

Collaborative care in rural health: receiving specialist expertise under constraint



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Rural health systems operate under persistent constraints related to geography, workforce scale, and service redundancy. As a response, collaboration between family physicians and specialists is best understood not only as a discrete intervention but also as an organizing principle for rural health system design. Evidence from collaborative care models, continuity-of-care research, and specialist access initiatives, such as provider-to-provider consultation systems, is relevant to rural contexts. The literature suggests that structured collaboration can strengthen primary care capacity, support continuity, and extend specialist expertise beyond episodic referral-based models. Although collaborative care does not eliminate broader workforce or infrastructure challenges, it offers a coherent organizational approach to delivering specialist-informed care under conditions of enduring scarcity.

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Rural health care systems operate under conditions of persistent constraint. Geographic distance, limited redundancy, and small clinical teams are enduring features rather than transient failures. Leadership in rural health care is, therefore, increasingly concerned not with eliminating scarcity, but with designing care models that function reliably in the face of it. In this context, collaboration between family physicians and specialists, a model called “collaborative care,” has been repeatedly proposed as a

means to improve access and quality of care. The literature suggests that collaborative care is best understood not only as a discrete intervention, but also as an organizing principle for rural health care systems.

Conventional specialist care models have evolved largely in urban environments. These models assume physical co-location, high patient volumes, and ready access to alternative services when disruptions occur. In rural settings, referral of responsibility to distant specialists often results in their episodic involvement without sustained integration into local care pathways. Although such arrangements may provide access to specific procedures or assessments, they are less well suited to supporting continuity, shared clinical reasoning, or longitudinal management in low-density settings.

Collaborative care represents a different organizational logic. In collaborative models, family physicians retain longitudinal responsibility for patients, while specialists provide structured, ongoing input through consultation, co-management, or advisory roles. The emphasis is not on transferring care, but on distributing expertise. This distinction has practical implications in rural contexts, where most care is delivered in primary care settings and specialist presence is intermittent.

Examples and models of collaborative care

Evidence supporting collaborative care is well established in clinical areas that are highly relevant to rural practice. A Cochrane systematic review of collaborative care for depression and anxiety demonstrated improved clinical outcomes compared with usual care across a range of settings and delivery formats.¹ The review showed that structured collaboration can improve management when specialist availability is limited. For rural systems, the importance of this finding lies in the mechanism: sustained specialist input enhances primary care capacity without requiring continuous on-site specialist presence.

Continuity of care provides a complementary lens through which to view the value of collaboration. A systematic review examining continuity of care and mortality found a consistent association between higher continuity with doctors and lower mortality, while acknowledging the observational nature of the evidence.² Rural patients are structurally exposed to discontinuity through travel distance, limited provider choice, and fragmented service pathways. Care models that repeatedly shift responsibility away from primary care risk undermining a factor that appears to be protective.



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Collaborative care aligns with continuity by reinforcing the central role of the family physician while extending access to specialist expertise.

Provider-to-provider consultation systems offer a practical example of how collaborative care can be operationalized. A systematic review of asynchronous electronic consultation services found that such systems improve access to specialist advice and may reduce unnecessary face-to-face referrals.³ Canadian experience has shown that primary care clinicians are used to e-consultation for specialist advice,⁴ although there are concerns that this will create expectations that they should provide care previously offered by specialists.⁴

These findings support a measured conclusion: structured access to specialist advice can strengthen primary care decision-making. They do not suggest that technology alone constitutes a care model, nor that virtual consultation replaces the need for clear clinical accountability on the specialist's side. Australian research has evaluated structured specialist access initiatives designed to reduce dependence on conventional outpatient pathways. For example in Queensland, a pilot program enabled general practitioners in urban and rural/remote practices to send asynchronous requests for specialist advice to general physicians) with responses typically provided within 72 hours.⁵ Notably, only about 13% of cases required a subsequent face-to-face appointment, indicating that specialist guidance can be delivered effectively without conventional referral pathways. This work shows that formalized GP-to-specialist asynchronous consultation, delivered securely and responsively, has the potential to improve access to specialist support for patients managed in primary care and may reduce the need for subsequent in-person specialist visits in underserved areas.

Implications of collaborative care for rural health care systems

Across these bodies of evidence, a consistent pattern emerges. Collaborative care is most effective when it is treated as system design rather than professional goodwill. Informal or personality-dependent collaboration remains fragile. Where expectations, scopes of co-management, and lines of responsibility are explicit, collaboration becomes more durable. This observation reflects an organizational rather than a clinical insight.

Several implications for rural health system design follow from this synthesis. First, collaborative arrangements benefit from clarity regarding which

conditions are managed in primary care with specialist support, which require shared care, and which necessitate transfer. Ambiguity in these areas is associated with defensive referral patterns and inefficient use of specialist capacity.

Second, incentive structures influence the sustainability of collaboration. Models that remunerate only face-to-face encounters implicitly devalue advisory and co-management roles. Where collaboration is expected but unsupported, it is experienced as additional workload rather than as an integral component of care delivery. Appropriately remunerating electronic and indirect consultations will lead to greater uptake.

Third, longitudinal collaborative relationships are more effective than one-off consultations. Ongoing relationships allow for shared understanding of local context, available resources, and acceptable risk, all of which are particularly salient in rural practice. At times, the use of telephone rather than e-consultations may result in better development of the relationship between the primary care provider and the specialist.

Finally, virtual collaboration should be considered enabling infrastructure rather than experimental innovation. The evidence base for provider-to-provider consultation systems is now sufficiently mature to support broader implementation, provided these systems are embedded within clear governance and accountability frameworks.

Limitations

This article draws on a selective body of literature rather than a systematic review, and much of the empirical evidence for collaborative care originates from specific clinical domains (notably mental health) and from health care systems with particular funding and governance arrangements.

Evidence on specialist access models primarily reports process and utilization outcomes rather than long-term patient outcomes, and rural-specific evaluations remain limited. Consequently, although the synthesis supports collaborative care as a coherent organizational approach, its transferability across all rural contexts and specialties should be viewed with appropriate caution.

Conclusion

Collaborative care does not eliminate the need for in-person specialist services, nor does it resolve broader challenges related to workforce distribution or infrastructure investment. It does provide a more coherent



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way of organizing care under conditions of permanent constraint. By strengthening primary care, supporting continuity, and extending specialist expertise beyond episodic encounters, collaborative care offers a viable organizational response to the realities of rural health systems. Taken together, the available evidence supports a shift in how specialist–primary care relationships are conceptualized in rural settings. Rather than viewing collaboration as an adjunct to conventional referral models, it may be more productive to view it as a foundational element of rural care design. This framing has implications for leadership, funding, and service organization, and provides a basis for further discussion about how rural health care systems can more deliberately organize expertise to meet population needs.

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