

Review Article

Experiences of People with Disabilities and Chronic Illnesses Accessing Healthcare in Rural and Remote Communities: A Scoping Review

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ABSTRACT

Background: Rural and remote communities face well-documented challenges in healthcare access, including workforce shortages and long travel distances. For people with disabilities and people with chronic illnesses, these challenges are compounded by accessibility barriers, fragmented services, and heightened dependence on accommodation, support, and continuity of care.

Objective: This scoping review aimed to map the literature on how people with disabilities and people with chronic illness experience accessing healthcare in rural and remote settings, with attention to barriers, facilitators, care pathways, and patient-identified priorities for improvement.

Method: Following the PRISMA-ScR framework, we systematically searched MEDLINE, Embase, CINAHL, PsycINFO, and Scopus from inception to July 2025. Eligible studies included qualitative, quantitative, and mixed-methods research describing healthcare access experiences among people with disabilities and people with chronic illness living in rural or remote regions. Data were charted on population, geography, care setting, access dimensions, and reported outcomes, and were synthesized using descriptive and thematic analysis.

Result: Twenty-five studies were included, spanning primary care, specialty care, rehabilitation, home care, and emergency services across rural and remote regions in high-, middle-, and selected low-income settings. Four themes emerged: (1) distance, transportation, and the “time tax” of care; (2) service scarcity and discontinuity across the care journey; (3) accessibility and accommodation gaps within rural health systems; and (4) relational, cultural, and privacy dynamics shaping care-seeking and trust. Across studies, telehealth and local “wraparound” relationships were frequently described as partial mitigations, but often limited by broadband access, disability-related communication needs, and reduced opportunities for hands-on assessment.

Conclusion: People with disabilities and chronic illnesses in rural and remote communities face layered access barriers that extend beyond geography to include accessibility, continuity, and the social realities of rural life. Future research should evaluate interventions that combine accessible transportation supports, strengthened local interdisciplinary capacity, disability-competent telehealth, and coordinated pathways for specialty and rehabilitation care.

Keywords: rural health, remote health, disability, chronic illness, healthcare access, accessibility

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INTRODUCTION

Healthcare access in rural and remote regions is shaped by structural conditions that consistently disadvantage residents, including geographic isolation, limited infrastructure, and uneven workforce distribution [1–3]. Long travel distances to primary care, specialty services, and diagnostic testing are common in rural settings and are associated with delays in seeking care and lower uptake of preventive services [1,3]. Sparse healthcare infrastructure further compounds these challenges, with fewer clinics, limited on-site diagnostics, and constrained outpatient capacity contributing to higher reliance on emergency departments for conditions typically managed in ambulatory settings [4,5]. These structural barriers have measurable clinical consequences, including delayed diagnoses, preventable hospitalizations, and progression of otherwise manageable chronic conditions [4,5].

Workforce maldistribution intensifies these access gaps, as rural regions experience persistent shortages of physicians, specialists, nurses, and allied health professionals [6,7]. Recruitment and retention challenges have been documented across decades, with shortages particularly pronounced in rehabilitation and allied health services that are essential for individuals with chronic illness or functional limitations [8,9]. Limited local availability of these services contributes to long wait times, fragmented care, and increased dependence on informal or family caregivers, especially among older adults and those with complex health needs [8,9]. Financial barriers further compound these challenges, as rural residents face higher rates of uninsurance, underinsurance, and medical debt compared with urban populations, disproportionately affecting marginalized and racially minoritized groups [10–12].

For people with disabilities and people with chronic illness, healthcare access encompasses more than proximity to services and includes the ability to physically enter and navigate care environments, communicate effectively with clinicians, receive appropriate accommodations, and obtain coordinated care across multiple settings [13–15]. Professional guidelines emphasize that accessible built environments, such as automatic doors, accessible exam rooms, height-adjustable examination tables, and adaptive equipment, are foundational to equitable care delivery [16,17]. Communication accessibility is equally essential and may include sign-language interpreters, assistive listening systems, accessible written materials, and the involvement of support persons, particularly for individuals with sensory or cognitive disabilities [13,14]. Effective access requires reliable documentation of accommodation needs and proactive adaptation of both administrative and clinical processes, which remain inconsistently implemented across healthcare systems [15,18].

