
Is access to health services a problem for rural consumers?
Perspectives of Metropolitan and non-Metropolitan Health
Consumers in Victoria

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ABSTRACT

Rural health practitioners, researchers and policy makers have repeatedly expressed concern about the ways in which rural consumers are disadvantaged in terms of access to health care. However, little research has investigated the perspectives of rural consumers and less has compared their perspectives to their urban counterparts. This paper analyses perspectives of metropolitan and non-metropolitan consumers in the Australian state of Victoria in terms of their access to health care, focusing on the extent to which access to care is problematic for rural consumers. A mail questionnaire to 2400 randomly selected Victorians found that metropolitan and non-metropolitan Victorians were similar in their self-reported levels of health and happiness, number of visits to their GP, number of GPs, reasons for visiting the GP, satisfaction with GP and concerns about quality of health care. Non-metropolitan consumers were more concerned about young people and economic issues and, not surprisingly, travelled further to medical services; however most did not perceive this as problematic. When asked about specific issues, both metropolitan and non-metropolitan consumers identified access, mostly waiting times/lists, as their major health concern. Non-metropolitan residents raised issues about waiting and access more frequently than their metropolitan counterparts, but there was no relationship with rurality. The study suggests that there are access issues, mostly about waiting for appointments and at clinics, facing both rural and urban consumers. Further, for rural consumers, waiting for care was more of a problem than distance and travel.

ARTICLE

Consumer Concerns and Access to Health Care

It is important to understand the preferences and perspectives of health consumers in order to improve health service delivery (Butler et al. 1999; Humphreys et al. 2003). Consumer perspectives of health reveal that most are satisfied with health services but that concerns remain (for example, see Cleary et al. 2003; Mellor et al. 2006). These concerns include short consultation times, waiting lists, lack of information, the need for more coordinated, integrated and holistic care, expectations of quality of care, access to services, doctor-patient communication and consumers not feeling heard (Clearly et al. 2003; McGowan 2006; Mellor et al. 2006; Mott 2001).

Marmot and Wilkinson (2006) argued that it is the social environment that is important to understanding what causes health outcomes and health behaviours. They call these environmental influences the 'social determinants of health' (Marmot and Wilkinson 2006). The social determinants include stress, family influences and socialisation in the early years, social status, employment and income, the psychosocial environment (particularly at work), transport, social support and cohesion, the politics of food, poverty, social patterning and its impact on individual behaviours, ethnicity and racial inequality, age, housing and sexual health. Experiencing some or many of these determinants results in poorer health and quality of life as well as shorter life expectancy (Marmot and Wilkinson 2006).

Previous research has found that rural residents have poorer health than their metropolitan counterparts (AIHW 2002; Humphreys et al. 2003; Humphreys 1999; Wakerman and Humphreys 2002). Poor health status among rural residents has been related to less access to health services (Wilkinson and Blue 2002). The limited number of services coupled with distance to services makes access more difficult, time consuming and expensive (Humphreys et al. 1997, 2003). Rural life necessitates transport (usually private transport) and travel to services can mean lost wages and costs in child care and fuel (Wilkinson and Blue 2002). Access is even more problematic due fewer medical, nursing and allied health providers per population (AIHW 2002; Humphreys et al. 1997, 2002; Larson 2002).

Importantly, living in a rural area is not a social determinant of health. But rural residents have poor health. This questions whether or not rural health outcomes are poorer due to rurality itself or the presence of other social determinants in rural areas, such as lower incomes, the need for transport, issues of social status, inclusion and support, and racial issues that may be more prevalent in rural areas. Research into rural health has identified some of the needs of, issues facing and challenges confronting rural health consumers (Bourke 2001; Humphreys et al. 1997, 2003). Significant attention has been given to how greater isolation, less access and longer distances to services mean that rural residents do not have the same access to health care as urban consumers (Cheers 1998; Humphreys et al. 1997; Wilkinson and Blue 2002). It is almost assumed that access issues in rural health are distinctly more problematic than in urban health with little analysis to ascertain this.

