Strategies to reduce barriers and inequities in access to health care services for rural/remote areas

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BACKGROUND

- People living in rural & remote areas have lower health status and earlier mortality than those in metropolitan areas[1]
- Living in a rural area is a proxy for socio-economic disadvantage,[2] which brings a constellation of cumulative risk, factors[3], including:
  - low use of health services.
- and high rates of:
  - Smoking
  - Obesity
  - Risky drinking
  - Poor dietary habits.
- Health status worsens with increasing rurality[3]
- There is a higher proportion of rural & remote Indigenous population, which has unique needs in terms of health care
- Rates of hospitalisation for ambulatory care sensitive conditions (ACSCs) are highest in remote areas, with rates decreasing as the location becomes more urbanised.[4]

OBJECTIVE

To identify strategies to improve accessibility to Primary Health Care (PHC) services for people living in rural and remote areas, particularly for those in greatest need.

METHODS

A review of the literature was undertaken. A range of bibliographic databases (PubMed, CINAHL, PsychInfo, Web of Science, Scopus), relevant websites, specialty journals, systematic reviews and the grey literature were searched. A snowballing technique was used to identify additional material.

RESULTS

- Particular PHC services (general practice, mental health, dental services) do not adequately meet the needs of people living in rural and remote areas[5]
- Barriers to accessing PHC occur at the level of policy, organisation and patient (Table 1)
- Strategies to improve accessibility are shown in Table 2.

Table 1. Barriers to using PHC services in rural/remote areas

Level	Barriers
Policy level	• Fragmented legislative roles & responsibilities[6] • Lack of inter-sectoral links • Inflexible & fragmented funding[7]
Organisation level	• Rationalisation of existing services; no sustainable replacement[8] • Health worker shortage; lack of skills/expertise • High staff turnover; use of locums in rural areas affects continuity of care, particularly for chronic conditions[9] • Lack of evidence-based interventions & preventive care • Lack of infrastructure for coordinated/integrated care[10] • Failure to connect with local community resources
Patient level	• Failure to empower patients in their own care • Poor patient interaction and continuity of care.

CONCLUSIONS

Compared to those living in metropolitan areas, people living in rural and remote areas of Australia have poorer health, lower socio-economic status, and higher rates of hospitalisations due to ACSCs. Moreover, access to PHC services is limited by difficulties recruiting and retaining an adequate health professional workforce. Therefore, a multi-faceted approach is needed to improve access to PHC services in rural and remote communities.

Full details of this review[11] are available on PHC RIS website
http://www.phcris.org.au/publications/policyreviews/index.php

Table 2. Strategies to improve accessibility to PHC for rural/remote populations

Strategy	Details
Service delivery models tailored to unique community needs[7]	• Different models of PHC delivery; optimal 'fit' depends on context (rural – remote continuum). See full report for details.[11]
Clarify policy framework, priorities & targets[12]	• Common vision reduces administrative & reporting costs • Clear policy framework enables integration across programs.
Consolidate funding streams to allow supply to match demand[6]	• Pooled funding models, with capitation, allows development of programs tailored to local need • Population based funding could follow the patient.
Recruitment & retention of rural workforce[14]	• Access to Allied Psychological Services (ATAPS)[13] • Rural Doctors Workforce; Divisions of GP Programs • Improve access to education and professional development[14] • Resources to assist health workers in rural & solo practices • Representation of rural health professionals on policy, program and management groups • Increase practitioners' access to same-discipline support • Encourage innovative practice and remuneration arrangements • Alternative workforce models (e.g., Remote Area Nurses –Qld)[15] • Flexible service models (e.g., outreach).[14]
Telehealth & Internet health models	• Potential opportunity to deliver a range of services • Practical barriers need to be addressed (e.g., medico-legal issues; remuneration; privacy & confidentiality; Internet connection; Doctor-patient interaction)[16] • Need for adjunct on-line services (e.g., electronic scripts, health records).

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