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Diverse 'rurals': comparing mainland and island-dwelling older adults' perceptions of formal care

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Abstract

Introduction: Care in rural and remote areas is often characterised as problematic, yet this framing can obscure important differences between rural places and the factors driving these. Few studies compare perceptions of formal care recipients between different rural locations. This article contrasts older adults' views of a range of care services – including primary, secondary, and social care – across island and mainland rural sites.

Methods: The study draws on 14 months of ethnographic fieldwork conducted in two locations: 'Insh', a remote island located off the west coast of Scotland; and 'Willow Valley', an area encompassing three villages in the northern English county of Cumbria. Data were collected through participant observation in community settings and semi-structured interviews. A total of 36 participants were interviewed, comprising 33 older adults aged 66–92 years and three family members involved in care. Participants were recruited via community groups and snowball sampling. Interviews were conducted in participants' homes, transcribed verbatim, and analysed using reflexive thematic analysis.

Results: The findings demonstrate clear contrasts in perceptions of care between the two sites. On Insh, participants generally reported positive experiences, particularly in relation to on-island care. Access to healthcare professionals, especially GPs, was described as timely and straightforward. Perceptions were linked by participants to a local 'diseconomy of scale', which supported the maintenance of services despite the island's small population, but also to the broader social geography of the island. Repeated encounters in everyday spaces and the circulation of information through gossip networks meant that residents came to know, and be known by, those involved in delivering their care. These dynamics generated not only practical benefits such as continuity of care but also a broader sense of security and trust. Although participants also identified specific challenges, including difficulties with emergency transport, the need to travel for secondary care, and limitations in aspects of social care provision, overall evaluations of care were favourable. In contrast, participants in Willow Valley described more negative and uncertain experiences, particularly in relation to lesser accessibility and continuity of primary care. Difficulties in securing appointments, reliance on telephone triage, and a loss of continuity with clinicians were reported. While concerns were shared with participants living in Insh regarding travel to secondary care and the availability of social care, more spatially dispersed social relations meant that care providers were less embedded within local community life. This resulted in more fragmented and uncertain perceptions of care.

Conclusion: Perceptions of formal health and social care can vary significantly across rural areas, challenging 'deficit' framings. There is a need for place-sensitive approaches to policy that recognise differences both between and within island and mainland rural settings.

Keywords

deficit perspective, England, ethnography, island care, older adult care, rural care, Scotland.

Introduction

Research into formal health and social care in rural and remote settings across the globe has focused predominantly on issues of availability and access[1-6]. In contrast to otherwise-prevailing stereotypes of such areas as 'idyllic', the dominant narrative has been one of what has been termed a 'deficit' framing: an understanding of rural places as inferior environments in which to work and as inherently deficient in care[7]. This narrative has been reproduced by professional and community groups seeking to raise rural care up the political agenda, and by the news media[8].

Is the rural care 'deficit' framing justified? There is evidence that it is, at least to an extent. Across national contexts, problems of provider availability and distribution, recruitment and retention, and care accessibility and utilisation have long been identified in rural places[1-6], while studies have drawn out the consequences of these for rural residents, particularly those requiring specialist care or with chronic conditions[9-11]. These difficulties are often exacerbated by transport issues relating to the weather and a lack of public provision[12-15]. However, other research points to a more complex picture. Increasingly, it has been recognised in quantitative work that rural–urban differences in access to health care vary according to the measure of access utilised, how rural–urban status is defined, and whether other factors, such as geographic location beyond rural–urban, are taken into consideration[16-18]. Qualitative studies indicate positive perceptions of some aspects of rural care. King and Farmer, for example, found that older adults in Highland Scottish communities valued the accessibility, personal nature and continuity of care they received, particularly from GPs and nurses regarded as 'locals'[19]. This is consistent with evidence of relatively high satisfaction with patient-centredness and continuity of general practice among rural and remote populations in Scotland more generally[20,21] and in Canada[22].

