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Satisfaction with access to healthcare: qualitative study of rural patients and practitioners

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Aim: To gain insight into factors affecting patient and practitioner satisfaction with access to healthcare in a remote rural island community. **Background:** General practice based primary care is the focus of health service delivery in rural areas of the UK. Individuals from rural populations have reported inequalities in access to healthcare. User satisfaction with service performance is recognised as an important outcome of healthcare. Further investigation into factors underpinning patient and practitioner satisfaction with access to rural healthcare is required. **Design of Study:** Qualitative interviews with patients and primary healthcare practitioners. **Setting:** Isles of Scilly, Cornwall, UK. **Methods:** A topic guide was developed following review of the literature. In-depth, semi-structured interviews with a purposive sample of 23 participants were conducted with individuals from all inhabited islands. Detailed field notes were kept, and interview content was partially transcribed and analysed thematically. **Findings:** Principal themes identified were common to patient and practitioner participants. These were: concerns expressed regarding the equitable provision of services; obstacles to using health services; and the outlook of patients and professionals, including expectations, choice, patient–practitioner relationships and community cohesiveness. Emerging themes gave insight into a range of factors affecting satisfaction with access to healthcare. **Conclusion:** Despite numerous policy initiatives aimed at reducing inequities in health service provision, problems with access and uptake of health services persist amongst individuals from remote rural populations. If implemented, recent National Health Service proposals may address some of the challenges identified by participants. Service developments need to take account of local priorities, expectations, geography and demography to achieve favourable outcomes.

Key words: access; primary care; qualitative research; rural health; satisfaction; service delivery and organisation

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How this fits in

Despite increasing National Health Service (NHS) resources, remote rural communities in the UK experience disadvantage with availability of health services. Patient and practitioner satisfaction is considered an important outcome of healthcare provision. This study is the first to use qualitative methods to investigate factors affecting satisfaction with healthcare access in a remote UK island community, from both a patient and practitioner viewpoint. At a time when the NHS proposes to improve local healthcare accessibility, this study helps inform new developments regarding meeting the healthcare needs of individuals from remote rural areas.

Introduction

General practice based primary care is the focus for health service delivery in rural UK (Deauville, 2001). The Department of Health (2000; 2001) highlighted access to primary healthcare as a priority and emphasised the need for equitable delivery. Similar services must be available to those with comparable healthcare needs (Goddard and Smith, 2001). Remote rural practices exist in areas of low population density with poor transport links to district general hospitals. Inherent geographic, social and cultural characteristics potentially act as exacerbating factors for inequality (Gillies, 1998; Jeffries, 2004). The Institute of Rural Health has developed a toolkit (Swindlehurst, 2005) aiming to ensure that healthcare services are 'rurally sensitive' and that inequalities with regard to access are addressed. The National Health Service (NHS) Improvement Plan (Department of Health, 2004) aimed to ensure patient choice and equity of access to NHS services. However, despite increased resources, Mungall (2005) suggested that rural populations might not have access to the range of services available to those from central urban areas.

Satisfaction with service provision is recognised as an important outcome of healthcare which influences health-related behaviour (Strasser *et al*., 1993). Sans-Corrales *et al*. (2006) recently noted the association of satisfaction with accessibility of primary healthcare services. Both perceptions and expectations are referred to when expressing satisfaction (Wensing *et al*., 1998; Campbell *et al*., 2001). Perceptions of accessibility are influenced by socio-demographic and cultural characteristics of service users as well as the structural and geographical characteristics of local health services, all potentially affected by rurality (Campbell *et al*., 2001; Deauville, 2001). Although international studies have explored satisfaction with rural services (Lucas and Rosenthal, 1992; Horner *et al*., 1994; Slifkin, 2002; Reschovsky and Staiti, 2005; Kroneman *et al*., 2006; Luman *et al*., 2007; Sounness *et al*., 2008), little research has considered factors determining patients' and practitioners' satisfaction with access to rural healthcare in the UK. A Welsh Assembly Government (2005) review, documenting service models to improve primary healthcare accessibility in the UK, suggested that further investigation was warranted to explore factors underpinning patient and practitioner satisfaction. We aimed to address this important agenda using qualitative techniques.

