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# ***Access to Health Services in Western Newfoundland, Canada***

**Issues, barriers and recommendations emerging  
from a community-engaged research project**

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This article reports on research initiated by the Rural Secretariat Regional Councils for the Corner Brook–Rocky Harbour and Stephenville–Port Aux Basques Regions (Figure 1), and undertaken in the Western Health Authority region of Newfoundland and Labrador (NL), where Corner Brook (pop. 19 886) is the only community of over 10 000 people (Statistics Canada 2011).

The Rural Secretariat is a government entity and the Rural Secretariat Regional Councils are comprised of citizens appointed by the Government of NL. The Regional Councils have a mandate to provide advice to the Provincial Government on issues affecting the long-term sustainability of their regions.

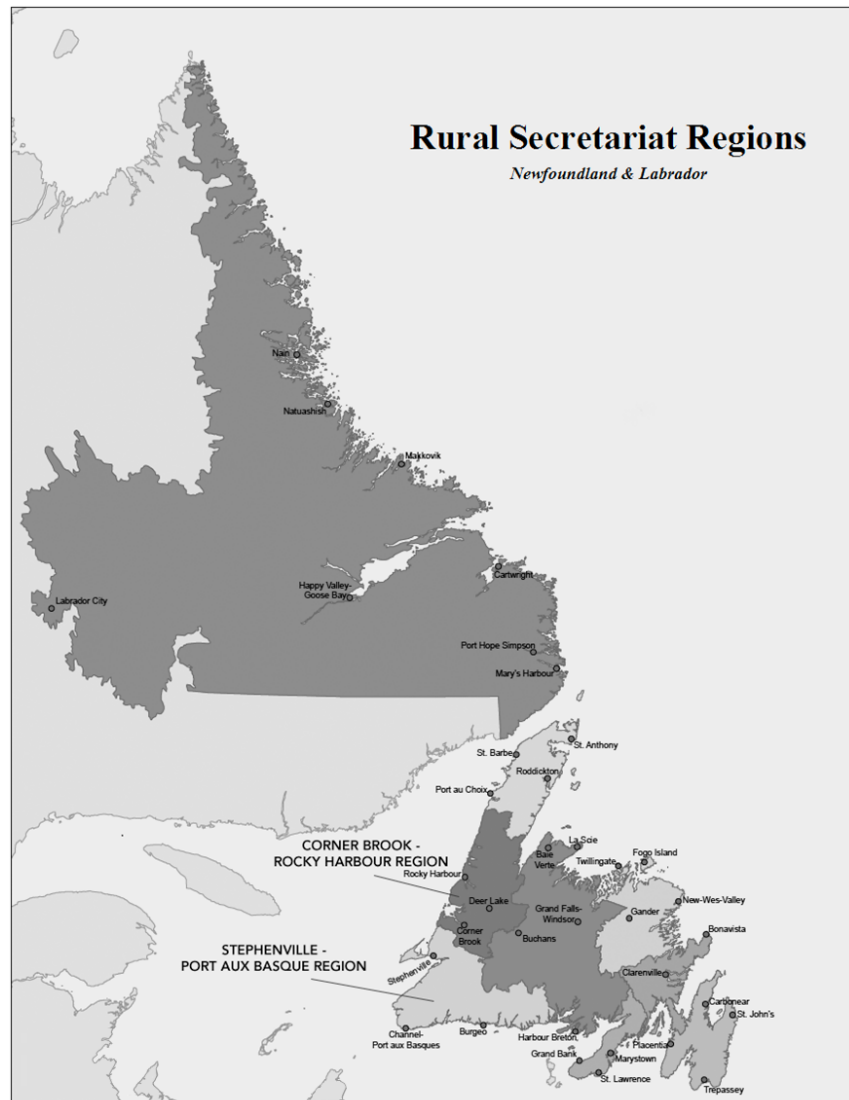
The objective of this research was to document healthcare access issues of individuals and groups less likely to participate in formal telephone surveys and focus groups in the Rural Secretariat Regions and to use these views and experiences as a starting point for exploring recommendations and solutions. The research is intended to serve as evidence to inform Regional Council policy advice on Access to Health Services in the associated Rural Secretariat Regions and to supplement a Needs Assessment undertaken in 2011/2012 by the Western Regional Health Authority.

## **BACKGROUND: HEALTH SERVICES IN RURAL AND REMOTE REGIONS**

Newfoundland and Labrador, the most eastern province in Canada, has a population of 514 536 people. The provincial capital has a metropolitan population of 196 966 people comprising 38.3 per cent of the provincial population (Statistics Canada 2011). Outside of St John's, the rest of the population lives in much smaller centres, with 62 852 people (12.2 per cent) residing in municipalities of under 25 000 and 254 718 people (49.5 per cent) residing in municipalities of under 10 000 people (Statistics Canada 2011).

