping ability of local informal (volunteer) sectors. With the shift in public policy towards in-home and community care, service deprivation in rural areas may remain unaddressed due to these beliefs.
Smith-Carrier et al., 2015	Explore the experiences of members of an interprofessional team that provides home-based primary care in Ontario to determine the features and processes of home-based primary care provision.	Using grounded theory (that was part of a larger mixed-methods study), semi-structured interviews were conducted with 17 service providers.	Two themes: (1) home-based primary care consisted of benefits (improved access, care planning, medication management, and health outcomes; perceived provider and patient satisfaction) and barriers (administration and care coordination challenges; high time and energy demands); and (2) interprofessional collaboration facilitators (positive relationships; shared vision; leadership; communication; ongoing learning and support) and interprofessional collaboration hindrances (power dynamics and conflict; competing disciplinary values; unclear roles).

Spoorenberg et al., 2015	Explore views of community-dwelling older adults on 'Embrace' (integrated care and support model); and determine the extent to which this model meets their health and social needs	Using grounded theory, semi-structured interviews were conducted with 23 older adults receiving integrated care in northern Netherlands.	Two focus areas: (1) experiences with aging and related themes: health struggles, increased dependency on others, decreased social interaction, loss of autonomy, and fears about health in foreseeable future; and (2) experiences with 'Embrace' and relating themes: productive relationships with the case manager, supportive and informed interactions, and feeling safe, secure, and in control. 'Embrace' empowered participants and allowed them to stay in control, even while dependent on others.

Stage 5: Collating, summarizing and reporting the results. To analyze the data extracted from the articles included in the review, we used an inductive and iterative process similar to thematic analysis (Clarke et al., 2015). The first step was to familiarize ourselves with the main foci of each of the articles and cluster the study findings in one or more categories. As new categories emerged, we re-read previous articles to determine if any of the new categories also applied. The final set of categories were: (a) evaluating current service delivery, (b) service use, (c) service users' views, (d) informal supports, (e) rurality, and (f) focusing on change or action. Once we had exhausted this process of analyzing and sorting the articles based on thematic content, we then examined the characteristics of each of these categories. This allowed us to collapse the categories and generate and refine four main themes that best reflect the current knowledge on service users' views of healthcare restructuring.

3.0 Results

Four themes were found to be salient: (a) fragmented service delivery, (b) service discrepancies between urban and rural geographies, (c) reliance on informal supports, and (d) tailoring restructuring to meet community needs. Most records discussed more than one theme in their content due to the overlapping and interconnected nature of these themes. Five articles were case studies (Allan et al., 2007; Davenport et al., 2005; Hanlon & Halseth, 2005; Hanlon et al., 2014; Herron & Skinner, 2013), four were based on surveys or questionnaires (Ferris et al., 2016; Longo et al., 2012; Menec et al., 2015; Ryser & Halseth, 2011), two consisted of experimental designs (de Stampa et al., 2014; Reckrey et al., 2015) and one was a mixed methods study (Lehmann & Halíková, 2015). The remaining articles reported on qualitative research conducted with either service users (Aronson, 2006; Averill, 2012; Bascu et al., 2014a; Bascu et al., 2014b; Grimmer, et al., 2015; Spoorenberg et al., 2015), service providers (Hanlon et al., 2007; Smith-Carrier et al., 2015), family members or care partners (Bernoth et al., 2012), administrators (Skinner et al., 2008), or a combination of these groups (Lafortune et al., 2015; Sharman et al., 2008).

3.1 Theme 1—Fragmented Service Delivery

Older adults face several challenges when accessing healthcare services. Davenport et al. (2005) point to broad issues such as lack of housing and care options, integration and coordination of services (e.g., home care), and discrepancies between rural and urban geographies which create systemic challenges that impinge on older adults' ability to navigate care services in a timely manner. These issues are further aggravated when healthcare administrators allocate resources to hospital admissions, pharmaceuticals, physicians (general practitioners and specialists), and admissions to residential care while overlooking the growing need to allocate resources to (a) aged care, (b) disability, (c) rehabilitation, (d) hospice, (e) mental health, (f) prevention, and (g) public health screening (Longo et al., 2012). In a BC study that explored the views of home care workers, Sharman et al. (2008) found that past restructuring efforts in the home support system resulted in a reduced amount of home care, undermined the quality of care, and disrupted the continuity of care. In her study exploring the views of female older adults who receive home care services, Aronson (2006) links such service withdrawals to the care inconsistencies experienced by her research participants.

The fragmentation that results from the insufficient allocation of healthcare resources for older adults could be heightened by key societal factors, including availability of healthy foods and appropriate housing (Ferris et al., 2016),

economic indicators, age structure of the population, and unemployment rates (Lehmann & Halíková, 2015). This affects the availability and the variety of care services for older adults (Lehmann & Halíková, 2015), and leads to negative health outcomes such as depression, poor health, and increased problems with instrumental activities of daily living (Ferris et al., 2016).