Methods

This study took place on the Isles of Scilly, Cornwall, UK, during February and March 2007. The Isles consist of five inhabited islands (principal island St Mary's and the off-islands of Tresco, Bryher, St Agnes and St Martins), 28 miles from the UK mainland. The population of almost 2500 doubles during the summer as a result of seasonal workers and tourists. The population has a mean age of 41.9, compared to a mean of 38.7 for the whole of England and Wales. Over 90% of the resident population was born in England, with 97% being of white ethnic background. Over a fifth of the employed population works in skilled trades occupations with the percentage of unemployment in those of working age only 1.1%, compared with 3.3% in the whole of Cornwall (Cornwall County Council, 2001). Tourism is estimated to account for approximately 63% of all employment (Isles of Scilly Partnership, 2001). Education is available on the islands until the age of 16 years. In 2004, 93% of pupils achieved five or more General Certificates of Secondary Education (GCSEs) at grade C and above, compared to an average in the whole of

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England of 53.7% (Department for Children, Schools and Families, 2007).

The Cornwall and Isles of Scilly Primary Care Trust (PCT) was established on 1 October 2006 as part of a national re-organisation of primary care. The PCT delivers services from local hospitals, primary care and community facilities, working with other health and social care organisations (Cornwall and Isles of Scilly Primary Care Trust, 2008). On the Isles of Scilly, three full-time general practitioners (GPs), working together with nurses and midwives, provide primary healthcare from a general practice facility and 12-bed community hospital on St Mary's, with minor injuries unit, delivery room, palliative care suite and X-ray resource. Specialist care is provided by visiting mainland consultants. Other services include physiotherapy, counselling by community psychiatric nurses and alcohol and drug agency workers, podiatry, diabetic clinics, audiometry, optometry, and visits by Macmillan and stroke nurses. Patients pay a subsidised fee to travel 20 min by helicopter, with a further 30 min journey by road or rail, for additional services at a mainland hospital. There are resident ambulance technicians along with the UK's first ambulance boat (Figure 1), capable of transporting patients between islands as well as to the mainland when foggy conditions make helicopter flights impossible. The First Responder Scheme is made up of volunteers trained in resuscitation, who attend designated emergency calls received by the ambulance service and will often arrive first on the scene. In addition, a medical launch (Figure 2) exists to transport GPs, community staff and patients between the islands, and is available for both scheduled and non-scheduled work seven days a week, including emergency use should the ambulance boat be unavailable (Jeffries, 2004; Dalton and Jeffries, 2005).

A qualitative grounded theory approach was adopted, as the topic relates to participant perceptions and is not yet fully understood. It was not possible to form hypotheses before collection of data. Instead, it was necessary to draw conclusions after the coding and categorisation of data was complete. Our findings were then compared and contrasted to previous literature (Britten *et al.*, 1995). Semi-structured interview data was collected on St Mary's and inhabited off-islands by the first author. In the initial phase, convenience sampling was used to identify one GP and four patients. Purposive sampling through GP patient lists guided by practitioners'

Figure 1 Isles of Scilly ambulance boat

Figure 2 Isles of Scilly medical launch

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knowledge of the population ensured heterogeneity of the participant sample in the main study phase. Health professionals of various ages, gender, professional and geographical background, who might be able to comment on local healthcare accessibility, were identified. Due to the small population, all available GPs were recruited as participants. For patients, initial contact was made in person or by telephone. Those approached were given written information about the study, and advised that participation was voluntary, would not affect their healthcare, could be withdrawn at any time without explanation, and that data would not be used for any purpose other than that of the research. Before interviews, any questions were discussed and a consent form signed.