**Figure 1: Map of Rural Secretariat Regions, with Corner Brook–Rocky Harbour and Stephenville–Port aux Basques Rural Secretariat Regions labelled\***

\* Mapping support provided by the Newfoundland & Labrador Statistics Agency, Department of Finance, Government of Newfoundland and Labrador



The Commission on the Future of Healthcare in Canada stated that '[h]ealth indicators have consistently shown that the health status of people living in rural communities, especially people in northern communities, is not as good as in the rest of the Canadian population' (Romanow 2002, p. 161). Current literature suggests that this disparity in health and wellbeing can, in part, be explained by barriers to accessing adequate healthcare. These barriers include long wait times to access healthcare workers, lack of access to transportation, travel difficulties associated with poor weather and high cost of travel. Rural communities are reported as being underserved by both family physicians and specialists, resulting in fewer people having a family doctor or consulting with a specialist.

In addition to barriers to accessing health services, research also suggests that specific populations in rural and remote areas may face additional barriers related to their Aboriginal identity, rural culture and/or the rural setting. Wardman, Clement and Quantz (2005) found that many Aboriginal individuals described fear of racism, discomfort in healthcare settings and concerns over confidentiality as barriers to accessing care. In 2002, Gruen, Weeramanthri and Bailie found that barriers to accessing specialist health services included not only a lack of public

transport to regional centres and high cost of accommodation and food, but also cultural inappropriateness of services. In a study examining barriers to accessing cancer care among Indigenous Australians, issues raised included fear of the medical system, collective memories of colonialism, and lack of understanding of Aboriginal and Torres Strait Islander values and customs (Sahid, Finn & Thompson 2009).

Research also suggests that rural women may face gender-specific barriers to accessing healthcare. Leipert and George (2008) found that some women were reluctant to access care because they felt that seeking healthcare conflicted with cultural expectations and characteristics of rural women such as strength and self-reliance. In 2004, the Gender, Women, and Social Policy Community of Scholars at Charles Sturt University in Australia found that many women felt they did not have adequate access to birthing, mental health, women's health and counselling services (Alston et al. 2006). Reduced access to care may have a significant effect on rural women's health outcomes. Gryzbowski, Stroll and Kornelson (2011), for example, reported that rural women who had to travel to access maternity services had an increased number of adverse perinatal events including increased utilisation of neonatal intensive care unit services.

Rural settings may also exacerbate barriers experienced when accessing mental health services. Forbes, Morgan and Janzen (2006) found that, while both rural and urban residents with dementia reported barriers to accessing healthcare such as long wait times and cost, rural residents often additionally reported that they did not know where to access care. Boydell et al. (2006) found that barriers to accessing mental healthcare for children in rural areas may include not only a lack of services and a lack of awareness of services, but also a fear of stigma related to the smaller social networks in rural communities.

Overall, at least three related points emerge from a review of existing rural health services research. First, access to health services in rural areas is often inadequate because of a lack of physicians and other health human resources, a lack of health facilities and/or health services, and distance and weather-related travel issues. Second, access issues are not uniform and barriers may vary depending on the community or group in question – for example, Aboriginal or gender identity may be linked to specific barriers. Third, depending on the specific setting, access to some services (for example, mental health services) may be particularly inadequate.

#### **METHODS AND METHODOLOGY: A COMMUNITY-ENGAGED APPROACH**

Research methods included the distribution of a paper and online survey as well as several 'kitchen table' discussions. Kitchen table discussions are an innovative method used to engage participants from rural communities. As with focus groups, a kitchen table

discussion involves an organised discussion with a selected group of individuals to gain information about their views and experiences of a topic, but kitchen table discussions are designed to be less formal than focus groups. According to Kitzinger (1994), interaction is the crucial feature of focus groups and this can be intimidating at times, especially for inarticulate or shy members. The method of focus group discussion can discourage certain people, such as those who are not very articulate or confident and those concerned about trusting others with personal or sensitive information (Gibbs 1997). Because we are most likely to interact with people we know in an environment we are comfortable in, kitchen table discussions are hosted by community members in their own homes and with participants who are known to each other, such as family members, neighbours or friends. According to Morgan (1988), meeting with others whom the participants think of as possessing similar characteristics is more appealing than meeting with those who are perceived to be different. This helps break down some of the formalities of focus groups and may help in capturing community voices and the views of people less likely to participate in formal focus groups. As with all community-based research initiatives, the dissemination of research outcomes was an important objective of this project. The research was initiated by the Rural Secretariat Regional Councils and input from their members was incorporated throughout the construction of the survey and during data analysis. Regional Council and community members were also active in distributing and delivering the surveys, hosting and participating in the kitchen table discussions, and reviewing and commenting on the project results and report. Representatives of the Western Regional Health Authority and the Department of Health and Community Services were kept informed and up to date on the project, and also provided advice on the research design and analysis.

### **Surveys**

Surveys were distributed in both paper and online formats. They were deliberately distributed to many rural and remote communities where individuals may have been less likely to complete a telephone survey. Survey data were collected in one of four ways: 1) conducted face to face; 2) distributed to individuals to complete and submit; 3) placed in public locations such as town offices, clinics and community halls; and 4) completed online. In addition to general demographic information, the survey included questions about participants' perceptions of the availability of primary healthcare, the importance of healthcare providers, the services they felt they did and did not have adequate access to, and barriers to accessing healthcare.

Completed paper surveys were sent to the Health Research Unit of the Faculty of Medicine, Memorial University of Newfoundland, for data entry and analysis.