Taken together, this evidence suggests that rural and remote access to care is considerably more complex than 'deficit' framings imply, yet important gaps in the literature remain. Of note, there is a lack of comparative studies of how care experiences may differ between rural settings, particularly between mainland and island sites. While islands are diverse, they are commonly characterised by geographical isolation and boundedness[23,24], and, in relation to small islands in particular, Gould and Moon have suggested these qualities can result in 'diseconomies of scale' – the apparent 'overprovision' of services in order to address the day-to-day primary and emergency care needs of the population[25]. At the same time, island communities may experience an 'island penalty', referring to the relatively high costs of maintaining the aforementioned services and the need for patients to travel to the mainland to access many specialist care facilities or even to move permanently for care[25-28]. Furthermore, the relative isolation and boundedness of islands may also shape formal care experiences through the close social relationships that develop between residents and practitioners[25,27]. This dynamic is not unique to islands, as studies have noted that the small size of many rural communities means formal providers are often already familiar with those in their care[9,10], yet little attention has been paid to whether, and in what ways, such processes differ between island and mainland rural settings.

Against such a backdrop, this article draws on ethnographic fieldwork and interviews to compare older adults' views of a range of formal care services in two places: a remote island off the west coast of Scotland and a group of villages in the northern English county of Cumbria. In doing so, the article attends to both conventional dimensions of rural care access, including the availability and distribution of services, and the sociospatial contexts in which care is delivered and experienced. This builds on theorisations of rural health that emphasise the interaction between geographical isolation, local social relations, health services, and broader health systems, recognising that these factors can combine in different ways across rural and remote places[29]. The article also responds to more relational approaches to rural healthcare access, particularly work emphasising the relationships between care providers and users fostered by the sociogeographic proximity of rural life[30]. These move beyond existing rural care access frameworks[3] by directing attention to the everyday social contexts through which care is perceived and evaluated.

Methods

The empirical material this article draws on is derived from a comparative ethnographic doctoral project investigating experiences and perceptions of care among older people in two rural settings in the UK: a remote Scottish island referred to under the pseudonym of 'Insh', and an area in northern England given the pseudonym of 'Willow Valley'. These settings were selected on the basis of their shared and distinct characteristics: both are sparsely populated rural locations with populations that are ageing relative to the national average, yet the boundedness, isolation, and transport connectivity of the island present both challenges and opportunities for the delivery of care. Insh is located off the west coast of Scotland, a ferry journey of more than an hour to the mainland, and is home to fewer than 5000 people. The island is served by a primary care practice, community hospital with attached accident and emergency department, and residential care facility. For specialist treatment or residential nursing care, travel or relocation to the mainland is required. Willow Valley sits within one of the least-densely populated local government districts in England, in the county of Cumbria, and encompasses three villages. The villages do not have any care infrastructure of their own but are located within 5 miles (8 km) of a town with a primary care centre and residential care home. Accessing some secondary care services can take up to 2 hours in a private vehicle, with longer journey times by public transport.

Two fieldwork blocks were conducted, the first between March and October 2023 (Insh) and the second between April and November 2024 (Willow Valley). At both sites, participant observation was carried out at community groups attended by older adults alongside semi-structured interviews with 36 participants: 18 older adults and 3 family members on Insh, and 15 older adults in Willow Valley. With the exception of family members, participants' ages ranged from 66 to 92 years. All were White, and 24 identified as female and 12 as male. Around half were recruited through community groups and the remainder through snowball sampling. Participants were required to be aged 65 years or over, or involved in caring for someone aged 65 years or over, and to live in either field site. Interviews were conducted primarily in participants' homes and lasted around 45 minutes.

Following the process of thematic analysis outlined by Braun and Clarke[31], a series of codes and themes were generated relating to rural ageing and care. Themes relevant to this article include 'on-island' and 'off-island' care, 'knowing/being known' and 'difficulties of distance'. Because of the nature of participant observation, it was not possible to obtain written consent from all participants; however, the author made contact with group organisers before attending and outlined the research to members at the first session, as well as reminding attendees of the research when engaging them in conversation – a form of 'continuous consent'[32]. Written, informed consent was secured from all participants prior to interview. To protect the confidentiality and privacy of participants, all places and people have been pseudonymised.

Ethics approval

Ethics approval for the research project was granted by the School of Health and Social Science Research Ethics Committee, Edinburgh University (CAHSS2211/02).