Interviews were conducted over a six-week period at the patient's home, workplace, or at St Mary's health centre. Most lasted approximately 30 min and all were digitally audio-recorded, partially transcribed within time constraints, and anonymised. Analytical contribution to the study was considered when selecting text for transcription. Interview material was supplemented by extensive field notes, which aimed to document key points mentioned by participants and were later used to aid the coding of transcribed interview data. Field notes were analysed alongside the interview data. A topic guide, developed from review of the literature, was used to provide an initial interview structure and evolved in response to analysis and following a pilot with two of the practitioners. The modifications increased flexibility of the guide, with structured questions used only when participants were unable to expand answers independently. Interviews were conducted in a conversational style, with participants encouraged to comment on issues they personally identified, to establish free-ranging exploration of topics. After completion, participants' agreement for data use was verbally confirmed. All data, including those derived from the convenience sample, were analysed. Data collection continued until no new themes were seen to emerge.

The text was read repeatedly to allow familiarity with data. A coding framework allowed identification of themes and sub-themes common to several interviews. Practical reasons prevented triangulation of data analysis when undertaking interviews. It was not possible to involve other researchers to code themes independently or reach a consensus regarding interpretation, as the author worked alone.

Results

None of the people approached declined to participate or withdrew. The characteristics of the 23 participants are presented in Table 1.

Three principal themes and several sub-themes emerged through analysis. As similar factors were

Table 1 Characteristics of participants ($n = 23$)

PATIENTS ($n = 16$)	*n*
Age (years)	
20–44	5
45–64	5
65 and over	6
Gender	
Male	7
Female	9
Ethnicity	
White	16
Occupation	
Professional	2
Administrative and secretarial	3
Skilled trade	2
Sales and customer service	3
Retired	6
Location of home for preceding five years	
St Mary's	6
Off-island (Tresco, Bryher, St Martin's, St Agnes)	6
Mainland UK	4
Frequency of healthcare utilization	
>10 encounters with healthcare services in the last year	9
<10 encounters with healthcare services in the last year	7
PRACTITIONERS ($n = 7$)	
General practitioners, including one locum	4
Nurses	2
Health visitors	1
Age (years)	
20–44	2
45–64	5
Gender	
Male	3
Female	4
Ethnicity	
White	7
Length of time in current role	
< 5 years	4
> 5 years	3

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identified by both patients and practitioners, data were aggregated for the final analysis. Principal themes were: concerns regarding equitable provision of services, including resource allocation, practitioner recruitment and training, and local initiatives established to address inequities in service provision; concerns regarding obstacles to the use of provided services, including speed and timing of access, travel and transport difficulties, and the contribution of voluntary or charitable support in attempting to address these obstacles; and the outlook of patients and professionals including users' expectations of rural health services, patient choice, patient–practitioner relationships, and the cohesiveness of island society.

Equitable provision of services

Expressed satisfaction was related to resource availability, which in turn was perceived as affected by service utilisation costs and centralised control from mainland policy: clinical examinations on off-islands were limited by restricted availability of equipment and chaperones. These patients also incurred waiting time for prescription deliveries by boat from St Mary's. Island geography complicated access for the physically disabled. A lack of local clinical specialist advice and infrequent island clinics caused patients to travel to mainland services, and unsubsidised helicopter fares for escorts on these journeys were of concern for the elderly:

> *Many elderly people feel that they do need an escort. That has to be clinically justified in order for the escort to get a concessionary fare. That is a point of contention.*
>
> (Practitioner)

> *Accessibility to opticians, chiropody, physiotherapy, occupational therapy is certainly restricted to that on the mainland and as people get more elderly and more infirm it is more difficult to access.*
>
> (Patient)

Healthcare practitioners were usually recruited from the mainland as local training was unavailable and transport to mainland facilities was costly. Practitioners highlighted the challenges of long working hours and multi-skilled roles but also expressed job-satisfaction, and patients appeared to value their competence.