### Kitchen Table Discussions

At the end of the survey, participants were asked if they would be willing to participate in a kitchen table discussion in their area. Ten kitchen table discussions were held in homes of participants or in the community. The discussions were audio recorded and notes were made from these recordings and then analysed. Analysis focused on four areas: (1) general experiences with health services; (2) experiences with specific health services and professionals; (3) access issues; and (4) solutions to resolve issues related to access. The number of participants in each discussion ranged from a minimum of three to a maximum of nine. There were male only, female only and mixed gender discussions. Age ranges varied and there was one youth-specific discussion as well as an Aboriginal-specific discussion.

### SURVEY RESULTS

Results are shown for the total group of participants, for participants from the Corner Brook–Rocky Harbour Region and for participants from the Stephenville–Port aux Basques Region. Not all participants responded to all questions; all results and corresponding percentages presented below were calculated based on the number of respondents who answered each question, not the overall number of respondents.

#### Participant Demographics

In total, 1048 surveys were collected. As Table 1 shows, there was a wide variation in demographic characteristics; however, the majority of participants from both regions were female, married and had a post-secondary education.

Table 1: Summary of participants' demographic characteristics: Corner Brook–Rocky Harbour region, Stephenville–Port aux Basques region and overall

<b>Variable</b>	<b>n (%)</b>		
<b>Regions</b>			
Corner Brook–Rocky Harbour	441 (42.1)		
Stephenville–Port aux Basques	607 (57.9)		
	<b>Corner Brook– Rocky Harbour</b>	<b>Stephenville– Port aux Basques</b>	<b>Overall</b>
<b>Age category</b>			
15–24 years	21 (5.7)	20 (4.1)	41 (4.8)
25–34 years	46 (12.4)	74 (15.2)	120 (14.0)
35–44 years	75 (20.3)	103 (21.1)	178 (20.7)
45–54 years	74 (20.0)	126 (25.8)	200 (23.3)
55–64 years	100 (27.0)	127 (26.0)	227 (26.5)
65–74 years	45 (12.2)	32 (6.6)	77 (9.0)
75–84 years	8 (2.2)	5 (1.0)	13 (1.5)
85+ years	1 (0.1)	1 (0.1)	2 (0.2)
<b>Gender</b>			
Male	94 (26.6)	153 (31.7)	247 (29.5)
Female	260 (73.4)	330 (68.3)	590 (70.5)

<b>Marital status</b>			
Single	57 (15.6)	64 (13.2)	121 (14.2)
Separated/Divorced	25 (6.8)	30 (6.2)	55 (6.5)
Married/Common Law	268 (73.2)	372 (76.5)	640 (75.1)
Widowed	16 (4.4)	20 (4.1)	36 (4.2)
<b>Highest level of education completed</b>			
Some school	40 (11.0)	44 (9.2)	84 (10.0)
High school certificate	50 (13.7)	96 (20.1)	146 (17.3)
Post-secondary	275 (75.3)	338 (70.7)	613 (72.7)
<b>Household income</b>			
<\$10 000	12 (4.5)	10 (2.8)	22 (3.6)
\$10 000–\$24 999	32 (12.6)	37 (10.3)	69 (11.3)
\$25 000–\$49 999	50 (19.8)	108 (30.1)	158 (25.8)
\$50 000–\$99 999	98 (38.7)	146 (40.7)	244 (39.9)
>\$100 000	61 (24.1)	58 (16.1)	119 (19.4)

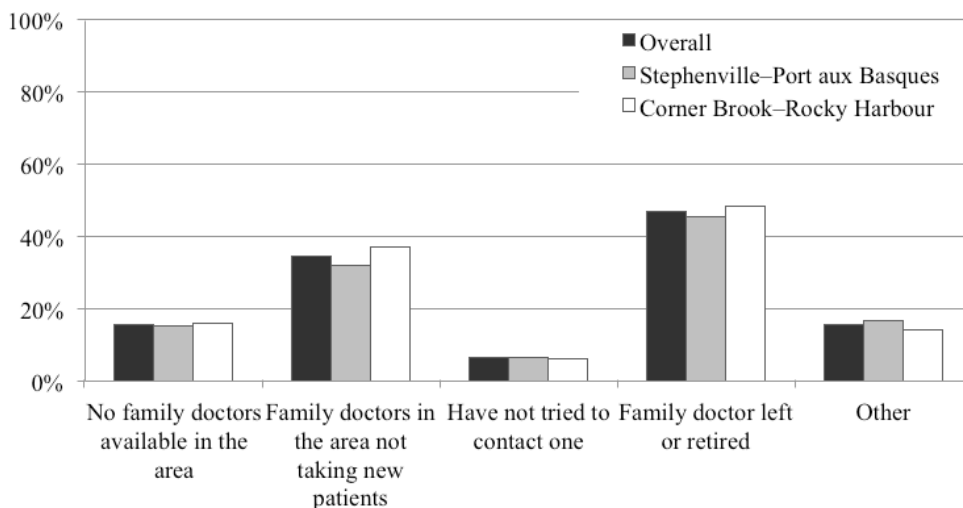
### Family Doctor Access

Table 2 summarises the results related to accessing a family physician: 14.2 per cent of individuals from the Corner Brook–Rocky Harbour region and 9.9 per cent of individuals from the Stephenville–Port aux Basques region were without a family physician. The main reason cited for not having a family doctor was that ‘the physician had left the area or retired’, which was the reason given by 47.1 per cent of respondents overall (see Figure 2). It is also of note that over 36 per cent of respondents from both regions had to travel outside their communities to see their family physician. Respondents from the Stephenville–Port aux Basques region were twice as likely as respondents from the Corner Brook–Rocky Harbour region to report that it took them over 90 minutes to travel to their family physician.