3.2 Theme 2—Service Discrepancies between Urban and Rural Geographies

Discrepancies between urban and rural geographies vary in nature and the unique health needs of both urban- and rural-dwelling older adults need to be considered when developing services for older adults (Davenport et al., 2005). For example, in rural settings, funding drives service delivery—i.e., the type of healthcare services people receive is funding-dependent rather than based on the healthcare needs expressed by the community (Allan et al., 2007). In their study, Menec et al. (2015) found that service users in rural communities provided low ratings to domains of age-friendliness, some of which included transportation, housing, local supports and health services, and opportunities for community involvement.

Rural communities often experience scarcity of resources that support independent living. In light of limited living options in their home communities, many older adults are expected to either function independently at home (Herron & Skinner, 2013) or resort to long-term care facilities (Skinner et al., 2008). To better support rural-dwelling older adults to age in their home communities, Hanlon and Halseth (2005) advocate for an increased focus on broader social and community-based services such as urban planning, housing, and transportation. Bascu et al., (2014b) suggest a number of policy interventions including improved consistency in home care, accessible built environments, increased public transportation, thorough service provision of health service information, improved meals on wheels, and initiatives to promote social well-being in the home environment.

Research related to the development of ethical rural care policies emphasize that emotions and care relations between service providers and recipients are overlooked in rural areas and should be taken into consideration (Herron & Skinner, 2013). In the context of older adults as care recipients, inadequate aged care has been found to result in isolation and loneliness (Bernoth et al., 2012), highlighting the need to examine the health of older adults from a holistic lens. This was demonstrated in a study by Bascu et al. (2014a), which found that older adult participants viewed aging from a holistic perspective. The study identified key elements to healthy aging to be maintaining social interaction, keeping active, feeling independent, having an optimistic outlook, and remaining cognitively engaged.

3.3 Theme 3—Reliance on Informal Supports

Through undertaking key informant interviews, Hanlon et al. (2007) found that rationing of services, lack of personalized care, and disruption to care delivery processes occur when social care responsibilities are downloaded from state provision to volunteer provision. Aronson (2006) discovered that inconsistencies in care provision such as these tend to contribute to female older adults' efforts to maintain well-being by using coping strategies, such as engagement of other peoples' help and self-reflective adjustments to adapt to changing availability of supports. In their study on informal supports used by low-income (<$20,000 per year) female older adults living alone, Ryser and Halseth (2011) further confirmed that this population relies on family supports to meet day-to-day needs. However, the researchers outlined that small family networks easily

become overwhelmed, suggesting that diversification of formal and informal supports would be beneficial.

Through interviewing 55 senior administrators from government offices, health and social care institutions, and volunteer and community groups, Skinner et al. (2008) found that the belief in rural settings that communities can compensate for the lack of healthcare services for older adults (e.g., by providing informal support) may result in the continuation of service deprivation in rural areas. In contrast to this, a case study on the role of voluntarism in two resource frontier communities discovered that voluntarism was viewed as a social activity that facilitated close interrelationships among older adults while community development was seen as a collective exercise; further, local voluntary efforts contributed to the development of an age-friendly community (Hanlon et al., 2014).

3.4 Theme 4—Tailoring Restructuring to Meet Community Needs

To facilitate aging in place, researchers have identified the need to focus on social infrastructure, coordination of and access to services, and cultural (including language) and economic barriers (Averill, 2012; Lafortune et al., 2015). By sharing their perspectives on aging in place, participants in a study by Grimmer et al. (2015) identified the need for responsive, integrated, and accessible primary and community care services for older adults. In order to facilitate optimal community-based primary health care for older adults, Lafortune et al. (2015) highlighted the need for self-management resources, successful collaborative practice, and family and person-focused care. They suggested specific strategies, including supporting system navigation, developing standardized care pathways and information systems, and increasing and integrating care teams within primary care. According to Lehmann and Halíková (2015), restructuring efforts should be tailored to the economic, social, and demographic indicators of the community. Averill (2012) also pointed to the need for restructuring efforts that target key priorities for rural-dwelling older adults including sustained access to prescriptions, improved transportation, and increased primary, specialty, assisted, and home care.

De Stampa et al. (2014) and Reckrey et al. (2015) both tested the implementation of integrated and team-based approaches to home-based primary care and found that these interventions did not significantly reduce the number of hospitalizations. However, Smith-Carrier et al. (2015) discovered that interprofessional team-based collaboration in home-based primary care did improve (a) access to services, (b) care planning, (c) medication management, (d) health outcomes, and (e) provider and patient satisfaction. This team approach also facilitated positive relationships, shared vision, communication, leadership, and ongoing learning among team members. In another study, Spoorenberg et al. (2015) found that an integrated care approach promoted informative and supportive interactions, facilitated productive relationships with case managers, and contributed to participants feeling safe, secure, and in control.