> *Having someone so well qualified in charge of the ambulance boat is very reassuring, we are very lucky.*
>
> (Patient)

> *I think it's a money thing isn't it, having someone here who's trained for whatever we need.*
>
> (Patient)

Locally appreciated initiatives included the off-island surgeries, technologies such as remote blood pressure monitors and Internet communications for specialist consultation, the medical launch, and emergency services including the ambulance boat and voluntary co-responders:

> *The medical launch of course, that is truly different from anywhere else, that is great to have a boat dedicated to healthcare.*
>
> (Practitioner)

> *The co-responders are the next step up from first-aiders, they have good knowledge, they're very, very quick, and in some cases it's probably a matter of life and death.*
>
> (Patient)

Obstacles to using services

Participants identified speed of access to GP services, referral times to mainland secondary care, and travel time of emergency services as potential obstacles; however, they reported positive experiences regarding these:

> *In terms of access in time, getting a GP appointment, seeing a practice nurse, our access is probably much better than on the mainland, knowing that it is instant is very reassuring.*
>
> (Patient)

> *It's probably no longer than waiting for an ambulance on the mainland and when you get to hospital you are seen straight away, instead of waiting in casualty somewhere on the mainland.*
>
> (Patient)

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Inappropriate appointment timing for secondary care resulted in patients spending a night on the mainland, with disruption to family and working life and additional expenses. Timing of primary care appointments for off-islanders was a highlighted problem; weekly or fortnightly surgeries were regarded less convenient than twice daily surgeries on St Mary's. During winter, the availability of fewer scheduled boats made attending appointments on St Mary's difficult; however, private or emergency service transport was considered sufficient for urgent requirements:

> *Unless the mainland person making the appointment is aware of Scilly and the transport, they sometimes make appointments at 7pm in the evening, inconveniencing the patients in an overnight stay.*
>
> (Practitioner)

> *The receptionists do their very best to try and give us a reasonable time but a 9am appointment on a November Tuesday, when there's no boats whatsoever is very difficult.*
>
> (Patient)

Travel difficulties also included costs of inter-island boats. Tides and weather were accepted as potentially unavoidable problems. Difficulties in attending elective procedures with pre-booked mainland transport were regarded as less significant than difficulties in attending urgent appointments:

> *Tides and weather can be a problem, but out of everyone's control and it can also be a problem on the mainland too, with ambulances in the snow.*
>
> (Practitioner)

> *There have been problems with admissions to mainland hospitals, with onward transport from the heliport; people having to get a taxi.*
>
> (Practitioner)

Voluntary and charitable transport support, contributions of volunteers in collecting prescriptions and fundraising events were appreciated:

> *There is the voluntary hospital car service, the League of Friends come and picks them up and that's so helpful, it really is.*
>
> (Patient)

> *The big thing was this launch they got, this was backed by all the islanders, you know with charity and coffee mornings, all that type of thing, it's now been taken over by the ambulance trust.*
>
> (Patient)

> *Medication can be checked by a volunteer if the patient has poor vision or something.*
>
> (Patient)

The outlook of patients and practitioners

Participants anticipated and accepted access difficulties as inevitable. Patients with lower expectations appeared more self-reliant. Requirements and expectations varied; some off-island populations relied heavily on emergency services whilst others presented infrequently to GP surgeries. Overall, participants aspired to equivalence in service provision with mainland populations, reflecting both discussions between islanders and mainland friends, and their perceived rights as taxpayers. St Mary's services appeared to meet visitors' expectations, but dissatisfaction was expressed regarding infrequency of off-island surgeries:

> *You know you're not going to have a hospital next door, that's the choice you make when you move here, I wouldn't think it was a negative thing but just a consideration.*
>
> (Patient)

> *There will be an Orthotics visit within the next 6 months but you'll find that someone has welded a bit of car tyre to their shoe and off they go.*
>
> (Practitioner)

> *They get the same treatment as we get and they are amazed, she said 'I would still be in a queue in casualty and I certainly wouldn't have been rushed through'.*
>
> (Patient)

A perceived pleasant work–life balance was the basis of some health practitioners expressing job-satisfaction. Participants valued the choice of three GPs with different clinical interests and personalities. This choice was less realistic or satisfactory on particular off-islands, where an individual GP may only visit every six weeks.