Table 2: Family doctor access: Corner Brook–Rocky Harbour region, Stephenville–Port aux Basques region and overall

<b>Variable</b>	<b>n (%)</b>	<b>n (%)</b>	<b>n (%)</b>
	<b>Corner Brook–Rocky Harbour</b>	<b>Stephenville–Port aux Basques</b>	<b>Overall</b>
<b>Have a regular family doctor?</b>			
Yes	374 (85.8)	538 (90.1)	912 (88.3)
No	62 (14.2)	59 (9.9)	121 (11.7)
<b>Family doctor located in your community?</b>			
Yes	228 (63.7)	330 (63.8)	558 (63.8)
No	130 (36.3)	187 (36.2)	317 (36.2)
<b>Time to your family doctor</b>			
30 minutes or less	284 (79.8)	412 (80.0)	696 (79.9)
31–60 minutes	46 (12.9)	60 (11.7)	106 (12.2)
61–90 minutes	16 (4.5)	15 (2.9)	31 (3.6)
More than 90 minutes	10 (2.8)	28 (5.4)	38 (4.4)
Range (minutes)	1–480	1–480	1–480
Mean (minutes)	26.2	28.1	27.3

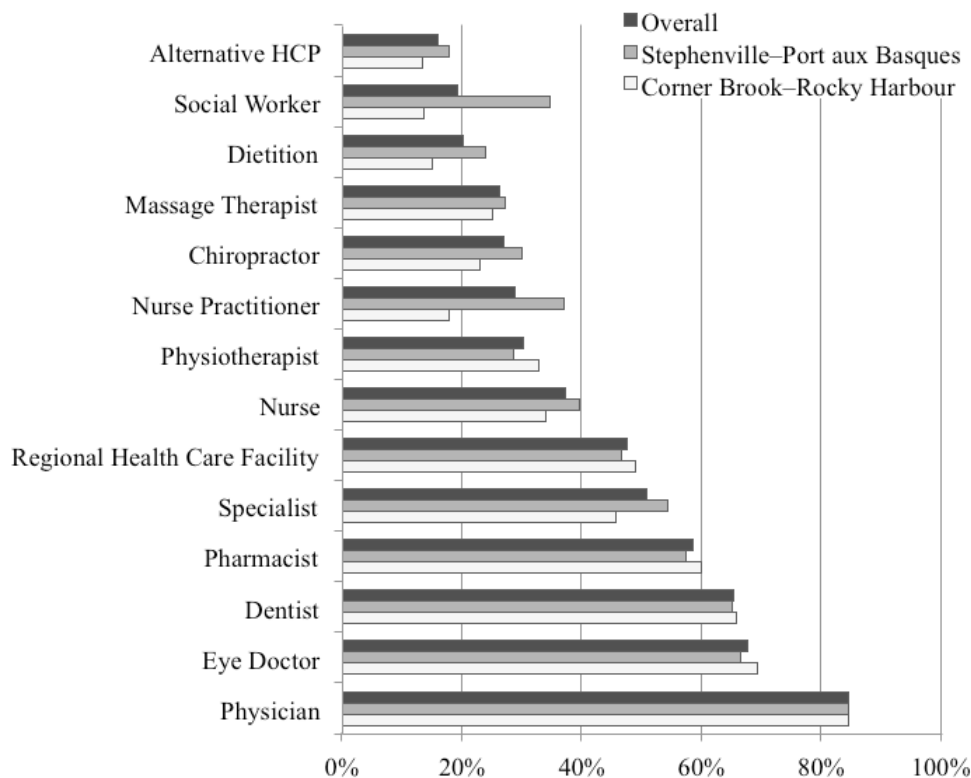
Figure 2: Main reasons provided by respondents when asked why they did not have a family doctor: overall, Corner Brook–Rocky Harbour region and Stephenville–Port aux Basques region



**Main Health Contacts**

Respondents were also asked to identify the health providers with whom they had contact. Results are shown in Figure 3. Of the healthcare providers identified, physicians were the most cited health contact. Among notable differences, respondents from the Stephenville–Port aux Basques region reported contact with social workers (34.7 per cent) and nurse practitioners (37.1 per cent) more frequently.