In rural and remote contexts, disability-related access needs intersect with existing structural constraints, amplifying barriers to care [19–22]. Rural regions often have fewer accessible healthcare facilities, limited home-care capacity, reduced availability of adaptive equipment, and fewer accessible transportation options, increasing reliance on informal caregiving networks [19,20,22]. Disability status further increases the likelihood of delaying or forgoing care due to transportation challenges, clinic hours, and travel burden, particularly when specialty services are concentrated in distant urban centers [22–24]. Rurality also carries distinct social and cultural dimensions, including reduced privacy in small communities, heightened stigma related to disability or chronic illness, and complex relationships with local providers that can be simultaneously supportive and limiting when disability-specific expertise is lacking [24–26].

Despite extensive rural health research examining distance, workforce shortages, and population-level outcomes such as hospitalization and mortality, the lived experiences of people with disabilities and chronic illnesses navigating healthcare in rural and remote settings remain fragmented across conditions, regions, and care contexts [23–25].

Disability and chronic illness introduce distinct mechanisms of inequity, such as inaccessible built environments, limited availability of assistive technologies, lack of disability-informed clinical practices, and the cumulative burden of frequent long-distance travel, that are not fully captured by traditional rural health frameworks [13,24]. A scoping review is therefore well-suited to map the breadth of existing evidence, synthesize patient-reported experiences, identify recurring barriers and facilitators, and highlight gaps in knowledge that can inform future research, policy, and intervention design. Accordingly, this review synthesizes literature on the experiences of individuals with disabilities and chronic illnesses accessing healthcare in rural and remote communities, with particular attention to structural, relational, and systemic factors shaping access, care quality, and equity.

METHOD

Protocol and Reporting

This scoping review followed the Preferred Reporting Items for Systematic Reviews and Meta-Analyses extension for Scoping Reviews (PRISMA-ScR) guidelines [27]. Methodological conduct was guided by established scoping review frameworks to support systematic mapping of a heterogeneous evidence base. An a priori protocol defined the research questions, eligibility criteria, search strategy, and data charting plan. The protocol emphasized breadth of inclusion and conceptual exploration of access experiences rather than formal assessment of intervention effectiveness or study quality.

Search Strategy

We searched MEDLINE (Ovid), Embase, CINAHL, PsycINFO, and Scopus from inception to July 15, 2025. Searches combined terms related to (1) rural and remote contexts, (2) disability and chronic illness, and (3) healthcare access and patient experience. Controlled vocabulary and free-text terms were adapted for each database to maximize sensitivity. Reference lists of included studies were screened, and targeted grey literature searches were conducted across rural health agencies and disability advocacy organizations, recognizing that experiential and community-based evidence is often underrepresented in indexed academic databases.

Eligibility Criteria

Studies were included if they: (1) reported empirical data (qualitative, quantitative, or mixed-methods); (2) focused on people with disabilities and people with chronic illness living in rural or remote communities; and (3) described experiences accessing healthcare services, including primary care, specialty care, rehabilitation, home care, emergency care, or telehealth. Studies capturing patient, family caregiver, or community perspectives were all eligible for inclusion. Studies were excluded if they focused solely on urban populations, did not report patient or caregiver experiences, or addressed rural health generally without disability- or chronic illness-specific findings. No restrictions were placed on geographic region, healthcare system, or study design, consistent with scoping review methodology.

Selection Process

Two reviewers independently screened titles and abstracts and assessed full texts for inclusion. Screening was conducted using predefined inclusion and exclusion criteria to promote consistency and reduce selection bias. Disagreements were resolved through consensus. Reasons for exclusion at the full-text stage were documented to enhance transparency in study selection.

Data Charting and Synthesis

A standardized charting form captured study characteristics (country, rurality definition, population, condition or disability type, care setting), access barriers and facilitators, and reported outcomes. The charting form was piloted on a subset of included studies and iteratively refined as needed. Findings were synthesized descriptively and through inductive thematic analysis. Themes were developed iteratively to capture cross-cutting patterns in access, accommodation, and structural constraints across diverse rural contexts, without privileging any single healthcare model or outcome framework.

