Chapter 14

Understanding Telehealth: Constructing Meaning to Promote Assimilation

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ABSTRACT

During the past few decades, many healthcare authorities sought to integrate new methods of delivering care to patients. Among the priorities faced by these organizations, a major issue arose of how to provide healthcare to patients who live in rural or remote regions suffering from a lack of accessible professional resources and services that comply with WHO’s call for providing fair access to healthcare. Many attempts were made to integrate new technologies such as telehealth into the healthcare system, but in many cases, telehealth was not successful due in part to limited assimilation into healthcare organizations and work practices. Telehealth addresses operational issues such as a shortage of professionals in rural or underserved geographical regions. Using a breadth of reference theories such as institutional theory, structuration theory, and organizational learning theory, we propose a conceptual model that integrates the determinants of telehealth assimilation and identifies factors that impinge upon the process of assimilation. We posit that telehealth assimilation can only be understood by taking a multilevel approach to the phenomenon, whereby assimilation starts at the individual level, permeates through other organizational levels such as groups, and finally ends at the organizational and inter-organizational level. Further, assimilation of technological innovations must be considered within their institutional context. Derived from our conceptual model, we make several propositions and hope that our work will significantly guide future research and managerial actions geared toward integrating healthcare in the workplace.

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INTRODUCTION

Ensuring equal access to health care is one of the challenges currently faced by many western countries (WHO, 2006). Countries have to ensure that the level of healthcare services provided is not only adequate but that those services are fairly distributed (Bourgueil et al., 2006). The importance of this issue is even greater for countries like Canada with vast territories. For example, the province of Quebec alone has an area equivalent to three times that of France and 20% of Quebec’s population lives in rural areas that account for 80% of the inhabited territory.

Many studies (Gravelle and Sutton, 2001; Roos et al. 1997; Politzer et al., 1991) have found geographic variations in the delivery of health services in western countries despite the existence of universal healthcare systems. These geographical variations in the provision of health care are linked to numerous factors including staff shortages, local policy, terms of physicians’ practices, transportation, and other variables (Field and Briggs, 2001). Inadequate delivery of health services translates into healthcare inequalities (Veugelers et al., 2004). Several studies show that low doctor-to-patient ratios in rural areas compared to those in urban areas are associated with poorer population health in the former (Gulliford, 2002; Vogel, 1998).

Some western countries have adopted a number of policies to address the issue of geographical distribution of health professionals and access to healthcare. However, most measures proved unsuccessful. For example, policies - such as providing financial support for training and living - aimed at increasing the number of professionals in remote areas did not work as expected (Bourgueil et al., 2006). The United States first implemented financial aid in the 1970s and more lately, financial aid measures have been implemented in Canada (Ward, 2004). Financial aid often takes the form of grants or loans with preferential terms coupled with a requirement of settling in deficit areas for a certain period. These measures proved successful only in the short term since physicians often bought back their loan or grant (Bourgueil et al., 2006). Despite financial support for settling in remote areas, physicians still continue to settle in areas with high population density even though competition is stronger in those areas (Barer and Stoddart, 1999).

Some measures targeted the physician training through adaptable curricula and internships taking place in rural or remote areas. It was believed that early experience in remote areas would positively influence a student’s motivation to practice in such areas. In addition, other measures were developed aimed at limiting the installation of doctors in well-deserved areas and at requiring foreign doctors, through immigration policies, to settle in remote regions. In Canada, foreign doctors receive loans for settlement but must service remote areas for five years; otherwise, they have to pay back their loans. Some of these measures, as was the case in British Columbia, were abandoned due to violation of personal freedom of establishment (Ward, 2004).

Aid for the settlement or maintenance of exercise in deficit areas also took other forms such as financial incentives (higher wages or aid in kind). Higher wages for doctors in rural areas is the most common type of financial aid in Quebec and Ontario (Bilodeau et al. 2006; Bilodeau and Leduc, 2003; Barer and Stoddart, 1999). This measure, too, only proved satisfactory in the short term (Bourgueil et al., 2006). An alternative to financial aid or support is aid in kind that primarily breaks the isolation of health professionals in terms of daily practice conditions and lifestyle (Bilodeau et al., 2006). It includes full or partial reimbursement of expenses related to continuing education and travel due to geographical location or even the financing of investments in collaborative projects between health professionals such as telemedicine, professional networks, group practice, and others (Bourgueil et al., 2006). Nevertheless, aid in kind has not yet proven successful.