While clearly there is less access to services and greater travel is required in rural areas, this is true of all services, not just health. The extent to which rural consumers have experienced access to health care as problematic or as an aspect of rural life is unclear. While access to health care may well be problematic in remote areas, such parts of the Northern Territory, Queensland, Western Australia and South Australia, the ways in which the rural context disadvantages health consumers in states like Victoria is less certain. This paper questions whether or not less access to health care in rural areas is the lived experience of rural consumers or a problem learned by its continual discussion in rural health. To do so, this paper compared the perspectives of consumers residing in metropolitan Victoria (the city of Melbourne and surrounds including Geelong) and non-metropolitan Victoria (the remainder of the state). In particular, the comparison focuses on the extent to which consumers perceive access to health services of all types as problematic, especially consumers living in rural areas.

Methods

In order to understand the perspectives of consumers living across the state of Victoria, a questionnaire was selected for data collection as face-to-face contact was not practical. A self-completion questionnaire addressing consumer perspectives on a range of health issues was designed and pre-tested. In total, 1200 residents from the Melbourne metropolitan postcodes and 1200 residents from Victoria's remaining postcodes were randomly selected from the telephone directory, excluding business, fax and mobile numbers. In September, October and November 2000, the 2400 selected Victorians were mailed the questionnaire in three steps.

1. The self completion questionnaire along with a letter explaining the study and a reply-paid, self addressed envelope was mailed to all 2400. Because telephone directories tend to list head-of-household, the letter asked the adult of the household (18 years or older) who had had the most recent birthday to complete the questionnaire.
2. About a week later, all 2400 residents were mailed a postcard thanking them for returning the questionnaire and reminding them to do if they had not yet returned it.
3. Four weeks later those who had not yet responded were mailed another letter, questionnaire and reply paid envelope (see Dillman 1999).

Questionnaires were completed and returned by 1219 residents, resulting in an overall response rate of 58 per cent (50% from metropolitan residents and 65% from non-metropolitan residents). The responses were coded, entered into a computer database and statistically analysed.

It is recognised that both metropolitan and non-metropolitan are diverse. In particular, non-metropolitan Victoria differs greatly in terms of access to health services. For this reason, an index of rurality was created for non-metropolitan areas of Victoria. The index considered population size of a respondent's postcode as well as their distance to the nearest centres with populations of at least 20,000 and 10,000 and the distance to Melbourne where the major specialist hospitals and centres are located. The rurality index (RI) created was: $RI = \text{square root} [(20,000/(\text{distance}) + 10,000/(\text{distance})) \times \text{population}] + 0.5(3.5 \text{ million}/\text{distance to Melbourne})$. Pearson's r was used to test for a co-relationship between each of the health questions and the RI or level of rurality for the non-metropolitan sample.

Findings

The Sample

A total 1219 respondents completed the questionnaire of which 710 were from non-metropolitan Victoria and 509 were from the Melbourne metropolitan area.

- 53% were women
- Median age was 50
- 70% were married or living with their partner
- 83% were parents
- For 93%, English was their preferred language
- 29% had not completed secondary school
- 56% had private health insurance

Perceptions of Health, Happiness and Services

Respondents were asked to rate their own health and happiness. Around half of both the metropolitan and non-metropolitan samples rated their health as very good or excellent and just under 70% rated themselves as happy or somewhat happy. There were no statistical differences between residents of Melbourne and residents of other areas of Victoria in terms of their own ratings of health and happiness.

When asked why respondents usually visited their GP, most visited for a short-term illness:

- 48% from non-metropolitan and 50% from metropolitan visited due to a short-term illness
- 36% from non-metropolitan and 32% from metropolitan visited for a check-up
- 15% from non-metropolitan and 16% from metropolitan visited about a chronic or ongoing condition
- 2% from non-metropolitan and 3% from metropolitan visited for stress or anxiety.

When asked how satisfied respondents were with their last visit to the GP, 85% of respondents from non-metropolitan Victoria and 82% of respondents from metropolitan Melbourne were satisfied.

