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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.

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Introduction

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). Investigation into 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). The health system clearly strives for consumers to be more independent, engage in self management and to be compliant (CHFA et al. 1997) in order that their needs are meet and that they can independently address their concerns.

Within health, considerable attention has focused on consumers' lifestyles and behaviours, particularly how to encourage consumers to engage in healthy behaviours so that the population is healthier and the burden of disease lower. However, Marmot and Wilkinson (2006) argued that it is the social context that is important to understanding what causes health outcomes and health behaviours; it is the 'social determinants of health' that are crucial to understanding and improving health (Marmot 2006). Marmot and Wilkinson's (2006) 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. The interaction of some or many of these determinants makes one vulnerable to the impacts of the social determinants resulting in poorer health and quality of life as well as shorter life expectancy (Marmot and Wilkinson 2006).

While these factors have impacts for rural consumers, rurality itself has not been categorised as a social determinant of health. This questions whether or not rural health outcomes are poorer due to rurality itself or other social determinants, 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. For example, it is known that rural Australians have lower incomes (Bourke and Lockard 2000), have less access to public transport and require private transport (Wilkinson and Blue 2002), that some rural residents experience social isolation and marginalisation (Bourke 2003), and that two-thirds of the Indigenous population live in rural Australia (Thompson 2003). However, these incidences vary across rural and remote Australia and so it could be debated whether or not poorer health among rural residents exists because of rurality or the prevalence of the social determinants in rural areas. If context alone impacted health, it would be expected that rural consumers have particular health needs and issues, separate from their urban counterparts.

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). Such claims suggest that rural consumers experience access issues as more problematic than urban consumers. These statements are easily made with examples of travel, cost and workforce shortages cited as sources of disadvantage (see Wilkinson and Blue 2002). However, while the discipline of rural health makes repeated reference to the needs of rural health consumers, very little research has sought the perspectives of rural consumers and compared them with their urban counterparts. It is almost assumed that access issues in rural health are distinctly more problematic than in urban health with little analysis to ascertain this. This premise is questioned in this paper by comparing the perspectives of consumers residing in metropolitan and non-metropolitan Victoria, defined as Melbourne and surrounds including Geelong or the remainder of the state, respectively. In particular, the comparison focuses on the extent to which consumers perceive access to health services of all types as problematic, and the impact of rurality on consumer perspectives surrounding access to health care.

Access as a Problem for Rural Health Consumers

Previous research has found that rural residents have poorer health status than their metropolitan counterparts (AIHW 2002; Humphreys et al. 2003; Humphreys 1999; Wakerman and Humphreys 2002). Death rates, rates of injury mortality and rates of mental illness are higher in rural and remote areas, as are rates of mortality resulting from diabetes, asthma, respiratory disease and coronary heart disease (AIHW 2002; Dixon and Welch 2000; Humphreys 1999; Simmons and Hsu-Hage 2002). Further, rates of smoking and alcohol consumption, obesity, homicide and suicide are also higher in rural areas (AIHW 2002; Humphreys 2000). Poor health status among rural residents has been associated with 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 to a workforce shortage resulting in fewer medical, nursing and allied health providers per population than in urban areas (AIHW 2002; Humphreys et al. 1997, 2002; Larson 2002).

Despite fewer health professionals, health services are one of the most strongly valued services in rural communities (Collins 2001; Humphreys and Weinand 1991). The closing of hospitals and decline in health services concern local consumers because they are indicators of community decline (Collins 2001). Similarly, consumers are concerned about rationalisation of services and lack of resources (Bourke 2001; Collins 2001). Cost is another issue, including the cost of health care and the cost of accessing health services (Bourke 2001; Humphreys et al. 1997). Of all the issues raised for rural consumers, access to services is the most commonly cited problem in rural health, inclusive of the service's availability, accessibility, affordability, acceptability and accommodation (Penchansky and Thomas 1981). This includes distance to services, hours of operation, cost, access to information as well as waiting lists, waiting times and the lack of choice of services (Bourke 2001; Humphreys et al. 1997, 2003). The emphasis in many of the discussions of rural health has focused on travel and distance.