4.0 Discussion

Fragmented service delivery, service discrepancies between urban and rural geographies, reliance on informal supports, and the need for services conducive to community needs are the dominant themes in the extant literature on healthcare restructuring of primary and community care for older adults. This review determined that the perspectives of older adults on primary and community care and healthcare restructuring are largely absent in the literature in spite of older adults being the main recipients of home and community care services and alternate levels of care days (Office of the Seniors Advocate British

Columbia, 2018). Of the 24 articles included this scoping review, less than a third pertained to research that included older adults as service users, volunteers, or care providers. None of these studies provided service users and decision-makers a platform to work together to effect changes to the provision of healthcare services. They also did not emphasize the importance of bringing attention to social determinants of health in rural or urban communities when considering restructuring efforts.

Recent research shows that rural communities require healthcare solutions that cater to their unique needs rather than relying on a 'cookie-cutter' approach to service provision that is suited for urban centres (Hulko et al., 2021). Compared to urban areas, there is an increased expectation in rural regions that community members will provide informal supports to mitigate gaps in healthcare services for older adults (Skinner, 2008). This is common in rural communities where social care responsibilities are downloaded to volunteers (Hanlon et al., 2007). Since volunteer and family networks can easily become overwhelmed with the responsibilities of caring for older adults, there is a need for the state to reacquire these responsibilities (Ryser & Halseth, 2011), especially in resource-deprived rural communities. Hence, a more prominent local presence of state-funded healthcare options that share the responsibilities of caring for rural-dwelling older adults in their home communities could promote aging in place. With this provision, several barriers to optimal health care for rural-dwelling older adults would be addressed, resulting in a reduced need to resort to long-term care facilities elsewhere (e.g., urban centres), decreased dependence on informal supports and reduced caregiver burnout, and improved care access and delivery processes.

Previous research has noted that care for frail older adults is becoming increasingly fragmented (Arnaert et al., 2005) and previous restructuring efforts—such as the cuts to home care (Longhurst, 2017) and privatization of seniors' care (Longhurst & Strauss, 2020)—have not improved the situation. Rather, such efforts have disrupted the continuity of care and contributed to poor quality of care (Sharman et al., 2008). To enhance care for older adults and promote aging-in-place, Arnaert et al. (2005) advocate for policies that focus on the creation of integrated holistic care. In home-based primary care environments, Smith-Carrier et al. (2015) have found integrated team-based care to be effective in improving health outcomes. Therefore, healthcare repositioning initiatives should aim to increase integrated care in order to address the individual needs of older adults. *Coordinated access to team-based specialized community services* is now IH's strategic priority for seniors care for 2021–2024 (Interior Health, n.d.). Such efforts will need to be conducive to rural-dwelling older adults' holistic views of aging that prioritize social, physical, and cognitive engagement (Bascu et al., 2014a).

In order to reposition primary and community care services for older adults, it is important to integrate their views in the design and implementation of care delivery models. Approaches to care delivery that are co-designed by service users may have the potential to better address the healthcare needs of the aging population, especially in rural and remote regions (Hulko et al., 2021). Research on the repositioning of healthcare services for older adults—particularly primary and community care—needs to ensure that an increased emphasis is placed on service users' perspectives. One way of doing this is to involve older adult service users as active participants in research and ensure the integration of research findings into practice. A critical approach to research that facilitates older adults' active role in the co-design of healthcare services could create opportunities for meaningful collaboration between service providers and

service users. This could ensure that healthcare services prioritize and address the unique healthcare needs expressed by rural-dwelling older adults.

5.0 Conclusion

This scoping review examined literature on healthcare restructuring and the design and delivery of primary and community care services for older adults with an emphasis on the service user perspective. It determined that restructuring efforts of—and research on the restructuring of—primary and community care seldom consider the perspectives of older adult service users. The lack of attention to rural-dwelling older service users' views leads to fragmented service delivery, which further aggravates their sub-optimal experiences of care. An increased availability of state-funded healthcare options is essential for decreasing reliance on informal supports, which tend to become overwhelmed with facilitating the functioning of rural healthcare services. For healthcare services to be conducive to the needs of older adult service users, especially in rural communities, it is vital for healthcare restructuring initiatives and related research studies to increase their focus on the perspectives of older adults living in both urban and rural geographies. This could ensure that healthcare services are responsive to the unique and holistic needs of rural-dwelling older adults who choose to age in place.

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