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Access to Health Care Services in An Australian Rural Area – A Qualitative Case Study

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ABSTRACT

The study is aimed at investigating access to primary health care by examining various access parameters such as availability, accessibility, and affordability in Meander Valley, Northern Tasmania, Australia. Qualitative research design and data analysis were adopted. Semi-structured interviews were conducted with 30 people that were recruited through convenience sampling.

The findings indicated that participants generally expressed relative satisfaction with local health care service provision, although a number of participants cited satisfaction with some services and dissatisfaction with others. The main issues of concern were the absence of specialised, dental and after-hours care, high cost of services, and issues of access to transport. The resourcefulness of people with chronic health issues and their carers emerged as important, as was the relationship between lifestyle choices, alternative and mainstream health care options.

This study revealed major barriers to health care access by residents in rural Australia, which calls for urgent corrective measures. Further research should be directed to the exploration of the experience and expertise of carers and health professionals so as to obtain a more complete picture of access to health care services in rural settings. In addition, the study recommends a thorough investigation of the alternative health care options.

Key words: Primary health care, Health services, Rurality, Health care accessibility.

INTRODUCTION

This project was conducted in the community of Meander Valley to understand the current context of access to primary health care in rural Tasmania of Australia. Specifically, the study aimed to: 1) improve understanding about the factors that influence health care access in Meander Valley; 2) investigate the care experiences and attitudes of primary health care users in Meander Valley, Tasmania; and 3) provide recommendations on improving health care access in this rural setting and in a wider context.

BACKGROUND

The term 'access' has attracted much attention from health authorities and researchers. World Health Organisation (WHO)(2008) guidelines about access to Primary Health Care (PHC) include the principle of

universal access, a focus on populations with high health needs, and an optimal ratio of 1 General Practitioner (GP) per 1,000 head of population. One commonly cited framework uses five interdependent dimensions: availability, accessibility, accommodation, affordability and acceptability (Penchansky & Thomas, 1981).

Living in rural areas has been widely perceived to present major barriers to health care. Low population density, isolation, fewer economic and manpower resources, larger distances between residents and services are among the well documented deterrents to a satisfying care experience in rural settings (Arcury, Preisser, Gesler, & Powers, 2005; Mudler et al., 2000). Other non-spatial barriers include a narrower understanding of health, a culture of self-reliance, risk taking behaviors, or concerns for confidentiality (Harvey, Williams, & Hill, 2006), which render these socio-economically disadvantaged people more reluctant to access health care services. This is in keeping with a broader concept of geographical influences in health care access which notes that place has both direct influences (e.g., through distance) and indirect influences (e.g., through the shaping of attitudes and beliefs of rural people) (Judd et al., 2002).

Significant differences in health status have been reported to exist between rural and urban populations (Gregory, Armstrong, & Van Der Weyden, 2006; Wilson et al., 2009), with the former exhibiting poorer health than their counterparts. According to Walkeman et al. (2008), for example, higher illness levels, higher hospitalisation rates and higher prevalence of health risks factors are some of the defining characteristics of rural and remote communities in Australia. Higher rates of death from coronary heart disease (ischemic heart disease), cardiovascular disease, motor vehicle accidents, diabetes, suicide, prostate, colorectal and lung cancers are also identified as typical among rural Australians (Misan, Lesjak, & Fragar, 2008). Underpinning this vulnerability to poorer health of rural residents is the concept of access which needs to be addressed more thoroughly.

METHODS

This study adopted qualitative research design and data analysis. Qualitative data was collected from the semi-structured interviews with 30 people within Meander Valley, Tasmania recruited through convenience sampling. The taped interviews were transcribed and then imported into NVivo version for data analysis. The qualitative data were analysed using thematic analysis which requires the researchers to constantly analyse and compare newly gathered information before going back to new participants. For the analysis, QSR – NVivo v9.0 software was used to organise transcripts and codes. To ensure the reliability of the study, another researcher (an independent judge) who was doing research in the same general field was asked to review the raw data of the interviews. The independent judge reviewed verbatim transcripts of interview files. The researchers and the independent judge discussed the coding until agreement was reached. Selected characteristics of the participants are presented in Table 1.

Table 1- Characteristics of participants

	Number of participants (n/N)	Percentage (%)
Gender		
- Female	17/30	56.6
- Male	13/30	43.4
Age groups		
- 18 – 24	3/30	10
- 25 – 34	6/30	20
- 35 – 44	7/30	23.4
- 45 – 54	5/30	16.6
- 55 – 64	5/30	16.6
- 65 or over	4/30	13.4
	Total	100

FINDINGS AND DISCUSSION

Three dominant themes were identified as the major access parameters that significantly concerned the interview participants in their health care experiences, including availability, accessibility, and affordability of local health care services.

