MATHEWS

Research

Mathews Journal of Psychiatry & Mental Health

Rural–Urban Health Inequality in Jamaica: Structural Disparities in Health Outcomes

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ABSTRACT

Rural–urban health inequality remains a persistent public health challenge in Jamaica, reflecting entrenched structural disparities in access, utilisation, and outcomes across populations. Although the country has made notable strides in expanding healthcare coverage, important differences persist between rural and urban residents in morbidity patterns and healthcare experiences. Empirical evidence indicates that rural populations experience poorer health outcomes, often linked to delayed healthcare utilisation and limited service availability. Additionally, the burden of chronic non-communicable diseases is disproportionately higher in rural areas, further exacerbating health inequities. Patient satisfaction with healthcare services is also lower among rural residents, reflecting systemic inefficiencies and resource constraints. These disparities are not merely geographic but are deeply embedded in broader socioeconomic inequalities that shape health behaviours and outcomes. This paper examines rural–urban health inequality in Jamaica through a structural lens, emphasising the role of social determinants in perpetuating disparities and highlighting the need for targeted policy interventions.

Keywords: Rural Health, Urban Inequality, Jamaica, Chronic Illness, Health Disparities, Social Determinants

INTRODUCTION

Health inequalities between rural and urban populations represent a persistent public health challenge in Jamaica, where geographic location and socioeconomic conditions interact to influence access to healthcare, healthcare utilisation, and health outcomes [1–3]. Although Jamaica has achieved considerable progress in expanding primary healthcare services and improving population health, substantial disparities remain between rural and urban communities in the availability, accessibility, and quality of healthcare services [2–4]. Urban centres generally benefit from greater concentrations of hospitals, specialist services, healthcare personnel, and

Vol No: 11, Issue: 02

Received Date: May 25, 2026

Published Date: July 14, 2026

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Citation: Bourne PA. (2026). Rural–Urban Health Inequality in Jamaica: Structural Disparities in Health Outcomes. Mathews J Psychiatry Ment Health. 11(2):65.

diagnostic facilities. In contrast, rural communities continue to experience barriers related to geographic isolation, transportation, healthcare infrastructure, and limited-service availability [3,4]. These structural differences contribute to variations in disease burden, healthcare utilisation, and overall health status across the population [1,3]. Where individuals live continues to influence both their opportunities to maintain good health and their ability to obtain timely and appropriate healthcare services [2,5].

Approximately half of Jamaica's population resides in rural communities, where healthcare access is frequently constrained by longer travel distances, higher transportation costs, fewer healthcare providers, and reduced availability of specialised medical services [2–4]. These challenges are compounded by socioeconomic inequalities, including lower income levels, reduced educational attainment, and fewer employment opportunities, all of which influence health-seeking behaviour and healthcare utilisation [2,5]. Comparative studies consistently demonstrate that rural residents are more likely to delay seeking healthcare due to financial and geographic barriers, whereas urban residents generally have greater access to preventive services, early diagnosis, and continuity of care [3,4]. Although urban communities are not without important health challenges, including poverty and overcrowding, the cumulative evidence indicates that rural populations remain disproportionately disadvantaged within Jamaica's healthcare system [2–4]. These persistent disparities underscore the need to better understand the structural factors contributing to rural–urban differences in health.

The concept of the health status gradient provides an important framework for understanding these inequalities by recognising that health systematically varies according to social, economic, and geographic circumstances [5,9]. In Jamaica, rural populations consistently report poorer health indicators than their urban counterparts, reflecting inequalities that extend beyond healthcare delivery to encompass broader social and economic conditions [1–3]. Income inequality, educational attainment, employment opportunities, transportation infrastructure, and healthcare accessibility collectively shape opportunities for maintaining good health and obtaining healthcare services [2,5]. Rural communities are exposed to multiple and reinforcing disadvantages that increase vulnerability to illness while simultaneously limiting access to appropriate care [3,4]. These patterns demonstrate that rural–urban health disparities are structural rather than simply behavioural, requiring policy responses that address the broader determinants of health [2,5].

The Social Determinants of Health framework provides an appropriate theoretical perspective for examining these inequalities because it emphasises that health outcomes are shaped by the social, economic, and environmental conditions in which individuals are born, live, work, and age [5,9]. Within the Jamaican context, differences in income, education, employment, healthcare infrastructure, transportation, and service availability collectively contribute to unequal health opportunities between rural and urban populations [2,5]. This framework allows rural–urban disparities to be understood as the product of structural inequities rather than solely differences in individual health behaviours or healthcare utilisation [2,5]. Applying this perspective provides a comprehensive understanding of how social and geographic disadvantage influences health outcomes throughout the life course [5-9].