Health Concerns and Issues

To identify how health issues rated among other local issues, respondents were asked to rate their level of concern with 10 major issues in their local area. Approximately six in 10 respondents were concerned about crime, quality of health care and opportunities for young people (see Table 1). Approximately half were concerned about unemployment, environmental quality, education, access to health services and low incomes. Interestingly, quality of health care was more important than access to health care for both metropolitan and non-metropolitan consumers and there was no statistically significant difference between the two samples. Metropolitan residents were more concerned about crime and environmental quality while non-metropolitan residents were more concerned about opportunities for young people and economic issues.

Respondents were asked in an open-ended question what were the most difficult problems experienced as a health consumer. A total of 518 (73%) of the non-metropolitan respondents and 330 (64%) metropolitan respondents provided one or more answers (see Table 2). The most frequently identified issue for both samples was waiting, be it to get an appointment, for results or while at the health service. Importantly, there was no relationship between identifying waiting as an issue and the rurality index, suggesting that waiting is not related to how rural the area in which the consumer lived. Other access problems was the next most frequently identified issue and this was reported by significantly more non-metropolitan consumers, although percentages for both samples were small. A further 10% of residents from outside Melbourne and 9% of those from Melbourne specifically stated that they had not experienced any major problems as a health consumer. In non-metropolitan areas, issues such as waiting to get an appointment, access and staff shortage/turnover (reflecting access) were more frequently reported while finding a good doctor (reflecting quality of care) was more of an issue among Melbourne residents. Overall, however, waiting was clearly the major concern for Victorian health consumers regardless of where they lived.

Table 1:
Concern about issues in the local area by metropolitan and non-metropolitan residents

Issue	Non-metro Victoria (%)^a	Metro Victoria (%)^a
Crime	60	64
Quality of health care	61	60
Opportunities for young people	67	53
Unemployment	60	47
Environmental quality	48	58
Education	55	52
Access to health services	51	44
Low incomes	52	38
Need for economic growth	41	25
Availability of public transport	30	30

^a % rating the issue as concerned or 3 on a 3-point scale

Table 2:
Consumer problems by metropolitan and non-metropolitan residents^a
(% of sample providing this answer)

Problem	% of non-metro Victoria	% of metro Melbourne
Waiting lists/to get appt or at clinic/hospital or results	37	28
Access	11	7
None	10	9
Cost	4	7
Staff shortage/high turnover	7	2
Finding good care/doctor	3	6
Specific illness, diagnosis, treatment	4	4
Attitudes/approaches of doctor	3	3
Quality of service	2	2
Lack of services	2	1

^a respondents could give more than one answer

Access To and Use of Health Services

Access to health care was pursued in more detail for both samples. Respondents were asked how far they traveled to their family doctor and nearest hospital. Residents of metropolitan Melbourne traveled an average of 4.5km to their family doctor and 7.3km to the nearest hospital. Those living in non-metropolitan Victoria traveled further, on average 8.6km to their family doctor and 11.9km to the nearest hospital. Not surprisingly, there was also a larger range among the non-metropolitan residents, some traveling up to 130km to their doctor and nearest hospital. As expected, those who were more rural (according to the Rurality Index) traveled further to these services.

When asked how many times respondents had visited their GP in the past year for their own health needs, responses ranged from 0 to 50 for non-metropolitan residents and 0 to 60 for metropolitan residents. When asked how many times respondents had visited their GP for other members of their household in the past

year, responses from both samples ranged from 0 to 150. When asked how many GPs they see on a regular basis, 67% of non-metropolitan residents see one GP while some see up to 12 and some do not see a GP. The average was 1.2 GPs per consumer. For metropolitan residents, 62% see one GP while some see up to 12 GPs and others do not see a GP. The average number of GPs seen per consumer was 1.3. A total of 19% of both non-metropolitan and metropolitan residents had visited an Emergency Department instead of a GP in the past 12 months, as asked in the questionnaire.