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Lack of access to a female GP appeared a particular problem to younger women:

> *It is a lovely place to work, look at the surroundings it's great, and pressure is not as big as on the mainland.*
>
> (Practitioner)

> *Most people that come feel that they're joining a frontier practice but they probably have that sort of ground-breaking approach, they come here because they relish working in a challenging environment.*
>
> (Practitioner)

> *Everybody has their preference for a particular doctor but when they only see one every week it could be weeks and weeks before they see that particular doctor again.*
>
> (Patient)

Choice of treatment location was valued but often not expected. Lifestyle factors, including work and family commitments, affected participants' preferences: off-island patients preferred care on their own island; those needing secondary care preferred the closest, personally least costly location with shortest waiting times; and the elderly or immobile preferred treatment at home:

> *If it's an outpatient appointment, the choice of venue may be governed by the proximity of Marks and Spencer's.*
>
> (Patient)

> *If you need an escort, say it's your husband, then you've got to take into consideration that your children are going to get left behind, and care for them, it's not just one person involved, it turns into a full-scale operation.*
>
> (Patient)

Patient–practitioner relationships were thought to differ from those in urban communities. Patients suggested that knowledge of practitioners in social contexts and sharing respected boundaries within this relationship resulted in mutual satisfaction. Continuity of care with practitioners who knew patients' families and lifestyles was generally seen as beneficial, ensuring individualised care. The desirability of this approach was emphasised less frequently by off-islanders. Some expressed a preference for less familiar practitioners for sensitive healthcare needs:

> *Not having any family here, it's not like you can pop round to them for advice, but I would feel able to come to the doctor almost for anything, and I know that they're happy to see me if I have the slightest concern or doubt, and I find that very reassuring.*
>
> (Patient)

> *On the mainland, you never meet the doctor outside the surgery but here you get to know your doctor socially and I think that's a good thing because he's not the God up the top, which he was in the old days, and you build a better relationship.*
>
> (Patient)

> *The GPs generally deal with that incredibly well. The patients, for the most part, know – do not rush up in the Co-op by the frozen burgers and ask about your, you know, smear test results – there is a good understanding.*
>
> (Patient)

> *The fact that you have more time to spend with the patients is quite nice, you can put more effort in and explore their health beliefs and the way they live a bit more.*
>
> (Practitioner)

Cohesiveness, cooperation and compromise within island society enabled easier access. Participants felt the local knowledge and facilitatory attitude of health service reception staff was important. The medical launch, central to off-island healthcare, was shared by community members including the police and vicar. Practitioners, familiar with each other, valued talking frequently; although occasional personality clashes were considered unavoidable:

> *We are people and names rather than appointment numbers, it is far more a holistic service than it could possibly be on the mainland, and the receptionist knows who they are talking to, that smoothes the path.*
>
> (Patient)

> *Because it is such a small social community, if patients ask their neighbours, 'can you bring me to the doctor', they will do.*
>
> (Patient)

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It's like serving a lifeboat, you have to know your team, and know what their strengths and weaknesses are.

(Practitioner)

The access here is made easy and it runs smoothly because of the good communication, because we all know each other.

(Practitioner)

Discussion

Summary of main findings

This study used qualitative methods to explore satisfaction with access to healthcare services amongst patients and practitioners in a remote island setting. Three principal themes emerged: equitable provision of services, obstacles to using those services and the outlook of patients and professionals.