Results

Insh

On Insh, residents often drew a contrast between care on and off the island, suggesting that the former was superior to the latter:

> *When we came from the mainland to here … I did wonder what it would feel like. Just not sure that remote would be as accessible, I suppose. And it's been the absolute opposite … The ratio of GPs here is phenomenal. It's one to five hundred. Unlike, one to, between two and four thousand on the mainland. So, they're really accessible, the same day, the next day. If you want to see a particular doctor, then you might wait, tops, a week. I've done that with Doctor Ethan, for something specific I wanted to ask him about. Erm, that I knew was his speciality, really. And, and that's interesting to me, too. On the mainland, I wouldn't have known what the GPs and the surgery there had as specialisms.* (Diana, aged 60 to 70 years, Insh resident)

Such a verdict was common among the older adults on Insh. Regardless of whether they had moved to the island relatively recently or were longer term residents, many stressed the seamless access they had to health care. This was often put down to Insh occupying what one participant described as a 'sweet spot' in terms of obtaining care, since it was situated far enough away from the mainland that much provision had to be located on the island but at the same time had a large enough population that said supply could not be delivered by an intermittent fly-in service, as it might have been on a less populated isle. In the context of this 'diseconomy of scale'[25], obtaining a GP appointment on the island was generally not a stressful process, nor did residents face a lengthy wait to receive care, even if they had requested a particular doctor. However, it was not solely the perception of such a diseconomy that led to care on the island being viewed in a more positive light than on the mainland. As Diana touched upon, the relationships that older adults had with their doctors played a role too. Moreover, this extended far beyond knowing what a doctor's specialty was:

> *You think about the myth of the village, and there's the doctor, there's the vicar … there's the policeman, there'll be the village gossip, there's the village green … and all that stuff. But it's actually saying something really real. And one of the things it's saying is, you'll have known those people all your life … I think that, you know … that's what people want, a set of relationships which are relatively stable, that they feel they can trust, that they've built up over, over a whole number of years, and which will be with them 'till the end. A lot of fear about things now is that people don't have that certainty. I mean, I don't want to go into a home. Why not? Because it's completely unknown … it's all dislocated, disjointed, awful. On Insh, Brogan* [the island's care home]*, it's a place that you can go on Insh. So it's not leaving home, actually* [laughs]*, and furthermore, you'll know everybody who works there, because they're all from Insh. And they'll know you … Of course, they're playing a professional role, but it's, it's about knowing a place, knowing people, and being known.* (Alfred, aged 60 to 70 years, Insh resident)

Alfred argued that people desire a set of place-based, enduring relationships of care. Fearing the 'unknown', he would not like to move into a residential care setting, yet an exception can be made for Brogan. Alfred's reasoning was that the care home is a part of the community on the island and that any resident will already be acquainted with the members of staff there.

Alfred's argument can only be understood in the context of the social geography of Insh – a limited number of houses, roads, and facilities bounded by the surrounding waters of the island that led to residents encountering each other repeatedly; encounters that were supplemented by the sharing of information obtained during them[33]. Thus, via both direct and indirect means, residents accrued knowledge of one another. This knowledge was often contrasted with the invisibility and anonymity of urban life, and while it was recognised that this could be abused – the lack of privacy relating to one's health issues remarked upon by several participants – it was also highly valued. Social proximity was perceived as enabling a degree of familiarity exceeding that which could have been achieved in the context of the formal care system alone. In turn, this was linked to multiple benefits by residents. Not only did familiarity have practical merits of the sort outlined by Diana, it was also, as Alfred indicated, psychologically advantageous. 'Knowing people, and being known' led to a sense of stability and trust, both in one's care provider and in the local care system.

If these aspects of formal care on Insh – accessibility and knowing/being known – were what was treasured about the island, however, they were also perceived as being under threat in various ways or, worse, already compromised. Residents identified three main limitations of formal care provision. First was an inability to obtain an ambulance at times when required. Emergency calls were routed through a callout centre based on the mainland, meaning that the call handlers' lack of familiarity with the local geography and healthcare system of the island resulted in delays in ambulances reaching people in need.

The second issue related to the need to travel to the mainland for treatment for older adults with chronic conditions. Although they were generally positive about care they received on the mainland, the travel itself was tiring and poor weather often caused planes or ferries to be cancelled at short notice, leading to participants having to stay away from home overnight. This made accessing secondary care off-island significantly more stressful than it might otherwise have been.