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 and more isolated areas, such as the Northern Territory and much of Queensland, Western Australia and South Australia, the ways in which the rural context disadvantages health consumers in states like Victoria is less certain. In addition, access to health care has been socially constructed as the most common problem in rural health (see Best, 1993). Furthermore, generalised claims about 'rural consumers' categorise rural health consumers as a homogenous group who are all disadvantaged in terms of access to care and implies that rurality is another social determinant of health (Marmot and Wilkinson 2006). Together and separately the construction of rural health discourses and the homogenisation of rural consumer experiences reinforce claims about access to health care being problematic for all rural consumers. Therefore, it must be questioned 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. This paper sought out the perspectives of non-metropolitan Victorians, allowing for differences in levels of rurality, and compared them to the perspectives of metropolitan residents to analyse how these consumers understand their own access to health care.

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. Questions included were based on key issues in the literature, especially around access to health care, as well as the requirements of the funding body (see Bourke and Munir, 2004). The questionnaire was eight pages in length, consisting of 43 questions and presented in a booklet format. It was estimated that it took 15-20 minutes to complete.

Victorian postcodes were categorised into metropolitan (the area surrounding Melbourne ranging from Frankston to Sunbury and to Geelong (inclusive)) and non-metropolitan (the remainder of the state). In total, 1200 residents from the Melbourne metropolitan postcodes and 1200 residents from the 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 self completion questionnaire along with a letter explaining the study and a reply-paid, self addressed envelope. 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. About a week later, all 2400 residents were mailed a postcard reminder and 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 analysed with the assistance of the Statistical Package for the Social Sciences (SPSS).

A range of questions are the basis of this analysis. As used in a variety of rural community studies, the questionnaire initially presented 10 key issues and asked respondents how concerned they were about each issue in their local area on a three point scale. The goal was to compare the importance of health issues relative to other issues at the outset. Respondents were also asked an open-ended question, what was the most difficult problem they had experienced as a health consumer. This was to identify problems in the words of respondents. A range of answers was provided and coded into 18 main categories to reflect the comments. Each category with more than 10 responses became a dichotomous variable, representing those who identified the problem and those who did not.

Respondents were also asked to rate their overall health on a five point scale ranging from poor to excellent (as used in the SF36 (Ware 2006)) and to rate their happiness in the past month on a five point scale from unhappy to happy. A few questions asked distances to health services, including how far respondents travelled to their family doctor and how far they travelled to their nearest hospital (in km). Respondents were also asked how many times they had visited a GP in the past 12 months for their own needs and another question asked about visits in the past year for other members of the household. In addition, respondents were asked how many GPs they see on a regular basis. They were also asked if at any time during the past 12 months they had visited an Emergency Department instead of their GP. Another question asked the purpose of most visits to a GP, ranging from a short-term illness or check-ups to stress or management of a long-term condition. Respondents were asked how satisfied they were with their last visit to their GP on a five point scale ranging from very dissatisfied to very satisfied.

In this paper, frequencies as percentages are presented for each of the above items and compared between the two samples, those from metropolitan Melbourne and those from non-metropolitan areas of the state. For all items (except the most serious local issue) t-tests were employed to test for statistical differences ($p<.05$) between the two samples. A t-test was used to identify if any differences between the mean (or average) for the non-metropolitan sample and the mean of the metropolitan sample were occurring randomly or if they represented a significant difference between the two samples (Agresti and Finlay 1986). T-tests were also employed to test for demographic differences within each sample, including differences between men and women, those with and without partners, parents and non-parents, those with and without health insurance and those for whom English was and was not their first language. Further, Pearson's r was used to test for a correlation or relationship between each of the health questions and age (in years) and education level (seven categories ranging from less than primary school to university degree). While these t-tests and Pearson's correlations were conducted for all health questions for the two samples, they are only reported where statistically significant differences or relationships were found ($p<0.05$).