Availability of local health services

Meander Valley was noted by the participants to have a serious lack of health professionals and facilities. Issues of inadequate staff and limited supply of health care services were echoed throughout the interviews. “There is no chemist, there is no doctor, there are no other services, so everything is quite limited at this stage” (Participant 20). Some reportedly required services included an X-ray facility, a defibrillator, a local surgery, a kidney dialysis service.

Importantly, the undersupply of health professionals was most pronounced with regard to specialists. Some participants asserted, for example, that there was no mental health service available within the area despite the fact that there was a mental health social worker and Medicare covered counseling services. The way that people dealt with mental health crises in the bush and the need for even a basic service were well expressed in the following comment:

...five years ago we lost one of our sons in an accident and one of the others has handled it badly...he gets really depressed about it... I rang the Beyond Blue helpline and all they said was we will send you some brochures and that’s as far as it went... there was no follow on from it.
(Participant 10)

Other specialist services, such as paediatric and geriatric specialists were also mentioned as being non-existent.

Among the structural barriers of insufficient service provision, the issue that drew most resentment from the interview participants was the inadequacy of local after-hours and emergency services. Many expressed a desire for improved services to avoid travelling to other localities such as Launceston or Hobart. One participant stated,

the worst frustration is when an emergency does happen everything has got to go through GP direct or whatever it is and you have to spend a lot of time on the phone and not be able to directly access anything after hours (Participant 17)

Another issue regarding infrastructure unavailability was associated with dental services. The participants pointed to a notably unmet need for regular access to dental care. "People are going to lose the teeth that they've got because they haven't had regular access to dental care" (Participant 28). Obtaining out-of-locality dental care was reported as a possible solution for many people, but concerns of high cost and the factor of time continued to worry some participants.

The repeated citations of the shortage of health professionals and the dearth of services and facilities are consistent with previous reports concerning health care access in rural communities. McGrail and Humphreys (2009), for example, considered this issue "the most obvious barrier to accessing services at times of need", and Rosenblatt (2004) "one of the signature characteristics of the rural health care system." Conspicuously, this under-representation of staff and services is universal, which requires urgent corrective distribution measures.

Accessibility

Accessibility has been described in the literature to involve such aspects as mode of transport, Internet-based treatment, disability access, or language barriers (Young, Dobson, & Byles, 2000). However, two sub-themes were identified as presenting a formidable concern to the participants, namely the lack of health services information and transport difficulty.

The interview data indicated a widespread uncertainty about whether specific health services were available in their region or not. This lack of awareness is very similar to observations made by Dixon-Woods et al. (2006), who revealed a "persistent concern that more deprived people may lack awareness of some services." Poor communication was mentioned as one possible cause of the problem.

We have Meander Valley newspaper but it doesn't come out every week and people that live here or are in transit might not even be aware that that could have something in it regarding facilities or what to do if you get bit by a snake. (Participant 15)

Due to the unfavorable conditions of isolation and distance to care facilities, mobility presented a significant factor in the discussions of health care accessibility and utilization. A number of interviewees described transportation as particularly problematic. Limited transportation, for instance, was stated to interfere with people's ability to get to their appointments on time and restricted their options to visit out-of-town specialists as well.

There is an issue here for transport for elderly people that can't drive and they have to get to appointments that are always an issue here. (Participant 24)

The issues seemed to be worse in cases where specialised treatment is required. One interviewee cited an occasion in which a patient was in need of a regular medical treatment. Whilst her condition did not justify ambulance transport, she could not utilize community transport because of the risk attached to her condition. Arguably, this accessibility problem rendered the service unavailable.

Reported transportation difficulties such as geographical isolation, lack of public transportation, and ownership of individual cars, or the lack thereof, are concurrent with other previous findings about socio-economically disadvantaged population worldwide, such as those by Dixon-Woods et al. in the United Kingdom (2006), and Mudler et al. (2000) in America. However, this transportation-related barrier emerged in our study as a particular concern probably because of the aging population in

Meander Valley, who are more vulnerable to health problems and yet usually rely on others for transportation.

Affordability

Affordability is about the ability to meet the costs of accessing health services. In this rural context, major financial constraints included transport and payment for health services, which pose formidable barriers to accessing needed health care among the study participants.