Figure 3: Health providers that respondents had contact with: overall, Corner Brook–Rocky Harbour and Stephenville–Port aux Basques

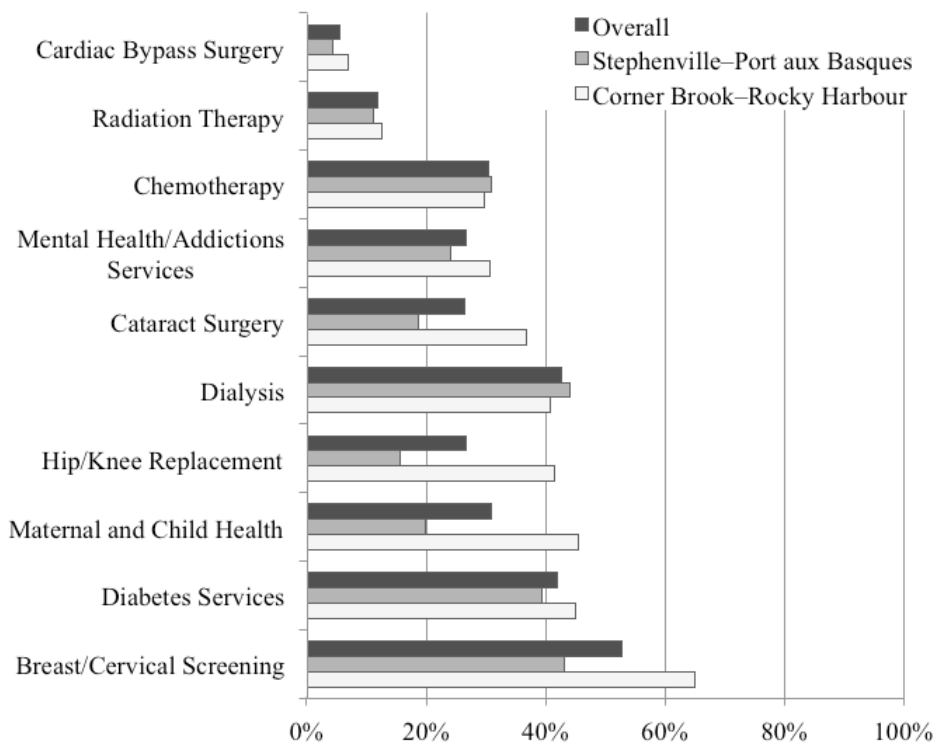


**Access and Barriers**

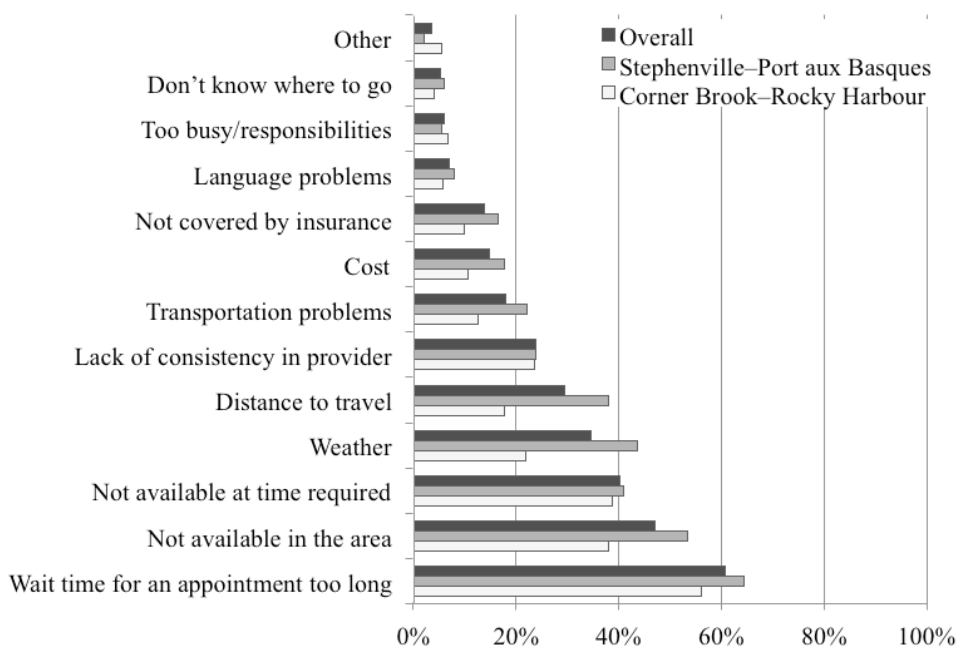
Figure 4 shows the percentages of participants who indicated they had adequate access to selected services. Both regions indicated they had poor access to radiation therapy and cardiac bypass surgery. Respondents from the Corner Brook–Rocky Harbour region reported much higher rates of access for breast/cervical screening and more access to hip/knee replacement and cataract surgery than respondents from the Stephenville–Port aux Basques region. Wait times for obtaining an appointment was the number one barrier cited by respondents from both health regions (see Figure

5). Respondents from the Stephenville–Port aux Basques region reported weather and distance as barriers to accessing services more frequently than respondents from the Corner Brook–Rocky Harbour region.

**Figure 4: Adequate access to selected services: overall, Corner Brook–Rocky Harbour and Stephenville–Port aux Basques**



**Figure 5: Barriers to accessing health services identified by participants: overall, Corner Brook–Rocky Harbour and Stephenville–Port aux Basques**



A final open-ended question on the paper and online survey asked participants for any additional comments about access to health services in their community. A total of 375 participants provided additional commentary. When these comments were thematically coded, seven themes were identified: (1) Physician shortages; (2) Difficulty accessing specialist services; (3) Difficulty accessing emergency services; (4) Consistency of care issues; (5) Difficulty with travel and the cost of travel; (6) Wait times; and (7) Potential for nurse practitioners.