Discussion

In seeking the perspectives of health consumers, the study found many similarities between Melbourne metropolitan residents and non-metropolitan residents of Victoria. Residents from metropolitan and non-metropolitan Victoria had similar reasons for visiting their GP and similar levels of satisfaction with their GP. Overall, levels of satisfaction with medical services were generally high and similar to other studies (Khayat and Salter 1994; Veale et al. 1995). Metropolitan and non-metropolitan Victorians rated themselves similarly on health and happiness measures, and similar to levels found in other rural studies (Humphreys et al. 2003). While other studies suggest that urban residents visit their GP more frequently (Humphreys et al. 1997; Larson 2002), this was not confirmed here. Further, more respondents had visited a GP in the past year than the Australian average (Humphreys et al. 1997; Veale et al. 1995).

In a more in-depth analysis than is presented here (see the academic version of this paper), there was evidence to suggest that rural consumers who were older and/or with lower incomes, socioeconomic status, education levels and without private health insurance rated their health poorer. These same consumers had more concerns about access issues and used health services less than their urban counterparts. This suggests that the social determinants of health (see Marmot and Wilkinson 2006) impact rural consumers and that rural health, like urban health, needs to target disadvantaged and marginalised consumers to address its access and other health concerns.

Perspectives of local issues differed, with non-metropolitan residents being more concerned about opportunities for young people and economic issues, while metropolitan residents were more concerned about crime and environmental quality. Despite this, perspectives of health care were not viewed differently and quality of care was considered to be more important than access to health care. What is also important here is that quality of health care was rated as the second concern among both samples while access to health care was ranked as the seventh issue. This is important given the focus on access within rural health research, policy and strategies for change.

While quality of care was a general concern for all health consumers, when asked to identify specific problems, both metropolitan and non-metropolitan Victorians identified waiting to get an appointment, receive treatment, obtain results or be seen at the clinic as their major problem experienced as a health consumer. Further, among non-metropolitan residents there were few differences between those living in more and less rural areas. Access issues for rural consumers were more about waiting than the usually mentioned distance or travel (see Cheers 1998; Humphreys et al. 1997; Wilkinson and Blue 2002). This also confirms other studies that found waiting and access are key concerns for not only rural (Humphreys et al. 2003) but also other consumers (Khayat and Salter 1994; Steven and Douglas 1988). This

implies that addressing waiting lists and times is important for about a third of Victorians, regardless of where they live.

Importantly, a higher proportion of non-metropolitan residents were concerned about access issues, including waiting times, access to services and staff shortages/turnover, while more metropolitan residents were concerned about quality of care or finding a good doctor. Not only did non-metropolitan consumers rate access as more of a concern in the open-ended question, they also travelled further to health services, with some travelling up to 130km to a doctor and hospital (also see Humphreys et al. 1997; Wilkinson and Blue 2002). However, while many non-metropolitan consumers identified greater distances to services, they did not state distance as a problem; travel to services is a part of rural life. Therefore, while access to services may be less among rural consumers, the extent to which this is perceived by consumers to be a problem is small.

In summary, the major findings of this study are that:

- The social determinants of health (see Marmot and Wilkinson 2006) impact rural as well as urban consumers; rural health should target supporting marginalised consumers.
- Access to health care was not rated as the most important local issue; quality of health care was viewed as more important.
- Access to care is a key issue facing rural and urban consumers alike.
- More non-metropolitan consumers rated access issues as problematic and more metropolitan consumers indicated that quality of care was problematic.
- Access issues listed as problematic were not about travel or distance, but about waiting to get an appointment, for results or at the clinic.
- Addressing waiting lists is important for at least one-third of Victorian consumers.

Overall, this study found surprising similarities in consumer perspectives between residents of metropolitan Melbourne and those from non-metropolitan Victoria. The study suggests that there are concerns about waiting times and lists which need to be systemically addressed across the state's health care system. Findings also suggest that some of the health problems in rural areas may be attributable to social determinants rather than rurality. This study recommends that addressing consumer problems in health requires investigating concerns about waiting times and lists and improving health for disadvantaged consumers as identified by the social determinants of health (Marmot and Wilkinson 2006). Further, continual focus on distance and travel to services as the key issue in rural health is misleading.

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