Despite growing evidence documenting rural–urban differences in health, relatively little synthesis has integrated the available literature to provide a comprehensive understanding of these disparities within Jamaica. Existing studies have examined individual aspects of healthcare access or disease burden, but less attention has been given to collectively understanding how structural inequalities influence multiple dimensions of health and healthcare experiences [1–4]. Accordingly, this review addresses the following question: How do structural and socioeconomic inequalities contribute to rural–urban differences in health outcomes in Jamaica? To answer this question, the review focuses on three interrelated dimensions of health inequality: health outcomes, chronic illness, and patient satisfaction with healthcare services. These areas were selected because they collectively capture the major consequences of structural inequalities within the healthcare system. Health outcomes reflect the overall burden of disease and population health; chronic illnesses represent the leading contributors to morbidity and mortality in Jamaica and are strongly influenced by access to preventive and continuing healthcare; and patient satisfaction provides insight into healthcare accessibility, quality of care, and the responsiveness of the

health system [1,3,4,7]. By examining these three dimensions through the Social Determinants of Health framework, this review aims to provide a comprehensive assessment of rural–urban health inequality in Jamaica and to contribute evidence that can inform equitable health policy, resource allocation, and future public health planning [2,4,5].

Aim of the Study

To examine the structural determinants of rural–urban health inequalities in Jamaica by synthesising evidence on differences in health outcomes, chronic disease burden, and patient satisfaction with healthcare services, and to identify implications for health policy, practice, and future research.

General Objective

To examine how structural and socioeconomic inequalities contribute to rural–urban differences in health outcomes, chronic illness, and patient satisfaction with healthcare services in Jamaica.

Specific Objectives

1. To examine differences in health outcomes between rural and urban populations in Jamaica.
2. To assess the prevalence and management of chronic non-communicable diseases among rural and urban populations.
3. To evaluate differences in patient satisfaction with healthcare services between rural and urban communities.
4. To identify the structural determinants—including poverty, education, healthcare accessibility, workforce distribution, transportation, and healthcare infrastructure—that contribute to rural–urban health inequalities.
5. To examine the applicability of the Social Determinants of Health framework in explaining rural–urban health disparities in Jamaica.
6. To identify policy and practice interventions that could reduce rural–urban health inequalities and improve equitable access to healthcare services in Jamaica.
7. To identify priorities for future research on rural health equity and healthcare delivery in Jamaica.

Research Questions

The study addressed the following research questions:

Primary Research Question

How do structural and socioeconomic inequalities contribute to rural–urban differences in health outcomes, chronic illness, and patient satisfaction with healthcare services in Jamaica?

Secondary Research Questions

1. What differences exist in health outcomes between rural and urban populations in Jamaica?
2. How does the burden and management of chronic non-communicable diseases differ between rural and urban communities?
3. How do levels of patient satisfaction with healthcare services differ between rural and urban populations?
4. Which structural determinants most strongly influence rural–urban health inequalities in Jamaica?
5. How does the Social Determinants of Health framework explain the observed rural–urban differences in health outcomes and healthcare experiences?
6. What policy and health system interventions are most likely to reduce rural–urban health inequalities in Jamaica?
7. What gaps remain in the existing literature, and what directions should future research take to improve understanding of rural–urban health disparities?

METHODS

This study employed a narrative literature review to synthesise existing evidence on rural–urban health inequalities in Jamaica. A narrative review was considered the most appropriate methodological approach because it permits the integration of evidence from diverse study designs, including quantitative investigations, qualitative research, policy documents, and government reports, thereby facilitating a comprehensive understanding of complex public health issues [1–5]. Unlike systematic reviews,

which primarily seek to answer narrowly defined research questions through statistical synthesis, narrative reviews are designed to examine multidimensional phenomena by integrating empirical findings with conceptual and policy perspectives [5,9]. Given that rural–urban health inequalities are influenced by interacting social, economic, geographical, and institutional determinants, a narrative review provided the flexibility required to examine these interrelated dimensions within the Jamaican context [2,5].

The review was guided by the following question: How do structural and socioeconomic inequalities contribute to rural–urban differences in health outcomes, chronic illness, and patient satisfaction within Jamaica? To address this question, literature was identified from peer-reviewed journal articles, government publications, national reports, and regional and international public health documents relevant to rural–urban health disparities [2–7]. Emphasis was placed on publications addressing healthcare access, health outcomes, chronic non-communicable diseases, healthcare utilisation, patient satisfaction, and the social determinants of health in Jamaica or comparable Caribbean settings [2–7]. International literature was included where it provided conceptual or comparative insights that enhanced understanding of the Jamaican experience [6,7].

Studies were eligible for inclusion if they addressed one or more of the three review domains: health outcomes, chronic disease burden, or patient satisfaction with healthcare services. Priority was given to studies undertaken in Jamaica, followed by research conducted within the wider Caribbean and other settings with comparable health system characteristics [2–7]. Preference was also given to publications derived from nationally representative surveys, official government reports, recognised international organisations, and peer-reviewed scientific journals because of their methodological rigour and policy relevance [2–5]. Seminal publications describing the Social Determinants of Health framework were included to provide the theoretical foundation for interpreting rural–urban health inequalities [5,9]. Publications lacking methodological transparency or demonstrating limited relevance to the review objectives were excluded from the synthesis [1,4].

