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An exploration of rural–urban differences in healthcare-seeking trajectories: Implications for measures of accessibility

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ABSTRACT

Comparing accessibility between urban and rural areas requires measurement instruments that are equally discriminating in each context. Through focus groups we explored and compared care-seeking trajectories to understand context-specific accessibility barriers and facilitators. Rural care-seekers rely more on telephone access and experience more organizational accommodation but have fewer care options. Urban care-seekers invoke the barrier of distance more frequently. Four consequences of accessibility problems emerged across settings which could be used for valid comparisons of access: having to restart the care-seeking process, abandoning it, using emergency services for primary care, and health deterioration due to delay.

1. Introduction

Ensuring equitable access to health services is an enduring concern for health system planners and policy-makers. Despite gains in equity, access, and comprehensiveness of healthcare after the introduction of publicly-funded medical services in Canada in 1966,[1] international comparisons indicate that it has fallen behind its OECD counterparts in the performance of its health system, especially in timely access to healthcare (Schoen et al., 2005; Wilson and Rosenberg, 2004). This has led to massive investments across Canada to renew primary health care and improve access.

The issue of equitable access to health services in rural and remote communities, in particular, became a research priority in Canada in 2002, when the national Commission on the Future of Health Care revealed important health disparities between urban and rural communities in dimensions such as infant mortality, age-standardized mortality, rates of accidents and injuries, and rates of disability (Romanow, 2002). Rural and remote communities do not have the full range of health services necessary to meet their residents' needs. Metrics of service availability, such as hospitals per 1000 population, often suggest that rural areas have greater per capita availability of resources, but planners and managers struggle constantly to recruit and retain sufficient health human resources to make these existing structures functional, so they only provide a partial picture of availability. Surveys of population perception of service accessibility is another more direct metric used by planners and ministries of health to determine both need for health care and success in meeting that need.

The impetus for this study was a counter-intuitive finding from a 2002 survey we conducted of primary health care access in Quebec. The survey found that patients in the waiting rooms of randomly selected rural primary healthcare clinics evaluated their ability to get seen rapidly, and the organizational accommodation of their clinics, more positively than their metropolitan counterparts (Haggerty et al., 2007; Lamarche et al., 2010). This, despite longer travel distances to health services, fewer local options for primary healthcare, shorter clinic office hours, and longer appointment wait times for routine care. Our program of research has

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[1] Since the 1966 Medical Care Act, all "medically necessary services" provided in hospitals or by physicians are covered by public funds. Hospitals and major health facilities are owned, planned, and administered publicly. Community-based physicians retain their autonomy to deliver and manage services privately, and are remunerated with public funds, mostly on a fee-for-service basis.

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explored various hypotheses to explain this finding, including differences in organizational models of care and levels of interprofessional collaboration. The study reported here explored whether the finding was a measurement artifact related to the capacity of accessibility instruments to detect rural specificities of access.

Assessing the success of efforts to improve access and achieve geographic equity relies on having appropriate measures (Pong and Pitblado, 2001). In other analyses we have found that, indeed, the items in the instruments used in the 2002 survey are more discriminating in urban than in rural respondents (Haggerty et al., 2011).[2] The differential performance of accessibility measurement instruments by rural and urban status implies that there may be important differences in how rural and urban residents reach and obtain services. Urban–rural comparisons of accessibility will be biased if measurement instruments do not integrate some of these specificities. With a view to providing health planners and researchers with an accessibility measure that is valid for both for rural and urban areas, we set out to explore the care-seeking experience of rural and urban residents, and to examine the barriers and facilitators of access to primary care in these settings. This article reports on the qualitative component of our sequential mixed-method study aimed at developing accessibility measurement instruments sensitive to geographic context.

2. Background

2.1. Healthcare access in the Canadian/Quebec context

In Canada, approximately 20% of non-urban dwellers are spread over a large geographic territory. Since market forces tend to concentrate resources in urban areas, ministries of health typically allocate public resources to ensure an adequate spatial distribution of health services in rural and remote communities. Quebec, the second-largest province in Canada (with approximately 8 million, predominantly French-speaking, residents), has used legislation to address the issue of geographic distribution of health resources. The government has used mechanisms to limit the number of physicians practicing in metropolitan areas, such as limiting the number of licenses available and reducing remuneration for medical services provided by family physicians in urban centers during their first years of practice.[3] Although these coercive measures have proved successful in recruiting physicians to rural areas, they have not improved retention (Bolduc et al., 1996; Wilson et al., 2009) and have lead to high physician turnover.

