Why remote-care programmes succeed or fail on the unglamorous parts — and a short diagnostic for getting them right. *A digital-health and access-expansion brief.*

Telehealth is sold as a way to reach the unreached. Sometimes it does. Often it just gives the already-served another convenient channel while the unreached stay exactly where they were. The difference is rarely the technology. It is the design choices around it. This brief is a short diagnostic for programme leads and funders.

The promise and the trap

Remote care can genuinely extend a health system's reach — to rural areas, underserved populations, and people who can't take a day off to travel to a clinic. But a remote-care programme optimised for ease of launch will reach the people who are easiest to reach. Closing the access gap is a design intention you have to hold against the path of least resistance.

Six questions that decide whether remote care expands access

1. **Connectivity reality** — does it work on the networks and devices your target population actually has, or only on good ones? 2. **The first and last mile** — who helps the patient get on the call, and who acts on the outcome? Remote consultation without a local follow-through pathway raises expectations it can't meet. 3. **Trust** — will the population trust care delivered this way? Trust is built through familiar intermediaries (community health workers), not app stores. 4. **Workforce** — are clinicians trained and resourced for remote delivery, or is it bolted onto an already-stretched day? 5. **Financing** — who pays per encounter, and does the model survive after the pilot grant? *Enrolment that spikes on free pilots and collapses on launch is a warning, not a win.* 6. **Data & safety** — where does sensitive health data go, and is the remote pathway as safe as the in-person one it replaces?

The enrolment lesson

Programmes that expand coverage durably tend to share a pattern: they pair the remote channel with a **human on-ramp** (a community worker, an enrolment advisor), embed it in an **existing financing or insurance mechanism**, and measure **who** enrolled — not just how many. A 20% enrolment lift means little if it came entirely from the already-connected.

A design heuristic

> Design for the patient at the edge of the network — low bandwidth, low trust, > no advocate in the room. A remote-care model that works for her extends access. > One that works only for the connected just adds a channel.

How this was built. This brief reflects directing health quality-certification and access-expansion programmes — including remote-care and insurance-enrolment initiatives and managed-care coordination — in systems where the gap between technology and the underserved is the entire problem. It is a strategic brief, not clinical or investment advice.