Data extraction focused on evidence relating to health outcomes, chronic disease prevalence, healthcare accessibility, healthcare utilisation, service quality, and patient experiences among rural and urban populations [1–4,7]. Information was also extracted on structural determinants, including socioeconomic conditions, transportation, healthcare infrastructure, workforce distribution, and geographic accessibility, because these factors consistently influence health inequalities in Jamaica [2,5]. Comparative evidence from Caribbean and international literature was incorporated to identify similarities and differences in the structural drivers of rural–urban health disparities while maintaining the primary focus on Jamaica [6,7].

The evidence was synthesised using thematic analysis. Findings from the included literature were organised into recurring themes corresponding to the review objectives, namely health outcomes, chronic illness, and patient satisfaction with healthcare services [1,3]. Theme development combined inductive identification of recurrent patterns within the literature with deductive interpretation informed by the Social Determinants of Health framework [5,9]. This analytical strategy facilitated the integration of empirical evidence with established theoretical concepts while allowing comparisons across studies conducted in different contexts [2,5]. Areas of agreement, inconsistency, and evidence gaps were identified and interpreted to provide a balanced assessment of the current state of knowledge regarding rural–urban health inequalities in Jamaica [3,7].

As a narrative review, this study did not undertake formal meta-analysis or quantitative assessment of study quality. The findings should be interpreted as a conceptual synthesis of the existing evidence rather than estimates of pooled effect sizes or causal relationships [2,4]. Nevertheless, by integrating findings from peer-reviewed research, government publications, and authoritative regional reports, the review provides a comprehensive and contextually grounded understanding of the structural factors contributing to rural–urban health inequalities in Jamaica [2–7]. The resulting synthesis offers an evidence-informed foundation for future empirical research, health policy development, and strategies aimed at reducing inequities in healthcare access and health outcomes across rural and urban communities [5,9].

FINDINGS

Differential Health Outcomes

The literature consistently demonstrates that significant disparities exist in health outcomes between rural and urban populations in Jamaica, with rural residents experiencing poorer overall health, lower healthcare utilisation, and reduced access to timely medical care [1–4,7]. National evidence indicates that geographic location remains an important determinant of health status because access to healthcare infrastructure, specialist services, transportation, and socioeconomic resources differs considerably across regions [2–4]. Bourne [1], using nationally representative data from the Jamaica Survey of Living Conditions, reported that individuals residing in rural areas were significantly more likely to report fair or poor health than their urban counterparts, while urban residents were more likely to perceive their health as good or very good. These differences remained evident after considering variations in age, socioeconomic status, and healthcare-seeking behaviour, suggesting that place of residence independently contributes to health inequality [1]. Collectively, these findings demonstrate that health disparities in Jamaica reflect structural differences rather than merely individual behavioural characteristics [2,5].

Evidence from the Planning Institute of Jamaica and the Statistical Institute of Jamaica further indicates that healthcare utilisation differs according to geographic location [2,3]. Rural households consistently report greater difficulty accessing healthcare because of transportation costs, longer travel distances, fewer healthcare facilities, and reduced availability of specialised services [2–4]. Although Jamaica has expanded primary healthcare services through an extensive network of health centres and community clinics, specialist care remains concentrated in the Kingston Metropolitan Area and other urban centres, requiring many rural residents to travel considerable distances to obtain diagnostic investigations or specialist consultations [4,10]. The Ministry of Health and Wellness similarly reports that shortages of healthcare personnel and unequal distribution of services continue to disproportionately affect rural parishes, contributing to delays in diagnosis and treatment [4,10]. These structural barriers increase the likelihood that rural patients present with more advanced disease and experience poorer clinical outcomes than urban residents [3,4].

The burden of avoidable morbidity and premature mortality also demonstrates a clear rural–urban gradient. According to the Pan American Health Organization, non-communicable diseases account for more than four-fifths of all deaths in Jamaica, with hypertension, diabetes mellitus, cardiovascular disease, and stroke representing the leading causes of morbidity and mortality [7]. Although these conditions affect all geographic regions, disparities in healthcare accessibility, continuity of care, and preventive service utilisation contribute to poorer disease outcomes among rural populations [4,7]. National policy documents further identify delayed diagnosis, lower screening uptake, and interruptions in follow-up care as persistent challenges affecting rural communities [4,10]. Rural populations are more likely to experience preventable complications associated with chronic disease, reflecting inequities in healthcare delivery rather than differences in biological susceptibility [2,5].

The evidence further suggests that self-reported health status reflects these structural inequalities. Bourne [1] demonstrated that socioeconomic conditions, educational attainment, and healthcare accessibility were significant predictors of perceived health status among Jamaicans. Individuals with lower incomes, lower educational attainment, and residence in rural communities were considerably more likely to report poorer health than individuals living in urban areas [1]. Findings from the Jamaica Survey of Living Conditions similarly indicate that poverty remains disproportionately concentrated in rural communities, thereby limiting access to healthcare, transportation, nutritious food, and other resources essential for maintaining good health [2,3]. These cumulative disadvantages reinforce the health status gradient described within the Social Determinants of Health framework and provide empirical evidence that health inequalities are socially and geographically patterned rather than randomly distributed [5,9].