Primary healthcare in Canada is provided principally by family physicians in autonomous family practices. Patients are free to choose their physician, and being affiliated to a family physician is the entry point to comprehensive primary care as well as to other health services. Family physicians comprise approximately half of the physician workforce in Canada but also practice in hospitals. In rural areas, family physicians are not only the backbone of primary healthcare, but also deliver an important proportion of hospital services. In Quebec, it has been a challenge to attract physicians to comprehensive primary care practice, with the result that approximately 25% of residents are not affiliated to a family physician, the largest proportion in Canada (Canadian Institute for Health Information, 2008). Unaffiliated patients typically resort to walk-in clinics or hospital emergency rooms for episodic care. Though a larger proportion of rural residents have a family physician compared to metropolitan residents, the difficulties with physician retention make many physician affiliations fragile in rural areas.

2.2. Orienting concepts of access and accessibility

Despite access being a central feature of health systems, there are variations in its definition and conceptualization (Ansari, 2007; Levesque et al., 2013). Access is generally understood to be a function of how well available healthcare resources (supply) fit or interact with health need (demand) (Frenk, 1992; Mooney, 1983; Musgrove, 1986). Thus, health services are accessible if their specific characteristics – geographic location, organization, price, acceptability – fit with patients' capacity to seek and obtain care (Bashshur et al., 1971; Donabedian, 1973; Penchansky and Thomas, 1981; Starfield, 1998).

Building on the foundational work of Frenk (1992) we differentiate between access and accessibility. Access is the ability of populations to obtain appropriate services in response to need for care; it may be realized and expressed as use of health services, or it may be unrealized and expressed as unmet need for care. Accessibility, on the other hand, describes the nature of the health services whose location, organization or cost allow, facilitate, or impede the ability of a wide range of potential patients to seek and obtain care.

Frenk proposed that access can be conceived of broadly, spanning the stages from perceiving health care need to getting ongoing care. The classic Anderson–Aday conceptual model of predisposing factors, enabling factors, and illness variables can be applied to this broad spectrum (Andersen and Aday, 1978; Andersen, 1995). A literature synthesis by one of the authors (Levesque et al., 2013) further identifies five dimensions of accessibility: approachability; acceptability; availability and accommodation; affordability; and appropriateness. In this study, however, we focus on the more narrow care-seeking process, beginning after a potential patient's decision to seek care until obtaining the needed service.

3. Methods

3.1. Overview and context

We conducted 11 focus groups in one urban and three rural contexts. The urban context was a metropolitan municipality (population $>500{,}000$) with the full range of health services. The three rural contexts were towns (population 10,000–40,000) more than three hours from tertiary care centers by road, villages (population $<10{,}000$) in agricultural areas on average 30–60 minutes from both primary and subspecialty services, and remote villages (population $<10{,}000$) more than four hours from tertiary care centers. Although the towns are classified as urban by Statistics Canada (McNiven et al., 2000),[4] we considered only the metropolitan municipality as urban in this study because residents in the towns self-identified as rural due to their distance from metropolitan areas, which also corresponds to distance from tertiary care services.

[2] Both instruments were developed predominantly in urban areas. The Primary Care Assessment Tool (Shi et al., 2001) asks for the probability of receiving same-day advice or care for a sudden illness under various scenarios (clinic open/closed, weekday/night/weekend). The Primary Care Assessment Survey (Safran et al., 1998) elicits ratings of the opening hours, usual wait times for appointments, and ability get through to the clinic or talk to the doctor by phone.

[3] Physicians are mostly free to choose their location of practice in Quebec, as in the rest of Canada. The other 12 provincial health jurisdictions in the country have also instituted incentives and limitations to encourage physician location in rural and remote communities.

[4] This classification is based on a combination of population density and availability of a broad range of services.