In addition, it is recognised that both metropolitan and non-metropolitan are diverse and heterogeneous categories. In relation to access to health services, metropolitan areas have similarities. However, it is recognised that non-metropolitan Victoria differs greatly in access to health services. For this reason, an index of rurality was created for non-metropolitan areas of Victoria. The index, based on post-code areas, considered population size and the distance to the nearest centres with populations of at least 20,000 and 10,000 as well as the distance to Melbourne where the major specialist hospitals and centres are located. The rurality index (RI) created was: RI = square root [(20,000/(distance) + 10,000/(distance)) X population] + 0.5(3.5 million/distance to Melbourne)). Pearson's r was again used to test for a relationship between each of the health questions and the RI or level of rurality for the non-metropolitan sample. Again, this is only reported where a statistically significant relationships was found ($p<0.05$).

Findings

The Sample

Of the 1219 respondents, 710 were from non-metropolitan Victoria and 509 were from the Melbourne metropolitan area. Just over half were women (53%) and the median age was 50. In all, 70% were married or living with their partner, 83% were parents (of which just under half had children living with them) and for 93%, English was their preferred language. While 29% had not completed secondary school, 18% had completed secondary school or equivalent and 53% had educational qualifications beyond high school equivalency (19% had a university degree). Fifty-six per cent had private health insurance compared to 45% for all Australians (ABS, 2001). Compared to the Victoria's population, respondents were more likely women (51% of Victorians), married (52% of Victorians over 15) with Year 12 completion (44% of Victorians). Respondents were also older (median age of Victorians was 35) (ABS, 2001), which reflects that only adults were asked to participate.

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 (see Table 1). There were no statistically significant differences between residents of Melbourne and residents of other areas of Victoria. Younger residents, those with higher levels of education, those with private health insurance, those for whom English was their first language and those with partners rated themselves as healthier and happier in both samples. While women from both samples rated themselves as healthier, men from non-metropolitan areas rated themselves as happier than non-metropolitan women.

Most respondents visited their GP for a short-term illness (48% from non-metropolitan and 50% from metropolitan), checkups (36% from non-metropolitan and 32% from metropolitan) or to manage a chronic condition (15% from non-metropolitan and 16% from metropolitan) while few visited for stress or anxiety (2% from non-metropolitan and 3% from metropolitan). When re-coded into dichotomous variables, responses were not significantly different between the two samples. When asked how satisfied respondents were with their last visit to the GP, 8% of respondents from non-metropolitan Victoria and 9% of respondents from metropolitan Melbourne were dissatisfied. Most were satisfied with their recent visit to a GP, 85% and 82%, respectively. These differences were not statistically significant.

Table 1:
Self reported health status and happiness for metropolitan and non-metropolitan residents

Health/happiness level	Non-metro Victoria %	Metropolitan Melbourne %
Self reported health status	(mean=2.60)	(mean=2.56)
Excellent	14	16
Very good	36	33
Good	31	33
Fair	15	15
Poor	4	3
Self reported happiness	(mean=2.03)	(mean=1.98)
Happy	39	40
Somewhat happy	29	29
Mixed	25	25
Somewhat unhappy	4	4
Unhappy	3	2

* indicates a statistically significant difference in the means identified by a t-test, $p < .05$

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 2). 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. However, geographic location impacted perceptions of other issues. For example, 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. Other differences were also found. Consumers with lower educational levels were significantly more concerned about access to health services and younger respondents and those without private health insurance were more concerned about low incomes in both samples. Among respondents from non-metropolitan Victoria, those with lower levels of education were more concerned about the availability of public transport while those with partners were less concerned about economic growth and more concerned about access to health services. Residents of metropolitan Melbourne without private health insurance were more concerned about unemployment.

Table 2:
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
b mean based on a 3-point scale
* indicates a statistically significant difference in the means identified by a t-test, $p < .05$

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 3 overleaf). 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 rurality of residence. 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.