Table 1: Empirical Evidence of Rural–Urban Differences in Health Outcomes in Jamaica

Indicator	Rural populations	Urban populations	Source
Self-reported health status	Greater likelihood of reporting fair or poor health	Greater likelihood of reporting good or very good health	Bourne [1]
Access to specialist healthcare	Limited availability; longer travel distances to secondary and tertiary services	Greater availability of hospitals and specialist services	Ministry of Health and Wellness [4,10]
Healthcare utilisation	More barriers because of transportation costs, distance, and service availability	Greater utilisation because of improved accessibility	JSLC; PIOJ/STATIN [2,3]
Disease presentation	More delayed diagnosis and later presentation	Earlier diagnosis through improved access and screening	Ministry of Health and Wellness [4,10]
Preventable morbidity	Higher risk because of delayed access to healthcare	Lower risk associated with earlier intervention	PAHO [7]; Ministry of Health and Wellness [4]
Structural determinants	Higher poverty, lower educational attainment, weaker infrastructure	Better socioeconomic conditions and healthcare infrastructure	PIOJ/STATIN [2,3]; WHO [5]

Interpretation

The empirical literature consistently demonstrates that rural residents experience poorer health outcomes than urban residents because of structural inequalities affecting healthcare accessibility, socioeconomic opportunity, and service availability. While national health reforms have expanded primary healthcare coverage throughout Jamaica, substantial geographic inequities persist in the distribution of specialist services, healthcare personnel, and diagnostic facilities [4,10]. The evidence indicates that rural–urban differences in health outcomes are primarily explained by disparities in the social determinants of health rather than individual health behaviours alone [2,5]. These findings establish the first dimension of rural–urban health inequality and provide the foundation for understanding the higher burden of chronic disease and lower patient satisfaction observed among rural populations.

Higher Prevalence of Chronic Illness

The reviewed literature consistently demonstrates that chronic non-communicable diseases (NCDs) constitute the greatest burden of disease in Jamaica and disproportionately affect rural populations because of persistent inequalities in healthcare access, disease prevention, and continuity of care [4,7,8]. According to the Pan American Health Organization, non-communicable diseases account for approximately 80% of all deaths in Jamaica, with cardiovascular disease, diabetes mellitus, hypertension, malignant neoplasms, and chronic respiratory diseases representing the principal contributors to premature mortality [7]. Ferguson et al. [8] similarly identified hypertension and diabetes mellitus as major public health concerns, reporting that these conditions continue to increase despite improvements in healthcare delivery. Although these diseases occur throughout the country, evidence suggests that rural populations experience poorer disease control because they have reduced access to routine screening, specialist care, diagnostic investigations, and long-term disease management services [4,7,10].

National health policy documents indicate that hypertension remains one of the most common reasons for attendance at primary healthcare facilities throughout Jamaica, accounting for a substantial proportion of outpatient visits and chronic disease clinics [4,10]. Diabetes mellitus similarly represents a major contributor to morbidity and hospital admissions, particularly when diagnosis is delayed or treatment adherence is interrupted [7,8]. The Ministry of Health and Wellness has identified unequal geographic distribution of healthcare professionals, shortages of essential medicines, and limitations in laboratory and diagnostic services as continuing challenges affecting chronic disease management in rural communities [4,10]. Patients residing in rural parishes frequently experience delayed diagnosis, less frequent clinical monitoring, and poorer continuity of care than patients living in urban centres [4,10].

Evidence from the Jamaica Survey of Living Conditions also demonstrates that socioeconomic disadvantage contributes substantially to the unequal burden of chronic illness [2,3]. Rural households generally report lower household income, higher poverty levels, fewer educational opportunities, and more limited transportation options than urban households

[2,3]. These structural disadvantages reduce opportunities for preventive healthcare utilisation, routine medical follow-up, and adherence to prescribed treatment regimens [2,5]. The Social Determinants of Health framework provides an important explanation for the observed geographic disparities, emphasising that disease outcomes are shaped not only by biological factors but also by social, economic, and environmental conditions [5,9]. In Jamaica, these determinants collectively increase the vulnerability of rural populations to chronic illness and its complications [2,5].

Healthcare accessibility further influences disease progression and clinical outcomes. The Ministry of Health and Wellness reports that although primary healthcare clinics are widely distributed across Jamaica, specialist services, diagnostic imaging, and advanced laboratory investigations remain concentrated within urban hospitals [4,10]. Rural residents often require referral to regional hospitals for specialist assessment, increasing travel costs and delaying treatment [4]. The Pan American Health Organization similarly notes that disparities in service accessibility contribute to lower uptake of preventive screening programmes and less effective long-term management of hypertension, diabetes, and cardiovascular disease among underserved populations [7]. These structural barriers increase the likelihood of avoidable complications, including stroke, renal disease, peripheral vascular disease, and cardiovascular events, all of which contribute substantially to disability and premature mortality [7,8].

The available evidence also indicates that health literacy and continuity of care are important determinants of chronic disease management. Ferguson et al. [8] observed that successful control of hypertension and diabetes requires regular monitoring, adherence to prescribed medication, lifestyle modification, and continuous patient education. However, interruptions in medication availability, shortages of healthcare personnel, and inconsistent follow-up services disproportionately affect rural communities [4,8,10]. These factors reduce treatment adherence and increase the probability of uncontrolled disease, thereby widening rural–urban inequalities in health outcomes [2,5]. Collectively, the reviewed literature demonstrates that the greater burden of chronic illness observed among rural populations reflects structural inequities in healthcare delivery rather than intrinsic differences in disease susceptibility.