For people requiring regular specialist treatments, transport affordability was a problem:

\$20 a trip for the community car is just ridiculous ... it was a huge burden on our finances, and I wasn't eligible for any travel assistance because you have to live further away than 70 km...
(Participant 17)

Private dentists were reported to be unaffordable for many. Specialists and alternative treatments were mentioned as "extremely hard to access" being "very very expensive." When faced with a situation of inability to pay for health care services, the participants with low income either chose to refrain from using certain health care services or resorted to self-care like basic first aid. "But again you have to pay \$150 to do it [first aid course]" (Participant 10). The financial focus of these responses indicated that the costs of obtaining health care represents a real deterrent to residents in Meander Valley, as is consistently reported in the literature relating to rural low-income populations (Brabyn & Barnett, 2004; Mudler, et al., 2000).

Attitudes and levels of satisfaction

Despite serious concerns about the availability, accessibility and affordability of health care services in the area, many participants were relatively positive about their own care experiences in general. It is worth noting that the participants were highly aware of the influence of their rural circumstances. Many stated they were lucky to have access to existing services and were unlikely to expect more than what was available.

Excellent for a hospital of that type... You can't compare it with a big hospital doing different types of procedures in a city. (Participant 5)

In fact, most respondents showed certain empathy towards health care staff in their area, being fully aware of the excessive pressures and workload on the existing workforce. "It's not fault to them because they are so understaffed." (Participant 29)

Specifically, the Deloraine Hospital and Westbury Community Health Centre were reported favorably with no complaints about the service offered. The child dental service recently established in Deloraine earned particular accolades. The centers' initiatives in providing regular podiatry services and diabetes classes were praised and the staff at the Deloraine Hospital were congratulated for their efficiency and expertise.

Praises for the local services, however, were often intertwined with acknowledged limitations as the respondents had certain perceptions about what constituted a high quality health care service. Limited health care resources and staff impacted on service quality. The key quality concerns that generate high level of dissatisfaction were waiting time and continuity of care. Waiting time at the public dental clinic and for publicly funded elective surgery together with disability and aged care outreach services were

seen as major problems. Many participants indicated their appreciation of having a regular access a GP service as and when required. However, this need was reported to be met only on a few occasions.

The difficulty in recruiting and retaining health care professionals in the Meander Valley municipality is similarly reflected in other rural areas the world over, even in other developed countries with advanced health care system like America (Rosenblatt, 2004). It seems that ensuring stability is, and continues to be, a challenge that requires priority attention.

Suggestions for improvement

The most interesting findings from the qualitative data were drawn from the respondents' personal experiences and their suggested ways to deal with the access and quality issues under unfavorable situations.

One such suggested solution was to increase the efficiency of the relationship between availability and accessibility of health services. With GP services clearly stretched, there was widespread support for continuity of care from competent GPs as a key health service. The deployment of nurses with clinical skills (the nurse practitioner model) also received support as a way of overcoming the lack of effective GP service. The availability of after care hospital services, day programs for children and older people, the provision of occasional services such as podiatry, social work, psychology, diabetes education, breast cancer screening and dental care for children were put forward as viable solutions.

With an emphasis on community-based approaches, the community transport program had widespread support. It was suggested that drivers should have first aid training and that appropriate emergency equipment be stored in the vehicle. An affordable dental practice, more services for older people and those with disabilities, such as a hydrotherapy pool, were also cited as issues that warranted further investigation. "We need a mobile dental clinic or something to be able to meet the needs in the rural community." (Participant 20)

Another theme reflected very strongly throughout the interviews was the acknowledgement that the small population base of the study area made the viability and availability of specialist services questionable. This situation demanded a degree of community self-reliance. Accordingly, increasing residents' self-reliance through training was perceived a priority. Several participants provided extensive accounts of their considerable efforts to develop sufficient knowledge and information required to inform a system of health care that would work for them by accessing a mix of local, regional and interstate services. Some participants considered the inclusion of alternative health and lifestyle options more formally.

I would include things like Yoga, or esoteric things like Reiki or Bowen therapy....if I get ear blockages or ear infections for instance, I'd go to a GP....or if I was to require surgery....I'm not anti-western medicine by any means. (Participant 23)

This subtheme was echoed by other interviewees. Their choice to live in rural areas had been partly informed by a desire to live a more holistic lifestyle that encompassed better access to nature to support a healthy lifestyle. Alternative treatments such as naturopathy and chiropractic were favored for their preventative and holistic qualities.

RECOMMENDATIONS

- This study was about the lived experiences of residents in a rural Tasmanian community about health care. It also has its pragmatic function in providing some recommendations to enhance the

health and well-being of the residents, especially those living in rural areas. The key recommendations are as follows:

- Health centers in the municipality should be supported to better cater for services such as dental services, dialysis, defibrillator, x-ray and a hydrotherapy and/or heated pool, and to publicize available services more extensively.
- The absence of local services is the main reason for accessing services from outside of the region. Thus, it is important to explore ways of attracting services to the local area.
- The community car program should be promoted more widely. Support by way of a reduction in cost be considered for those with chronic conditions.
- Introduction of an after-hours GP service in the area and/or consideration in employing clinical nurses (nurse practitioners) to handle some tasks normally performed by GPs is recommended.
- The recruitment, retention and appropriate training of GPs should be supported.
- First aid training should be promoted within the community. A free or subsidized first aid training program should be offered.
- The relationships between lifestyle choices and health and between alternative health and mainstream health services should be investigated.
- More collaborative and integrative primary health care models should be considered in rural areas, which focus on community participation.