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 areas traveled an average of 4.5km (median=2km) to their family doctor and 7.3km (median=4.5km) to the nearest hospital. Those living in non-metropolitan Victoria traveled further, on average 8.6km (median=3.1km) to their family doctor and 11.9km (median=5.8km) to the nearest hospital. These differences were statistically significant between the two samples. 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.

Table 3:
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
* indicates a statistically significant difference in the means identified by a t-test, $p < .05$

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. These differences were not statistically significant between the two samples. Older residents in both samples were significantly more likely to see their GP more often while metropolitan residents with lower levels of education, for whom English was not their first language or without health insurance were significantly more likely to visit their GP more often.

When asked how many GPs do you 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. This difference between number of GPs seen per consumer was not statistically significant between the metropolitan and non-metropolitan samples. However, women from non-metropolitan Victoria and metropolitan residents for whom English was not their first language were significantly more likely to have more GPs. 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). This suggests that poorer health status among rural consumers was not identified but this study used a self-reporting measure.

Some differences between Victorians were identified but not necessarily due to rural or urban contexts. Victorians who were younger, more educated, with private health insurance, with partners and for whom English is their first language rated their health better, which is consistent with findings in public health that healthier people have higher incomes, education levels, partners and are socially included (George and Davis 1998; Marmot and Wilkinson 2006). This implies that health status is more related to socioeconomic status and the social determinants of health than geographic location, and that rurality alone does not result in poorer health. Therefore, improving health is about improving the lives of disadvantaged and marginalised consumers regardless of their rural or urban context.

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). It was older residents who were found to visit their GP more frequently as well as respondents from metropolitan Melbourne who had lower levels of education, no health insurance and for whom English was not their first language. As these consumers are more likely to have poorer health (George and Davis 1998; Marmot and Wilkinson, 2006), it is not surprising that they visit a GP more often. However, that their rural counterparts with lower levels of education, no health insurance and for whom English was not their first language do not visit a GP more frequently than healthier rural consumers is concerning. Therefore, access issues in rural areas, specifically acceptability of services (see Penchansky and Thomas 1981), may deter lower socioeconomic groups from using health services. It may be that rural health, like urban health, needs to target disadvantaged and marginalised consumers to address its access problems.

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. This suggests that a rural or urban context shapes how residents view local issues. 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. That those with lower education levels and non-metropolitan residents with partners were more concerned about access again highlights that access impacts some rural residents more than others, and the social determinants of health provide a useful understanding in rural as well as urban health.

While quality of care was a general concern for all health consumers, when asked about specific problems accessing health services was most commonly identified by both metropolitan and non-metropolitan Victorians. When identifying specific problems, both metropolitan and non-metropolitan Victorians were most likely to identify 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. While much has been publicised about the access problems for rural consumers, their access concerns found here 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. Neither metropolitan nor non-metropolitan consumers were very concerned about cost (see also Humphreys et al. 1997). 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, suggesting that 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. The emphasis on the tyranny of distance in rural health may reflect the information received and the construction of problems within rural health rather than the lived experiences of rural consumers. The key access issue facing both rural and urban consumers was waiting lists and times.

This study is limited in that it only compares metropolitan and non-metropolitan residents, the latter of which is a poor measure of rural. While an index of rurality was tested for the non-metropolitan residents, this was a continuum and there were fewer responses from the more remote areas of Victoria than from regional or rural centres. Further, the use of a questionnaire can mask many of the complexities of consumer health issues. In addition, the sample was too small to be representative of the state's population and it was also more educated, more female and more likely to be married than Victoria's population.

Despite these limitations, 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. While similarities may reflect similar experiences and an overstated rural health problem, it may also be the result of consumers being informed by urban-centric media, health systems and political discussions. Further, differences in education, age, income and other social determinants were also established. This implies that some of the health problems in rural areas may be attributable to social determinants rather than rurality, and some may reflect the information rural consumers are receiving about rural health. 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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