Table 2: Empirical Evidence of Rural–Urban Differences in Chronic Disease Burden in Jamaica

Indicator	Evidence for rural populations	Evidence for urban populations	Principal source
Burden of non-communicable diseases	Higher risk of poor disease control because of delayed diagnosis and limited continuity of care	Better opportunities for disease monitoring and specialist management	PAHO [7]; Ferguson et al. [8]
Hypertension management	Reduced access to routine monitoring and specialist services	Greater access to chronic disease clinics and specialist care	Ministry of Health and Wellness [4,10]
Diabetes management	Greater likelihood of delayed diagnosis and treatment interruptions	Earlier diagnosis and more consistent follow-up	Ferguson et al. [8]; PAHO [7]
Screening and preventive services	Lower utilisation because of distance, transportation costs, and healthcare accessibility	Higher utilisation because of better service availability	PIOJ/STATIN [2,3]; Ministry of Health [4]
Medication continuity	Greater vulnerability to interruptions resulting from geographic and resource limitations	More reliable continuity of pharmaceutical services	Ministry of Health [4,10]
Structural determinants	Higher poverty, lower educational attainment, weaker transport infrastructure, reduced healthcare accessibility.	Better socioeconomic conditions supporting chronic disease management	PIOJ/STATIN [2,3]; WHO [5]

Interpretation

The empirical evidence consistently demonstrates that chronic disease disparities between rural and urban Jamaica are primarily explained by inequalities in healthcare accessibility and the broader social determinants of health rather than differences in disease occurrence alone. Although hypertension, diabetes mellitus, and cardiovascular disease remain national public health priorities, rural populations experience greater difficulty obtaining preventive services, maintaining regular clinical follow-up, and accessing specialist care [4,7,8]. These structural barriers contribute to poorer disease control, higher complication rates, and increased healthcare utilisation for preventable conditions. The higher burden of chronic illness observed among rural populations reflects inequitable access to healthcare resources and reinforces the broader pattern of rural–urban health inequality identified throughout the literature [2,5].

Lower Patient Satisfaction with Healthcare Services

Patient satisfaction represents an important indicator of health system performance because it reflects patients' experiences with healthcare accessibility, service quality, responsiveness, and continuity of care. Across the reviewed literature, rural populations consistently report lower satisfaction with healthcare services than their urban counterparts, largely because of structural constraints affecting service delivery rather than differences in patient expectations [3,4,7,10]. Evidence from the Ministry of Health and Wellness indicates that while Jamaica has made substantial investments in strengthening primary healthcare services, considerable disparities remain in the distribution of healthcare professionals, diagnostic facilities, pharmaceutical services, and specialist care between rural and urban parishes [4,10]. These differences directly influence patients' perceptions of healthcare quality and their willingness to seek care promptly.

Healthcare accessibility remains one of the principal determinants of patient satisfaction. The Jamaica Survey of Living Conditions reports that households in rural communities continue to experience greater challenges accessing healthcare because of transportation costs, travel distances, and the limited availability of healthcare facilities compared with residents living in urban centres [2,3]. These barriers frequently delay healthcare utilisation, particularly for specialist consultations and diagnostic investigations that are concentrated in regional and tertiary hospitals [4,10]. As a consequence, rural patients often report greater inconvenience and higher indirect costs associated with obtaining healthcare services than urban residents [2,3]. These structural barriers reduce both the perceived accessibility and the overall acceptability of healthcare services among rural populations.

Service responsiveness also differs between rural and urban healthcare settings. According to the Ministry of Health and Wellness, shortages of physicians, nurses, pharmacists, and allied health professionals remain more pronounced in rural health facilities than in urban centres [4,10]. Workforce shortages increase patient waiting times, reduce consultation time, and limit opportunities for comprehensive patient education and follow-up care [4]. The unequal distribution of human resources also affects referral pathways, resulting in delayed access to specialist services and prolonged waiting periods for diagnostic procedures [10]. Collectively, these deficiencies reduce patient confidence in the health system and contribute to lower satisfaction with healthcare experiences among rural populations.

The availability of medicines and diagnostic services further influences patient satisfaction. National policy reports acknowledge that interruptions in pharmaceutical supplies and limitations in laboratory and diagnostic capacity continue to affect healthcare delivery, particularly within geographically isolated communities [4,10]. Patients requiring chronic disease monitoring frequently experience delays in obtaining laboratory investigations or specialist consultations because these services are concentrated in larger hospitals located in urban areas [4]. Such interruptions compromise continuity of care and increase the financial and logistical burden associated with managing chronic illnesses [7,8]. Urban residents, by comparison, generally benefit from greater availability of essential medicines, shorter referral pathways, and more comprehensive diagnostic services, thereby improving both treatment experiences and perceived quality of care [4,10].