### **Physician Shortages**

Participants frequently noted that either they were unable to find a family physician taking new patients or the wait time to see their family physician was too long, resulting in the use of emergency services for non-emergency situations:

*... people are not able to receive routine preventative care or regular care for any condition due to no available GPs in the Corner Brook area. People are forced to go to busy ER Departments for minor conditions due to having no doctor.*

### **Difficulty Accessing Specialist Services**

Several respondents thought more specialist services such as cardiology, diabetes and obstetrics should be available in their community:

*I cannot imagine the stress on expectant mothers who are living so far from a birthing unit. I am able to cover the cost of trips to Corner Brook, but there are many who find it a financial hardship to travel there or St John's for treatments. Frequently people are requested to be in Corner Brook so early in the morning they have to take a hotel there overnight in order to be on time. Couldn't people who have a distance to travel be given appointments later in the day?*

Many participants felt that mental health services in their area were inadequate and that this could have negative consequences for individuals' health:

*... Mental Health support is VERY hard to find. There are only a few specialists within the Corner Brook and Newfoundland areas. All colleges, universities and schools should have nurses/doctors on staff. People should be taught how to contact help such as Community help lines, EMS [emergency medical services], etc ...*

### **Difficulty Accessing Emergency Services**

A number of respondents reported that they had difficulty accessing emergency services due to long wait times once in the emergency room or a lack of facilities within the community:

*On the weekend there are no doctors available in Deer Lake. In case of any emergency or injury you have to travel to Corner Brook and if it's not a serious emergency you have to wait hours and hours.*

### **Consistency of Care**

A desire for more consistent care, in particular for a long-term, regular physician, was a common theme among participants:

*My family was without a family doctor for about 6 months last year before a new doctor took up the practice that had been vacated by our (much-loved) family doctor, originally from Western Newfoundland, who re-located to Conception Bay South. My concern now is that our current doctor may not stay in the area.*

### Difficulty with Travel and the Cost of Travel

Several respondents commented that having to travel to access specialist services could be challenging for a variety of reasons, including distance to travel, poor weather conditions, needing time off work to accommodate travel requirements and, most significantly, the financial costs associated with travelling:

*We are lucky to be near a decent medical facility and we are quite happy with the care we receive (for medical, dental and physio care). However, one family member has ongoing health issues that must be monitored and occasionally treated. We could have gone to St John's, but we had no place to stay there. Very expensive if you have to travel and have a recovery period before one can travel home.*

### Wait Times

Respondents expressed frustration with the length of wait times in three key areas: (1) for emergency services; (2) for doctors' appointments; and (3) to see specialists:

*When you have young children (like me) having a family doctor is important; however, rapid access is even more important since most problems with children arise quickly. Due to the large patient loads at the doctor's office it is virtually impossible to be 'fitted-in' when an urgent matter arises.*

*I find it hard to get a doctor's appointment without waiting 3-4 weeks.*

### Potential for Nurse Practitioners

Some respondents indicated a nurse practitioner was available in their area, that they had seen the nurse practitioner, and that their experience had been positive:

*As a health practitioner in the area I am acutely aware of healthcare needs of the population, especially the physical health needs. The lack of access to a family physician is a big barrier, but when nurse practitioner services have been available here, patient satisfaction with the service has been VERY high ...*

Other respondents indicated that a nurse practitioner was not available in the area and expanded on the use of nurse practitioners as a potential solution to non-emergency use of emergency rooms:

*What I do not understand is why a nurse practitioner cannot be made available to everyone who does not have a family physician. It is ridiculous and scandalous that people without a family physician are obliged to sit in the emergency room for hours waiting to see a doctor to have a simple prescription filled ...*

Respondents who commented on the role of nurse practitioners suggested that the government ought to provide better pay and/or create incentives to draw nurse practitioners into practice in rural/remote areas.

**OBSERVATIONS FROM KITCHEN TABLE DISCUSSIONS**

The following general observations represent a compilation and summary of the kitchen table discussions.

**Experiences Accessing Health Services**

Experiences accessing health services varied by community and included long wait times for tests and for emergency services, and limited access to physicians and nurse practitioners. Participants frequently noted frustrations, while Aboriginal participants noted a lack of cultural understanding on the part of health practitioners when accessing healthcare.

**Health Services and Professionals**

Experiences with specific health service professionals, both positive and negative, varied by community. Some reported limited access to health services such as physiotherapists, ophthalmologists and dentists, and a lack of empathy from health professionals was also noted as a concern. Participants cited good experiences with the provincial Health Line services and with nurse practitioners.

**Access Issues**

Services to which participants felt their community should have better access included blood pressure checks, patient navigators, friendship centres, dentists and nurses, community health and wellness programs, mental health and addictions services, rheumatology services, diabetic services, x-ray and radiation services, pharmacy and prescription services, and general practitioners. Doctors leaving smaller communities for bigger centres, difficulty filling prescriptions after hours and inferior mental health and addictions services were issues common to several communities. Participants reported that wait times, travel and travel costs could make accessing health services difficult. Additionally, communication barriers and lack of compassion from medical professionals were cited as other access issues.