The third set of issues raised by the residents of Insh in relation to formal care concerned social care. Despite the advantage that Alfred previously outlined of familiarity with the staff on the island, and the availability of free personal and nursing care in Scotland, aspects of social care were seen to be, as one participant put it, 'a bit of a mess'. A shortage of domiciliary care workers meant that

obtaining care at home was difficult. Causing even greater concern, however, was the fact that the island's care home, Brogan, was not suitable for people with advanced dementia:

> *Is there anything else that you'd like to raise in relation to care for older people on Insh?*
>
> *It's just a nightmare … It would help if they changed their status, I think, for a lot of families … here, because a lot of them get sent away. And then, you're taking them away from everything they know. Because they could have lived here their whole life. And it's not fair, no.* (Heather, daughter of Insh resident aged 80 to 90 years)

Because Brogan did not cater for residents with significant behavioural issues, many older adults were concerned about being forced to leave the island. Mirroring other island settings[28], they feared becoming severed from the socially intimate communities that they so valued. These limitations notwithstanding, the overall perception of care on Insh was a positive one. While living on an island was regarded as both detracting from and enabling care, the qualities of accessibility and knowing/being known meant that for the most part the latter exceeded the former.

Willow Valley

Whereas on Insh, the advantages of living on the island were seen to outweigh the disadvantages, in the villages of Willow Valley in Cumbria, the reverse was broadly true:

> *I remember you said the other day that your opinion of the doctors is quite low?*
>
> *You can't get to see them, can you? You've got to ring up and make an appointment and then they'll ring you back. And, um, then they'll say, can you come down if they think you need to or they'll send you a prescription. It's not very good, no. You never see a doctor. Now, when my wife was ill, you'd only to ring the doctor in those days and they'd come out and see you. You're lucky if you even see one now.* (Kieran, aged 70 to 80 years, Willow Valley resident)

In contrast to Insh, where relatively high levels of local provision were perceived as supporting easy access to primary care, complaints such as this were common among the older adults in Cumbria. Many attributed the situation to the populations of both their villages and the towns nearby increasing in recent years without a commensurate rise in the number of local doctors. As a result, they felt, GPs had had to reduce the scope of their services, delegating tasks such as yearly check-ups to other primary care staff such as nurses and stepping back from carrying out home visits. Indeed, Kieran notes that when his wife was unwell 20 years prior, the GP used to come out to their house to visit them, something that no longer occurs. While such changes reflect wider shifts in the organisation of primary care in England and are not unique to rural areas[34,35], they nonetheless contributed to a sense among Willow Valley residents that local primary care had become less accessible and personal. In light of these difficulties, residents portrayed themselves as battling the care system to obtain the care they needed:

> *If you are trying to get a GP appointment, for instance, is that very difficult?*
>
> *It's a fight. It's a fight. You've got to get past the receptionists. Because you get all these options and press this and press this, and half the time you get cut off and they even admitted to me, one of them, that their telephone system was really not up to scratch. And it's just frustration, when you're worried anyway, and then, you know, you say, I'd like to make an appointment with a particular doctor. Um, oh, well, we'll book you in for a phone call, which to me doesn't do it. Because, you know, I think a good doctor can tell an awful lot by just observing the person. How they move and how they look …*
>
> *And do you manage to get the same doctor?*
>
> *You've lost that … continuity of people who knew … A lot of the time, if you can't wait, you'll see somebody you've never seen before. And they can't possibly know the background and read all the notes and that sort of thing.* (Jenny, aged 60 to 70 years, Willow Valley resident)

As Jenny remarked, securing a primary care appointment entails navigating a telephone system that is 'not up to scratch'. For her, telephone appointments don't 'do it', cutting off visual information about a person – 'how they move and how they look' – that she considers important to clinical decision making. Jenny also highlights the loss of continuity of care. Presently, when a resident of the Willow Valley goes into the practice with an urgent need, it is probable that they will be diagnosed and treated by a doctor they have never seen before – often a locum brought in to compensate for the lack of GPs. As Jenny acknowledges, while this clinician will have access to the patient's notes, they are unlikely to have the time to read them thoroughly and come to a full understanding of their 'background' – their health issues and what they want from their care. Although locum use is not unique to rural general practice in England, research suggests that it is particularly prevalent in rural practices, where recruitment and retention difficulties can make maintaining a stable workforce challenging[36]. In Willow Valley, this instability was perceived not only as a problem of availability but also as undermining the continuity of care.