The literature also demonstrates that patient satisfaction is strongly associated with broader social determinants of health. Individuals with lower income, limited educational attainment, and restricted transportation options are more

likely to encounter barriers to healthcare access and are consequently less satisfied with the services they receive [1–3,5]. These socioeconomic constraints disproportionately affect rural households, reinforcing disparities in healthcare utilisation and patient experiences [2,5]. The reviewed evidence suggests that differences in patient satisfaction are not solely attributable to healthcare delivery itself but also reflect wider structural inequalities affecting the ability to obtain timely, affordable, and appropriate healthcare [5,9].

Table 3: Empirical Evidence of Rural–Urban Differences in Patient Satisfaction and Health System Performance in Jamaica

Indicator	Rural populations	Urban populations	Principal source
Healthcare accessibility	Greater travel distances and transportation barriers to healthcare services	Better geographic access to healthcare facilities	JSLC [2,3]
Availability of specialist services	Limited access requiring referral to regional hospitals	Greater concentration of specialist services	Ministry of Health and Wellness [4,10]
Healthcare workforce	Lower availability of physicians, nurses, and allied health professionals	Higher concentration of healthcare personnel	Ministry of Health and Wellness [4,10]
Waiting time	Longer waiting periods because of workforce shortages and referral delays	Generally shorter waiting times	Ministry of Health and Wellness [4,10]
Diagnostic services	More limited access to laboratory and diagnostic investigations	Greater availability of diagnostic services	Ministry of Health and Wellness [4,10]
Pharmaceutical services	Greater likelihood of interruptions in medicine availability	More consistent pharmaceutical supply	Ministry of Health and Wellness [4,10]
Continuity of care	Greater interruptions in follow-up and chronic disease management	Better continuity of care through integrated services	PAHO [7]; Ministry of Health and Wellness [10]
Overall patient satisfaction	Lower because of structural barriers affecting service quality and accessibility.	Higher because of greater accessibility and responsiveness	JSLC [3]; PAHO [7]

Interpretation

The reviewed evidence consistently indicates that lower patient satisfaction among rural populations is principally explained by structural characteristics of the Jamaican healthcare system rather than by differences in patient expectations. Geographic isolation, shortages of healthcare personnel, unequal distribution of specialist services, prolonged waiting times, and interruptions in diagnostic and pharmaceutical services collectively reduce the quality and responsiveness of healthcare experienced by rural residents [4,10]. Although Jamaica has strengthened its primary healthcare system over recent decades, the literature demonstrates that substantial inequities remain in healthcare accessibility and service delivery between rural and urban communities [2–4,7]. Improving patient satisfaction will require policies that strengthen the rural health workforce, expand diagnostic capacity, improve medicine availability, reduce waiting times, and enhance continuity of care. These findings reinforce the broader conclusion that patient satisfaction is an important manifestation of structural rural–urban health inequality and should be considered a key indicator in future evaluations of health system equity [2,5].

Summary of Findings

The reviewed evidence demonstrates a consistent and empirically supported pattern of rural–urban health inequality across Jamaica. Findings from nationally representative surveys, government reports, peer-reviewed studies, and regional public health publications consistently indicate that rural populations experience poorer health outcomes, a greater burden of chronic non-communicable diseases, and lower satisfaction with healthcare services than urban populations [1–4,7,8,10]. These differences are observed across multiple indicators, including self-reported health status, healthcare accessibility, chronic disease management, healthcare utilisation, continuity of care, and patient experiences with the health system [1–4]. Although the magnitude of these disparities varies across studies, the

direction of the findings remains remarkably consistent, providing strong evidence that geographic location continues to influence health opportunities and healthcare experiences in Jamaica.

The empirical findings indicate that these disparities are closely associated with structural differences in the distribution of healthcare resources. Rural communities continue to experience longer travel distances to healthcare facilities, fewer healthcare professionals, reduced availability of specialist services, limitations in diagnostic capacity, and less reliable access to essential medicines than urban communities [4,10]. National surveys further demonstrate that rural households experience higher levels of poverty and socioeconomic disadvantage, conditions that reduce healthcare utilisation and increase barriers to obtaining preventive and curative healthcare services [2,3]. Individuals living in rural communities are more likely to delay seeking medical attention, present with more advanced disease, and experience poorer management of chronic illnesses than their urban counterparts [4,7,8]. These findings consistently support the existence of a measurable rural–urban health gradient within Jamaica.

The evidence also demonstrates that chronic non-communicable diseases represent the principal contributors to health inequality between rural and urban populations. Cardiovascular disease, hypertension, diabetes mellitus, and stroke remain the leading causes of morbidity and mortality nationally, yet effective prevention and long-term management depend heavily upon timely diagnosis, regular monitoring, medication adherence, and continuous healthcare access [7,8]. The reviewed studies indicate that these conditions are more difficult to manage within rural communities because healthcare accessibility, workforce availability, and continuity of care remain comparatively weaker than in urban centres [4,10]. Rural populations experience a disproportionate burden of preventable complications associated with chronic disease, further widening existing health inequalities [2,5].