**Solutions to Improving Access**

General solutions identified by participants included bringing in the needed professionals to administer basic health services, improving access to midwifery practitioners, and providing financial support for costs associated with travel. Other suggestions included more and wider access to teleconferencing, community wellness programs and specific wellness programs for Aboriginal communities, patient navigators, increased hours and on-call availability of physicians, more home care and care for seniors, an increased number of nurse practitioners and better or more efficient use of nurses. A number of participants attributed long-term value to a preventative approach to healthcare and suggested that they would like to see a 'wellness' approach to health – i.e. an approach which focuses on maintaining mental and physical health rather than just treating illness.

## DISCUSSION

Findings of the current research are consistent with literature on access to healthcare in rural areas. Data from the Society of Rural Physicians of Canada (2013) indicate that, while 20 per cent of Canadians live in rural areas, only 10 per cent of physicians work in rural areas and only 3 per cent of specialists practise in rural areas. In the present study, 11.7 per cent of survey respondents reported they did not have a family physician and 36 per cent indicated they had to travel outside their community to access their family doctor. Many participants expressed frustration with a lack of access to basic primary care and specialist services in their communities.

In the survey results, 'long wait times' (60.8 per cent) and '[services] not available in the area' (47.1 per cent) were the two most frequently checked barriers to accessing health services. Long wait times also emerged as an important barrier to access in kitchen table commentary. Wait times and reduced service availability have been identified elsewhere as important barriers to accessing health services (Canadian Institute for Health Information 2012 report; Sanmartin and Ross' 2006 analysis of the Health Services Access survey). In Sanmartin and Ross' research, which was not specifically focused on rural and remote Canadians, 'personal' reasons, such as difficulty with transportation or cost, were identified as barriers to health services by fewer than 5 per cent of respondents. Our research, conversely, focused exclusively on a rural and remote Newfoundland population, where transportation problems and financial concerns were cited as barriers to access by 18 per cent and 15 per cent of respondents respectively. Other transportation and financial barriers reported included no medical insurance coverage, distance to travel, services not available in the area, and weather.

A variety of definitions of 'rural' and 'remote' exist in Canadian and international literature (du Plessis et al. 2001). Statistics Canada most notably defines communities of under 10 000 as part of rural and small town (RST) Canada (du Plessis et al. 2001). While this definition has been used frequently in health services research, recognition that 'rural' is a continuum has also become increasingly common, and contemporary Canadian health services research frequently classifies communities of under 25 000 people as 'rural' as well (see, for example, Harbir et al. 2012 and Szafran et al. 2013).

Another interesting finding of this research was the regional variability regarding access to different health services. Participants from both regions frequently noted they did not have adequate access to cardiac bypass surgery and radiation therapy (likely due to the distance from regional and provincial tertiary care services); however, regional analysis showed that respondents from the Stephenville–Port aux Basques Region reported particularly poor access to maternal and child health services in

comparison with the Corner Brook–Rocky Harbour Region. Other services such as hip/knee replacements and cataract surgery also showed wide variability across the regions.

Aboriginal participants indicated that their experiences with healthcare services sometimes reflected a lack of cultural understanding on the part of health professionals and indicated a desire for wellness programs specific to their needs and concerns. In other research from Canada and abroad, Aboriginal individuals have listed fear of racism, discomfort in healthcare settings (Wardman, Clement & Quantz 2005), cultural inappropriateness of services (Gruen, Weeramanthri & Bailie 2002) and collective memories of colonialism (Sahid, Finn & Thompson 2009) as barriers to accessing health services.

Our research focused specifically on the Corner Brook–Rocky Harbour and Stephenville–Port aux Basques Rural Secretariat Regions of Newfoundland and Labrador and is not intended to be a generalisation to other Canadian and international locations. The purpose was not to generalise findings but rather to describe and document views and opinions in this specific context. However, many of our results – including participants' noted frustration with wait times, reported difficulty accessing many specialist services, and difficulties associated with travel and cost of travel – are consistent with previous research on barriers to accessing health services in rural and remote areas (BC Ministry of Health 2007; Boydell et al. 2006; Wardman, Clement & Quartz 2005).

The innovative kitchen table methodology was used with the intent of reaching community members who may not otherwise have participated in the research. While there is no way to know whether this method was more or less successful than traditional focus groups, we believe the informality may have encouraged some participants. The host of the kitchen table discussion would often ask neighbours, friends or relatives to take part. These individuals would likely not have heard about the research if it was not for word of mouth or they may not have taken part if they hadn't known someone in the group. The data we gathered may have been gathered through traditional means but we chose to implement this innovative methodology in an attempt to enhance the involvement of community members. Because kitchen table discussions are usually held at a community member's home, the setting makes the meeting informal and participants tend to respond in this more relaxed environment. Because they are relaxed, participants are generally more willing to discuss issues and dialogue is maximised. Also, the group size is small, which increases the likelihood that all members will have a chance to be heard.

## **RECOMMENDATIONS**

Researchers from Canada, Australia and the United States have highlighted a number of initiatives and/or recommendations to improve access to health services for individuals living in rural and remote areas, as discussed below. The current study suggests the

exploration of (1) recruiting more rural and remote physicians; (2) investigating a nurse practitioner model of care; (3) assisting individuals with travel costs and developing specialist outreach services; (4) increasing the use of telehealth services; and (5) undertaking additional rural and remote health services research.