CONCLUSION

This study attempted to examine the issue of health care access by investigating the lived experiences of residents in the rural Tasmania municipal area of Meander Valley. Interviewed participants expressed relative satisfaction with local health care service provision in general, although most cited a mix of satisfaction with some services and dissatisfaction with others. This satisfaction was contextualized within the recognition that it was unreasonable to have high expectations about health service provision in rural and regional areas. Regarding health care access parameters, the main issues of concern included the absence of specialized, dental and after-hours care, high services costs, and transport difficulties. The resourcefulness of people with chronic health issues and their carers emerged as important, as was the relationship between lifestyle choices, alternative and mainstream health care options. Further research should be directed to the exploration of the experience and expertise of carers and health professionals so as to obtain a more complete evaluation of access to health care services in rural settings. Thorough investigation of the viability and practicality of alternative health care options is also recommended.

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REFERENCES

- Arcury, T. A., Preisser, J. S., Gesler, W. M., & Powers, J. M. (2005). Access to Transportation and Health Care Utilization in a Rural Region. *The Journal of Rural Health, 21*(1), 31-38.

- Brabyn, L., & Barnett, R. (2004). Population needs and geographical access to general practitioners in rural New Zealand. *The New Zealand Medical Journal*, 117(1199).
- Dixon-Woods, M., Cavers, D., Agarwal, S., Annandale, A., Arthur, A., Harvey, J., et al. (2006). Conducting a critical perspective synthesis of the literature on access to healthcare by vulnerable groups. *BMC Medical Research Methodology*, 6(35).
- Gregory, A. T., Armstrong, R. M., & Van Der Weyden, M. B. (2006). Rural and remote health in Australia: how to avert the deepening health care drought. *The Medical Journal of Australia*, 185(11/12), 654-660.
- Harvey, D., Williams, R., & Hill, K. (2006). A flying start to health promotion in remote north Queensland, Australia: The development of Royal Flying Doctor Service field days. *Rural and Remote Health*, 6(485).
- Judd, F., Murray, G., Fraser, C., Humphreys, J., Hodgins, G., & Jackson, H. (2002). The mental health of rural Australians: Developing a framework for strategic research. *Australian Journal of Rural Health*, 10, 296-301.
- McGrail, M. R., & Humphreys, J. S. (2009). A new index of access to primary care services in rural areas. *Australian and New Zealand Journal of Public Health*, 33, 418-423.
- Misan, G., Lesjak, M., & Fragar, L. (2008). Health of rural populations. In S. Liaw & S. Kilpatrick (Eds.), *A textbook of Australian Rural Health* (pp. 71-81): Australian Rural Health Education Network.
- Mudler, P. L., Shellenberger, S., Streiegel, R., Jumper-Thurman, P., Danda, C. E., Kenkel, M. P., et al. (2000). *The behavioral health care needs of rural women* (online): The Rural Women's Work Group of the Rural Task Force of the American Psychological Association and The American Psychological Association's Committee on Rural Health.
- Penchansky, R., & Thomas, J. W. (1981). The concept of access: Definition and relationship to consumer satisfaction. *Medical Care* 19(2), 127-140.
- Rosenblatt, R. A. (2004). A View from the Periphery — Health Care in Rural America. *The New England Journal of Medicine*, 351(11), 1049-1051.
- Walkerman, J., Humphreys, J. S., Wells, R., Kuipers, P., Entwistle, P., & Jones, J. (2008). Primary health care delivery models in rural and remote Australia — a systematic review. *BMC Health Services Research*, 8(276).
- WHO. (2008). World Health Statistics. Retrieved 20 June, 2008, from <http://www.who.int/whosis/en/>
- Wilson, N. W., Couper, I. D., De Vries, E., Reid, S., Fish, T., & Marais, B. J. (2009). A critical review of interventions to redress the inequitable distribution of healthcare professionals to rural and remote areas. . 2009; 9: 1060. *Rural and Remote Health*, 9(1060).
- Young, A. F., Dobson, A. J., & Byles, J. E. (2000). Access and equity in the provision of general practitioner services for women in Australia. *Australian and New Zealand Journal of Public Health*, 24(5), 474-480.