Patient satisfaction emerged as an additional indicator of healthcare inequality. Across the reviewed literature, lower satisfaction among rural populations was consistently associated with prolonged waiting times, transportation difficulties, shortages of healthcare personnel, interruptions in pharmaceutical services, and limited access to diagnostic investigations and specialist care [2–4,10]. These findings suggest that patient satisfaction reflects not only perceptions of healthcare quality but also the cumulative effects of structural barriers that influence healthcare accessibility and service delivery. Urban residents generally reported more favourable healthcare experiences because they benefited from greater proximity to healthcare facilities, higher concentrations of healthcare professionals, and more comprehensive service availability [4,7,10].

Taken together, the empirical findings provide compelling evidence that rural–urban health inequalities in Jamaica are multidimensional and structurally determined. The convergence of findings across national surveys, policy reports, and peer-reviewed investigations indicates that the observed disparities cannot be attributed solely to individual health behaviours or biological factors [1–5]. Rather, they reflect persistent inequalities in socioeconomic conditions, healthcare infrastructure, workforce distribution, and service accessibility that systematically disadvantage rural populations. These findings provide strong empirical support for the Social Determinants of Health framework, demonstrating that health outcomes are fundamentally shaped by the social, economic, and environmental contexts in which individuals live [5,9]. Addressing these inequities will require coordinated multisectoral interventions that extend beyond healthcare delivery to include investments in education, transportation, rural infrastructure, poverty reduction, and equitable distribution of healthcare resources throughout Jamaica [2,4,5].

DISCUSSION

The findings of this narrative review demonstrate that rural–urban health inequalities in Jamaica are persistent, multidimensional, and fundamentally rooted in structural rather than individual determinants of health. Across the reviewed literature, rural populations consistently experienced poorer health outcomes, a greater burden of chronic non-communicable diseases, and lower satisfaction with healthcare services than their urban counterparts [1–5,7,10]. These disparities were consistently associated with inequalities in healthcare accessibility, socioeconomic status, transportation infrastructure, workforce distribution, and service availability rather than differences in individual

health behaviours alone. The convergence of evidence across nationally representative surveys, government reports, and peer-reviewed investigations provides strong support for the Social Determinants of Health framework, which argues that health is shaped by the conditions in which individuals are born, grow, live, work, and age [5,9]. Within the Jamaican context, these structural determinants continue to generate measurable inequalities in health opportunities that disproportionately disadvantage rural communities.

The present findings are consistent with broader international evidence demonstrating that geographic inequities in health reflect unequal distribution of social and economic resources rather than merely physical distance from healthcare facilities [11,15,19]. Rural communities in Jamaica experience higher levels of poverty, fewer employment opportunities, lower educational attainment, and more limited infrastructure than urban populations [2,3,22]. These disadvantages interact to reduce healthcare utilisation, delay diagnosis, interrupt continuity of care, and increase the burden of preventable illness [4,7,10]. The poorer health outcomes observed among rural populations should not be interpreted as isolated failures of the healthcare system but rather as manifestations of cumulative social and economic disadvantage that has developed over many decades [2,5]. Similar patterns have been documented internationally, suggesting that Jamaica's experience reflects broader challenges facing rural populations in both developed and developing health systems [11,15].

One of the most important findings emerging from this review is the central role of poverty as a determinant of rural health inequality. Recent findings from the Jamaica Survey of Living Conditions demonstrate that although poverty has declined nationally, important geographic disparities remain, with rural communities continuing to experience the highest levels of economic deprivation [22]. Poverty influences health through multiple pathways, including reduced access to nutritious food, transportation, stable employment, adequate housing, and healthcare services [5,20,21]. Financial constraints frequently delay healthcare utilisation, reduce adherence to prescribed treatment, and limit opportunities for preventive care, thereby increasing the likelihood of advanced disease presentation and avoidable complications [2,3]. The persistence of these socioeconomic inequalities indicates that improvements in healthcare delivery alone are unlikely to eliminate rural–urban disparities unless accompanied by broader social and economic reforms.

The findings also highlight the importance of healthcare infrastructure and workforce distribution in shaping health equity. Although Jamaica has made substantial investments in strengthening primary healthcare and expanding universal access to essential services, specialist healthcare facilities, advanced diagnostic services, and highly trained healthcare professionals remain concentrated within urban centres [4,10]. This unequal distribution creates significant barriers for rural residents, who frequently incur higher transportation costs, longer travel times, and greater opportunity costs when seeking healthcare [2–4]. These barriers are particularly important for individuals living with chronic illnesses such as hypertension, diabetes mellitus, and cardiovascular disease, conditions that require regular monitoring, timely investigations, and continuous access to medication [7,8]. The unequal distribution of healthcare resources contributes directly to poorer disease control and lower patient satisfaction among rural populations.

The findings further demonstrate that healthcare accessibility extends beyond physical proximity to healthcare facilities. Accessibility also encompasses affordability, acceptability, availability, continuity, and quality of care [4,10]. Rural residents often experience longer waiting times, fewer healthcare personnel, reduced availability of diagnostic investigations, and interruptions in pharmaceutical services, all of which negatively influence healthcare experiences and treatment outcomes [4,7,10]. These findings reinforce the principle that equitable healthcare requires more than geographic coverage; it also requires equitable distribution of healthcare resources, adequate workforce capacity, reliable supply chains, and effective referral systems capable of meeting the needs of underserved populations [2,4].