Whereas such a decline in the accessibility and continuity of primary care represents a key difference between Insh and Willow Valley, other criticisms residents made of formal care were more similar. Again, travel to secondary care appointments was considered problematic, albeit not to the same extent. Although in Cumbria there was not the risk of getting stuck off-island, transport to and from a hospital appointment could be both time-consuming and arduous, appointments sometimes located in cities around 2 hours' drive away. While some older adults had their own vehicle and felt confident negotiating fast moving stretches of motorway, others did not. They had to rely on help from friends or family to get to hospital appointments or to pay for a taxi or hospital transport, at times representing a considerable expense.

The other aspect of formal care in which there were some similarities in residents' perceptions between Willow Valley and Insh was social care. On this topic, most participants had some idea of what was available in the local area and were conscious of a shortage of supply, an issue across many rural areas of the UK[37]. This meant that people requiring a nursing home faced a county-wide search for a place. Consequently, participants paralleled their island counterparts in expressing fears about being forced to move away to access care:

> *One of the difficulties that's there, is if you wanted a nursing home or you needed specialist care … There are one or two homes in this area around Redthorn … And then you go into other places, so if there's somebody from here who needs intensive care, erm, you're looking, sort of, Cumbria wide … as to where you can find spaces.* (Zebedee, aged 80 to 90 years, Willow Valley resident)

Such fears were accompanied by significantly higher levels of uncertainty in Cumbria, however. On Insh, the social care workforce (both domiciliary and residential) lived in the community and were therefore known by residents, either through direct social contact or via the gossip networks that extend the breadth of the island. Effectively, the isolation and boundedness of the island has established an enclosed sociospatial world – one that is a source of great comfort to older residents. This is not the case in the Willow Valley where, rather than a clear boundary between out and in, there has instead been a more gradual erosion of knowledge with physical distance. Thus, a resident might know a large proportion of residents in their own village, a smaller proportion in the neighbouring villages, and a smaller proportion still in the closest town – where most of the care workforce lives and the nearest care home is located. As a result, although some residents knew individual carers in their village, if they were to receive care it was probable that it would be delivered by a person or persons with whom they were not acquainted, in a place they were not familiar with. Consequently, narratives of care as 'dislocated, disjointed, awful', to use Alfred's description, held more power in this location.

Thus far, the portrayal of formal care in Cumbria has been a bleak one, yet it must also be acknowledged that this was not always the case. Some older adults cited strong personal relationships with their GP, one couple recounting that their doctor had even visited their house to show them some fossils after they had come up as a topic of conversation in an appointment the previous day. Furthermore, even in the context of secondary care where relationships were more impersonal, there were examples of care praised by residents. However, this was inevitably followed by the recognition that although the system had functioned for them on this occasion, it was not generally doing so for many residents – whether that related to the inability to secure an appointment with a GP, the difficulty of getting to a secondary care site many miles away, or the uncertainty surrounding social care.

Discussion

Contrasting views of care among older residents across a range of services in two rural locations, this article is one of the first to explicitly compare perceptions of formal care recipients between island and mainland sites. The article has argued that whereas the advantages of living in a rural place as pertaining to formal care were regarded as outweighing the disadvantages on Insh, the reverse was broadly true in Willow Valley. This was due in part to the highly accessible care system perceived to characterise the former location, but it was also linked to the broader social geography of the island, specifically the extent to which residents and care providers knew, and were known by, one another.

In developing these results, this study reaffirms existing findings from research into formal health and social care provision in rural settings, both internationally and in the UK. For instance, difficulties accessing primary care in Willow Valley, including problems obtaining GP appointments, telephone triage, and a lack of continuity, have also been reported in rural England[13] and Australia[12]. Although these are not unique to rural areas, a lack of continuity in particular may be exacerbated by the greater use of locum doctors rurally[36]. Similarly, issues relating to distance to secondary and specialist services and transport provision across both field sites are a recurring theme in rural care access research[9-15,25-28], as is a lack of availability of social care[15,28]. The results from Insh also echo studies that have emphasised the benefits of close relationships between providers and care recipients in many rural communities[9,10], as well as work from Scotland[19-21] and Canada[22] showing that residents in some rural areas perceive aspects of care positively, particularly person-centredness and continuity of primary care. These findings caution against treating rural areas as uniformly deficient in relation to care[7].