RESULTS

Study Selection and Characteristics

A total of 3,112 unique records were identified through database searching. Following title and abstract screening, 117 full-text articles were assessed for eligibility, of which 21 studies met inclusion criteria. Across studies, participant populations included individuals with mobility, sensory, and intellectual or developmental disabilities, as well as people living with chronic conditions such as diabetes, chronic obstructive pulmonary disease, heart failure, chronic pain, autoimmune disease, and complex multimorbidity. Care settings examined most frequently included primary care, specialty referral pathways, rehabilitation and therapy services, and home- and community-based care. Four interrelated themes emerged from the synthesis (Figure 1).

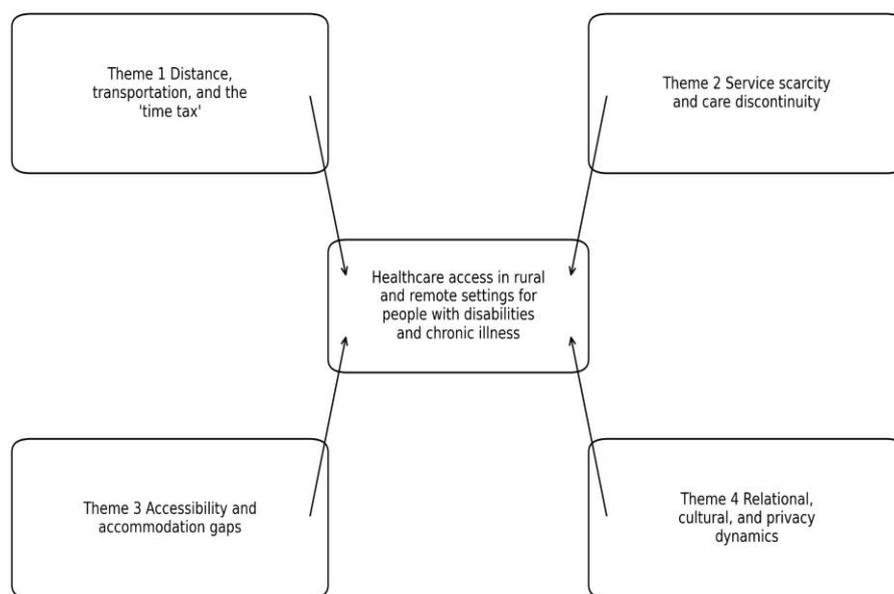


Figure 1: Schematic of identified themes.

Theme 1: Distance, Transportation, and the “Time Tax” of Care

Across studies, distance was not experienced as a simple geographic barrier but as a compounding logistical burden that shaped whether care was feasible at all. Participants described lengthy travel for specialty visits, diagnostics, or rehabilitation that often required early departures, overnight accommodation, missed work, and extensive coordination with caregivers, particularly for individuals using mobility devices or requiring assistance with transfers. These burdens were intensified by inaccessible vehicles, limited accessible public transit, and reliance on informal transportation arrangements in rural

contexts, consistent with prior findings on transportation barriers among rural residents and people with disabilities [19,22].

Transportation systems, when available, were frequently described as unreliable, inflexible, or poorly aligned with appointment schedules. Even dedicated rural shuttle programs were often inaccessible or impractical due to limited hours, physical barriers, or long wait times, echoing prior evidence that transportation availability alone does not ensure meaningful access [28–30]. For participants with fluctuating conditions such as fatigue, pain, or autonomic symptoms, travel itself was reported to exacerbate illness and reduce the perceived value of routine or preventive care, reinforcing patterns of delayed follow-up [19,22].

Participants consistently described these burdens as a “time tax” or “energy tax” that their urban or peers without disabilities did not face, encompassing lost wages, physical exhaustion, emotional strain, and caregiver coordination. As documented in prior rural and disability-focused research, this cumulative burden led many individuals to postpone appointments, reduce preventive care, or “save up” health concerns until multiple issues could be addressed in a single visit [19,22,31].