An important implication of the present review concerns mental health and psychiatric health equity. Although the literature reviewed focused primarily on physical health outcomes and chronic disease, the structural determinants identified are equally relevant to mental health. Poverty, unemployment, geographic isolation, transportation barriers, and limited healthcare accessibility are well-established risk factors for psychological distress, depression, anxiety, and

reduced mental well-being [5,9,23-25]. Individuals residing in rural communities who experience prolonged financial hardship, social isolation, and limited access to healthcare may also face greater barriers to obtaining timely mental healthcare, counselling services, or psychiatric treatment. The structural inequalities documented in this review are likely to influence both physical and mental health outcomes, reinforcing inequities across multiple dimensions of health. Expanding rural mental health services within primary healthcare settings, increasing access to community-based psychological support, and integrating mental health screening into chronic disease management programmes may represent important strategies for reducing rural–urban health inequalities in Jamaica while strengthening psychiatric health equity.

Taken together, the findings indicate that rural–urban health inequality in Jamaica should be understood because of interacting structural determinants operating across multiple sectors of society rather than deficiencies within the healthcare system alone. The persistence of disparities across health outcomes, chronic disease management, and patient satisfaction demonstrates that healthcare reform must be accompanied by coordinated investments in education, employment, transportation, rural infrastructure, poverty reduction, and social protection if meaningful improvements in health equity are to be achieved [2,4,5]. Such an integrated approach aligns with international evidence demonstrating that sustainable reductions in health inequality require multisectoral policies that address the underlying social determinants of health while simultaneously strengthening equitable access to high-quality healthcare services [5,9,11].

CONCLUSION

This narrative review provides compelling evidence that rural–urban health inequality remains a significant and persistent public health challenge in Jamaica. Across the reviewed literature, rural populations consistently experienced poorer self-reported health, greater barriers to healthcare utilisation, a higher burden of chronic non-communicable diseases, and lower satisfaction with healthcare services than their urban counterparts [1–4,7,8,10]. The evidence further demonstrated that these disparities are not simply consequences of geographic location but reflect longstanding structural inequalities in healthcare accessibility, workforce distribution, transportation, education, poverty, and healthcare infrastructure. Collectively, these findings provide strong empirical support for the Social Determinants of Health framework, highlighting that health outcomes are fundamentally shaped by broader social, economic, and environmental conditions rather than individual health behaviours alone [5,9].

The review contributes to the Jamaican health literature by synthesising evidence from nationally representative surveys, government reports, and peer-reviewed studies to demonstrate that rural–urban health inequalities extend beyond healthcare access to encompass chronic disease management, continuity of care, patient experiences, and overall health status. The consistency of findings across multiple sources strengthens the conclusion that structural disadvantage continues to influence opportunities for achieving good health among rural populations. Importantly, the review also demonstrates that inequities in healthcare access are closely linked to inequities in health outcomes, suggesting that improvements in service availability alone are unlikely to eliminate disparities unless accompanied by broader socioeconomic reforms [2–5].

The findings have important implications for health policy and clinical practice in Jamaica. Reducing rural–urban health inequalities will require sustained investment in strengthening primary healthcare services, expanding the rural healthcare workforce, improving transportation networks that facilitate access to healthcare facilities, increasing the availability of essential medicines and diagnostic services, and enhancing chronic disease screening and long-term disease management programmes within underserved communities [4,7,10]. Community-based health education initiatives strengthened health promotion programmes, and greater integration of preventive services into routine primary healthcare is also likely to improve early detection, treatment adherence, and patient engagement. Given the interrelationship between chronic physical illness and psychological well-being, integrating mental health screening, counselling services, and community-based psychosocial support into rural primary healthcare would further strengthen health equity while enhancing the responsiveness of Jamaica's healthcare system.

The review also identifies several priorities for future

research. Additional nationally representative studies are needed to quantify rural–urban differences in healthcare utilisation, patient satisfaction, chronic disease outcomes, and mental health status using standardised measures and longitudinal designs. Future investigations should also evaluate the effectiveness of interventions aimed at improving healthcare accessibility, workforce distribution, digital health technologies, and integrated primary healthcare delivery within rural communities. Such evidence will assist policymakers in identifying the most effective and cost-efficient strategies for reducing persistent health inequalities across Jamaica.

In conclusion, achieving equitable health outcomes in Jamaica will require coordinated multisectoral action that extends beyond the healthcare sector to address the wider social determinants of health. Policies that simultaneously strengthen healthcare infrastructure, improve workforce distribution, reduce poverty, expand educational opportunities, enhance transportation systems, and improve access to preventive and mental healthcare services will be essential for narrowing the rural–urban health gap. By providing a comprehensive synthesis of the available evidence, this review contributes to a growing understanding of health inequalities in Jamaica and offers an evidence-informed foundation for future research, policy development, and practice aimed at promoting equitable health and well-being for all Jamaicans [2,4,5,9].

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