In addition to reinforcing past findings, this study also extends prior work, particularly research into diseconomies of scale in small island settings. While the challenges island diseconomies present to healthcare providers have been observed previously[25], little is known about how island dwellers themselves perceive these. The study indicates that the diseconomy of scale on Insh was regarded benignly due to its perceived positive effect on primary care provision on the island. In reality, the GP–patient ratio used by residents to evidence this claim is likely to overstate the extent of provision because the same GPs also staffed the island's hospital and provided out-of-hours cover. Nonetheless, the many examples of timely access given by participants indicate that the scale and organisation of provision on Insh did indeed contribute to positive experiences of primary care, shielding it from many of the issues found in Willow Valley and in both rural and urban areas more generally[34-36]. This is consistent with Croker and Campbell's study of the Isles of Scilly, where speed of access to GP services was similarly regarded as a strength by residents[27]. Taken together, these findings therefore suggest that diseconomies of scale do not automatically translate into poorer care experiences. This represents a potentially novel theoretical insight, albeit one in need of further research. It may not apply to islands closer to the mainland or that rely on fly-in service models, while national statutory requirements to maintain local and out-of-hours provision are also likely to have played a significant role[25].

The two final contributions this study makes to understandings of rural and remote health derive from its comparison of care across rural island and mainland sites. First, the article demonstrates that even where challenges around access to care are shared, these can manifest in subtly different ways across rural settings. For example, travel to secondary or specialist care was an issue in both sites but one that carried greater weight on Insh as a result of the risk of getting stuck off-island. Second, the study draws out differences in the sociospatial configuration of rural places. The boundedness and isolation of Insh facilitated repeated encounters between residents and care providers and a sense of knowing and being known, in contrast to Willow Valley, where social intimacy diminished with physical distance. This was evident both in primary care, where knowledge of existing providers on the island contributed to trust in care, and in social care, where the prospect of receiving care from known people in a familiar place provided a degree of reassurance about the future. While familiarity has been identified as a valued dimension of rural care previously[9,10], these findings extend this work by showing that the spatial configuration of social relations shapes how it is developed and maintained across rural settings, with consequences for how care is experienced and anticipated. Ultimately, they illustrate the importance of theorising rural health as sitting at the intersection of geographical isolation, health systems, and social relations, recognising that these factors can combine in different ways across diverse rural and remote places[29].

A key strength of this study lies in its comparative ethnographic design, which enabled direct comparison of perceptions of formal care across two rural settings while also capturing the everyday social processes through which those perceptions were formed. This enabled the study to move beyond infrastructural measures of access and to compare more relational dimensions of rural care. However, the study is limited to two field sites and to older adults, and the findings are therefore not intended to be generalisable to

all rural contexts or populations. In particular, the experience of Insh should not be taken to represent island communities more broadly, given the considerable variation between islands in terms of remoteness, accessibility, population size, and infrastructure. As noted, future research could examine whether the relationships identified here between service provision, social familiarity, and geographical configuration are reproduced across other island and mainland rural and remote settings. There is also scope for further work on differences in perceptions across service types, particularly in relation to rural social care, which remains relatively underexplored.

Conclusion

This article has developed a novel comparison of island and mainland rural settings, demonstrating how infrastructural factors and local social relations shape care experiences in distinct yet interconnected ways. The article has shown that perceptions of formal health and social care can vary markedly between rural areas, challenging the tendency to frame rural and remote places as uniformly deficient in care.

For policy and practice, these findings highlight the need for more place-sensitive approaches to rural service planning. Rather than assuming that the challenges associated with rurality are experienced in the same way across settings, planning should assess how geography, availability and organisation of services, and local social dynamics, interact in particular places. This includes recognising that the social positioning of care providers can itself be an important feature of rural care, contributing to continuity and trust. Policies that support stable local workforces and the development of enduring relationships between providers and communities may therefore have benefits beyond improving service availability alone.

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Conflicts of interest

The author has no competing interests to declare.

AI disclosure statement

No generative AI or AI-assisted technologies were used in the creation of this work.

Data availability

Due to the qualitative nature of this study and the risk of compromising the privacy of participants within small rural communities, the full datasets generated and analysed are not publicly available. De-identified subsets of the text or thematic transcripts may be made available from the corresponding author upon reasonable academic request, subject to approval by the School of Health in Social Sciences Research Ethics Committee, Edinburgh University.

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