Theme 2: Service Scarcity and Discontinuity Across the Care Journey

Many studies described a persistent mismatch between high healthcare needs and limited local service capacity. Participants reported restricted access to specialists, rehabilitation providers, mental health services, and diagnostic testing, with long waitlists and fragile referral pathways that were often dependent on visiting specialists or rotating locum clinicians. These patterns are consistent with broader evidence of service scarcity in rural healthcare systems, particularly for people with complex or long-term care needs [32,33].

Discontinuity of care emerged as a central mechanism of harm. Participants described repeatedly “restarting the story,” inconsistent medication management, and fragmented follow-up after hospital discharge due to under-resourced home care services and limited local capacity for coordination. Similar patterns of poor informational and relational continuity have been associated with increased risk of inappropriate medication use, adverse events, and mortality in populations with multimorbidity [34,35]. Caregivers were frequently described as assuming informal care coordination roles, navigating opaque systems and compensating for gaps between acute, community, and social care sectors, consistent with prior caregiver-focused research [36,37].

Several studies described a recurring pattern of avoidable escalation, wherein the absence of timely, accessible early intervention led to worsening conditions that ultimately required emergency care. This pattern was particularly evident for pain crises, respiratory exacerbations, wound care needs, and mobility-related complications, reflecting prior evidence linking service fragmentation to increased emergency department use in rural settings [32,38].

Theme 3: Accessibility and Accommodation Gaps Within Rural Health Systems

Beyond service availability, many studies highlighted how healthcare environments and processes were not designed to accommodate people with disabilities or communication needs. Participants described inaccessible entrances, non-adjustable examination tables, limited accessible diagnostic equipment, inadequate transfer supports, and insufficient private space for caregiver-assisted communication. These findings align with established literature documenting persistent accessibility gaps in healthcare facilities, particularly in rural and smaller clinical settings [22,23].

Communication barriers were also prominent across studies. Deaf and hard-of-hearing participants reported limited interpreter availability, autistic participants described sensory overload and lack of sensory accommodations, and individuals

with cognitive or fatigue-related impairments reported appointment pacing and information delivery that did not meet their needs. These challenges were amplified in smaller facilities with limited staffing and training, reinforcing “one-size-fits-all” clinical processes that fail to account for disability-related needs [13,14,26].

Participants frequently described the need to self-advocate for accommodation, bring their own supports, or accept suboptimal examinations when accessible equipment or trained staff were unavailable. Professional guidance from organizations such as the American College of Obstetricians and Gynecologists emphasizes that accessible environments and proactive accommodation are essential components of equitable care, underscoring the gap between recommended practice and lived experience in rural settings [14].

Theme 4: Relational, Cultural, and Privacy Dynamics Shaping Care-Seeking and Trust

Rural healthcare experiences were strongly shaped by social context and interpersonal relationships. Several studies described the protective role of close relationships with local clinicians who knew patients’ families, adapted care informally, and assisted with navigating referrals, fostering trust and continuity, particularly when clinicians acknowledged patient and caregiver expertise in disability-related care [12,25,26].

However, the same small-community context also created barriers. Participants described concerns about privacy, fear of community gossip, and heightened visibility when seeking care, especially for mental health services or when requesting accommodations. Stigma related to disability or being perceived as “high-needs” further discouraged care-seeking, with some participants expressing concern that complaints or advocacy could damage relationships in settings with few alternative providers [22,39–41].

Cultural norms of self-reliance emerged as an additional influence on care-seeking behavior. Participants described minimizing symptoms, avoiding “making a fuss,” and delaying care to reduce burden on family members or local services. These patterns contribute to late presentation and crisis-driven care. These norms interacted with structural barriers such as distance, transportation limitations, and service scarcity, amplifying disparities for rural residents with chronic illness or disability [22,42–44].

DISCUSSION

This scoping review synthesizes a growing and diverse body of literature examining how people with disabilities and chronic illness experience healthcare access in rural and remote communities. Across conditions, regions, and care settings, the findings demonstrate that access barriers operate through layered and interacting mechanisms rather than a single dimension of distance. Geographic isolation, transportation constraints, service scarcity, disability-related accessibility gaps, and the social realities of rural life collectively shape whether care is feasible, timely, and effective. This multidimensional framing aligns with and extends prior rural health research, which has increasingly moved beyond distance-based models of access toward more holistic understandings of burden and inequity [10,24,41].