Somewhat unexpectedly, the themes and subthemes identified applied equally to both patients and practitioners. There was a lack of literature comparing the views of these populations. Themes did not appear to differ between tourists and islanders. The surprising concordance in subthemes might be explained by the closeness of shared community life, allowing patients and practitioners to relate to each other's perceptions.

Strengths and limitations of the study

The study recruited a heterogeneous participant sample including patients from all inhabited islands and a range of healthcare practitioners including doctors, nurses and a health visitor. In comparison with other recent studies of patients' (Horner *et al*., 1994; Leipert *et al*., 2008; Hoang *et al*., 2009) and health practitioners' (Noonan *et al*., 2008) views on rural healthcare provision, our study's sample of 23 interviews is judged acceptable. It may have been useful to gain the perspective of other practitioners such as a midwife for example; however, due to time constraints this was not possible. It is unusual for all participants approached to agree to participate in a study of this type, and for none to withdraw. Perhaps this is characteristic of the isolated society and the perceived importance of the subject. The study was limited by solitary data analysis carried out by the interviewer and a lack of independent researchers available for contemporaneous triangulation of data. Partial transcription of data was necessary due to time constraints and was supplemented by detailed field notes.

Studies that look at wide geographical areas when evaluating access to healthcare in rural settings may fail to recognise views from smaller, isolated communities. We focused on a small, isolated, relatively stable population to gain insights into perceptions of individuals from a uniquely placed island. A rich contextual background to the data has been provided, including what was involved for patients seeking healthcare on the main island and off-islands, the availability of different services and the priorities of participants, including how they were willing to compromise. The subject matter is important not just in the context of the NHS however. Whilst generalisation of findings to a different setting may be inappropriate, it seems reasonable that the main themes identified may be relevant to remote rural locations where other research has identified similar issues regarding access to healthcare (Gillies, 1998).

We used qualitative methods to enable in-depth exploration of participant perceptions and investigate a poorly understood research area. This study aims to inform new developments in local healthcare access. The methodology offers potential in informing service development which is responsive (De Silva, 2002) to participants' aspirations.

Comparison with existing literature

This study looks at the under-researched area of rural healthcare access. It is the first to use qualitative methods to investigate factors affecting satisfaction with healthcare access in a remote UK island community, from both a patient and practitioner viewpoint. Whilst questionnaire surveys routinely explore patients' evaluations (Steven *et al*., 1999; Ramsay *et al*., 2000; Boreham *et al*., 2002; Kroneman *et al*., 2006; Market and Opinion Research International, 2007; Jayasinghe *et al*., 2008), such approaches do not offer opportunities to discuss detailed experiences. Both quantitative and qualitative methods have been used in other countries to explore patient and practitioner satisfaction in order to improve services for rural communities (Elliott-Schmidt and Strong, 1997; Bryson and Warner-Smith, 1998; Reschovsky and Staiti, 2005; Jayasinghe *et al*., 2008; Sounness *et al*., 2008).