Research has shown that both having a rural background and rural curricular components while in training can influence medical students to eventually take up rural practice (Jones, Humphreys & McGrail 2012; Orzanco et al. 2011). Many medical schools in Canada – including Memorial University’s medical school – have taken steps to attract more rural students and provide extended rural educational opportunities. Available data suggests that Memorial currently ranks among the top universities in Canada with regard to recruitment of rural students and the production of rural physicians (SRPC 2013). Yet, while Newfoundland and Labrador’s medical school produces physicians who practise in rural areas, results from the present research suggest that additional steps may need to be taken to enhance recruitment and retention of medical graduates. Potential strategies to enhance recruitment and retention of medical graduates may constitute an area for continued discussion and research among government, university and community stakeholders.

In a study designed to examine barriers and solutions to enhance access to health services in Meander Valley, Northern Tasmania, Le et al. (2012) recommended attracting services to the area and recruiting and retaining more general practitioners. The authors also suggested the deployment of a nurse practitioner model as a potential solution to health services shortages. That this suggestion emerged from the context of interviews with individuals in a rural area of Australia and also from the present research suggests that rural individuals in Canada and other countries view nurse practitioners as an important option to improve rural health services. Enhancing recruitment of nurse practitioners to rural areas is another option that should be explored further.

In national and international research, difficulties with travel emerge as a key barrier to accessing health services for individuals living in rural and remote areas. Assistance with the cost of travel is an important potential solution to this issue. Specialist outreach services may also offer a solution to overcome the difficulty of accessing specialist services. In an evaluation of a specialist outreach service established in Northern Australia, Gruen, Weeramanthri and Bailie (2002) noted that the benefits of specialist outreach included increased numbers of patients seen, less disruption to families and work, reduced cost of transport, improved doctor–patient communication and improved cultural appreciation. Requirements for sustainable outreach included ensuring the program is adequately resourced and staffed; grounding the program in a multidisciplinary framework centred in primary care and not dependent only on specialists;

integrating the program with local primary care services, prior planning of visits and regular evaluation (Gruen, Weeramanthri & Bailie 2002).

In a federal government review of rural health access issues, Laurent (2002) cited increased use of telehealth services as a possible strategy for increasing rural access to health services. Telehealth can provide quicker access to specialist services (Laurent 2002) and can also reduce travel time and cost – an especially significant benefit given the large number of respondents in the present research who cited travel costs as a barrier to accessing health services. In a recent report focused on wait times in Canada, the Canadian Institute for Health Information (CIHI) listed telehealth as an important strategy for reducing waits in primary care, noting that '[v]ideoconferencing that eliminates the need for travel has been shown to reduce wait times for specialist consultations anywhere from 20–90% ... Telehealth activity across Canada has resulted in an estimated annual system cost avoidance of \$55 million and personal travel cost savings of \$70 million' (CIHI 2012, p. 20). In the present research, increased telehealth services emerged as a potential solution in some kitchen table discussions. While participants did not feel telehealth could be a complete replacement for face-to-face appointments, increased use of telehealth services could be both a cost-saving and service-enhancing solution, particularly for communities where travel and/or wait times were the primary barriers to accessing care.

While the above recommendations may constitute potential intermediate and long-term solutions to rural health services access issues, more research is clearly needed (Laurent 2002; Leipert & George 2008). Results from the present study suggest that an effective rural health research agenda should explore the unique needs of particular vulnerable (i.e. at an increased relative risk of an adverse health outcome – Flaskerud & Winslow 1999) groups (for example, the isolated elderly, the mentally ill, women and Aboriginal individuals) as well as the unique challenges of particular communities. Indeed, in this respect, it is noteworthy that regional analysis identified differences between communities with regard to access issues. In their evaluation of a specialist outreach service, Gruen, Weeramanthri and Bailie (2002) suggested that specialist outreach ought to be responsive to the unique needs of specific communities. Wakerman and Humphries (2011) have also argued that effective health service reforms should be 'contextualized' to suit the needs of communities and that such reforms should draw on community strengths. Additional research focused on the strengths, needs and unique challenges of particular communities and groups in Western Newfoundland may contribute essential insight into the most effective strategies and solutions to address health services access issues in this region.

## CONCLUSION

Many individuals and communities in Canada are denied equal access to health services for reasons that can be rooted in gender, geography, economics and lack of cultural competency, amongst others. This research, which has focused on Western Newfoundland, has revealed a number of health services access issues for individuals living in rural and remote communities. These issues include not only wait times and difficulty finding or obtaining an appointment with a family doctor, but also difficulty finding or affording transportation to larger centres to access primary or certain specialist services. Access issues can be particularly acute for women who have to travel long distances to access maternity care. Access issues can also be exacerbated for Aboriginal people who face additional barriers related to racism and lack of cultural understanding on the part of health professionals. Anticipated next steps with this project include the wide dissemination of findings in a variety of media throughout the regions, along with the creation of opportunities for deliberative dialogue and commentary on solutions to address challenges related to accessing health services.

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