A central contribution of the literature is the reframing of rural healthcare access as a cumulative “time,” “energy,” and “coordination” burden rather than a simple travel problem. Participants consistently described the compounding demands of long-distance travel, appointment coordination, caregiver involvement, and physical or cognitive exertion, particularly for those requiring frequent follow-up, rehabilitation, or interdisciplinary care. These findings are consistent with prior qualitative work demonstrating that rural residents with complex needs experience disproportionate opportunity costs and fatigue associated with care-seeking, often leading to delayed or foregone care [10,24,41]. Importantly, this burden was not evenly distributed, falling most heavily on

individuals with disabilities, fluctuating conditions, or limited financial and caregiving resources.

The review also highlights that geographic proximity alone does not guarantee meaningful access when healthcare environments and processes remain disability inaccessible. Across studies, participants described barriers related to inaccessible entrances, non-adjustable examination tables, limited diagnostic equipment, and inadequate accommodation of communication or sensory needs. These findings reinforce prior evidence that rural facilities often lack the infrastructure, equipment, and training required to deliver disability-inclusive care, even when services are technically available [24,45]. This distinction has important policy implications: efforts to expand rural service availability without parallel investments in accessibility standards, disability-inclusive training, and adaptive equipment risk reproducing inequities rather than alleviating them.

Telehealth emerged across literature as a frequently proposed partial solution, particularly for follow-up visits, medication management, and select specialty consultations. Consistent with prior studies, telehealth was valued for reducing travel burden and increasing flexibility for individuals facing mobility, fatigue, or transportation barriers [46–49]. However, the evidence also underscores substantial limitations, including inadequate broadband access, lack of appropriate devices, reduced capacity for hands-on assessment, and challenges meeting disability-related communication needs [46,48,50–53]. These findings align with guidance from professional organizations emphasizing that telehealth expansion must incorporate accessible platform design, interpreter integration, flexible pacing, and clear escalation pathways to in-person care to avoid worsening disparities [53–55].

Finally, the review highlights the importance of relational, cultural, and privacy dynamics in shaping rural healthcare experiences. Trusting relationships with local clinicians were often described as protective, facilitating continuity and informal adaptation of care, particularly in settings with limited provider options. At the same time, small-community contexts introduced unique challenges, including privacy concerns, heightened stigma, and reluctance to seek care or request accommodations for fear of damaging relationships. Cultural norms of self-reliance further influenced care-seeking behaviors, interacting with structural barriers to produce delayed presentation and crisis-driven care. These findings are consistent with prior rural health research emphasizing the dual role of social closeness as both a facilitator and barrier to equitable care [41–44].

This review has several strengths, including its focus on lived experiences across disability types, chronic conditions, and care settings, and its synthesis of evidence spanning multiple rural contexts. However, the evidence base remains uneven. Many included studies were qualitative and condition-specific, with limited comparative evaluation of interventions or standardized outcome measures. Definitions of rurality varied widely, and few studies examined outcomes beyond patient experience, such as missed appointments, emergency department use, or preventable hospitalizations. Future research would benefit from implementation-focused designs evaluating bundled interventions, such as accessible transportation supports, mobile or visiting accessible clinics, integrated rural rehabilitation capacity, and coordinated specialty pathways, using outcomes that capture both experiential and clinical impact. Greater attention to intersectionality, including socioeconomic status, race, and Indigenous identity, is also needed to fully understand how rural disability-related inequities are produced and sustained.

CONCLUSION

In summary, this scoping review demonstrates that healthcare access for people with disabilities and chronic illnesses in rural and remote communities is shaped by cumulative, intersecting barriers that extend far beyond geographic distance. Effective responses must move beyond singular solutions toward integrated strategies that address transportation, service continuity, physical and communication accessibility, and the relational realities of rural care. Without deliberate investment in disability-inclusive design, training, and infrastructure, efforts to expand rural healthcare risk reinforcing existing inequities. Addressing these gaps is essential to advancing equitable, person-centered care for rural populations with disabilities and chronic illness.

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