Our identified sub-themes concur with other studies (Gillies, 1998; Ramsay *et al*., 2000; Scottish Executive Policy Unit, 2000; Deauville, 2001; Goddard and Smith, 2001; Institute of Rural Health, 2004; Swindlehurst, 2005) exploring accessibility of rural healthcare. In addition, we have identified new factors affecting participant satisfaction with access to healthcare: a Welsh Assembly Government review (2005) suggested rural communities face more obstacles to using health services, including greater transport difficulties, than urban communities. Our findings reflected this observation and highlighted the practicability of mainland appointment times. This could be relevant to other remote island communities and of importance to service development plans. Rural patients in Australia (Elliott-Schmidt and Strong, 1997) chose to wait before travelling to seek healthcare and appeared to be influenced by costs, prior experiences, and beliefs that they could provide effective self-care (Horner *et al*., 1994). Self-reliance was evident amongst our off-island participants and, in addition, appeared associated with lower expectations, although there was variation across the off-islands. Cleemput *et al*. (2007) describe an association between low expectations of health, poor healthcare access and self-reliance in a study of gypsies and travellers. The reason for variation in perceptions across off-islands was unclear but might be associated with factors including island geography, frequency of GP surgeries and differences in population demographics on different islands. This could be an area for future research. We concur with the Welsh Assembly Government review (2005) that identified the voluntary sector as a valued contributer to rural healthcare. The first UK ambulance boat, charity funded, appeared to be a key local initiative and was recognised to address inequity in emergency healthcare access, along with the First Responder Scheme. In addition, local initiatives coupled with community cohesiveness and cooperation appeared important. Perhaps future policy developments should seek to incorporate and improve on innovative systems that already appear to work well; for example, the sharing of the medical launch with other community staff, an example which could be transferable to other island communities. A Cochrane review by Gruen *et al*. (2003) suggested that specialist outreach clinics in rural settings, as adopted on the islands and valued by participants, may offset potential disadvantages (Guagliardo, 2004). Our participants additionally identified the highly valued choice of treatment location as a relevant factor. Enabling patient choice is currently a topic of importance to health service providers (Fotaki *et al*., 2008). Interestingly, partcipants identified travel time of emergency services as a potential obstacle, although this was not reported to be a problem. Perhaps this illustrates anxiety amongst participants' about the potential for healthcare emergencies when emergency practitioners are not immediately available. There is a lack of literature to establish whether unsubstantiated anxiety of this kind is a common phenomenon in isolated communties.

Stokes *et al*. (2005), along with Baker and Streatfield (1995), suggested that patients prefer smaller practices with personal list systems. Patients (Farmer *et al*., 2006) expressed a positive view of rural practitioners who were seen as 'visible' members of the community. Our participants identified the importance of respecting the boundaries of the unique patient–practitioner relationships in a remote rural community (Gillies, 1998). It may be of interest to consider this further, perhaps to determine whether there are differences between patients' and practitioners' perceptions of where these boundaries lie and whether this might affect perceived satisfaction with access as there is currently a lack of literature regarding this. Australian literature recognises the importance of quality of life for rural practitioners (Alexander, 1998). Concerns over practitioner recruitment and retention have previously been highlighted (Pathman *et al*., 1996; O'Toole *et al*., 2008). On the Isles of Scilly, practitioners were usually recruited from the mainland and local training resources were unavailable. Whilst they highlighted the challenges of long working hours and multi-skilled roles, practitioners also expressed job-satisfaction, which appeared to outweigh any concerns over recruitment and retention.

Implications for future research and clinical policy

Seasonal variations in accessibility, affected by weather, tides and tourists, appeared more relevant than might be expected for mainland populations.

Future research is required to identify appropriate models for healthcare delivery related to the seasonally determined access needs of remote rural populations. Based on our results, consideration of patient choice and the role of local initiatives might also be important in the development of future patient-centred health services. Some such models rely on developing the skill-mix of healthcare practitioners in rural primary care teams (James and Williamson, 2007). Future research could usefully explore factors affecting workforce retention in remote rural areas, differences in perceptions of the patient–practitioner relationship, the affect of self-reliance on patient expectations, and any relationship between these factors and satisfaction regarding healthcare.

Conclusion

Our findings highlight that remote rural communities have particular healthcare needs occasioned by their geography and culture. For such communities, local professionals and service managers need to be able to respond to the needs of patients, tailoring healthcare to individual requirements and expectations, whether for continuity of care, choice of treatment location, or redistribution of resources. This study is the first to use qualitative methods to investigate factors affecting satisfaction with healthcare access in a remote UK island community, from both a patient and practitioner perspective. Such approaches have potential to inform health service planning in the provision of local services, addressing the healthcare needs and expectations of individuals in remote and isolated rural communities.

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