Rural Health and Healthcare:  
a North West perspective

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## Contents

**Figures, tables, case studies**

<table>
<thead>
<tr>
<th>Topic</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Foreword</td>
<td>1</td>
</tr>
<tr>
<td>Report structure</td>
<td>2</td>
</tr>
</tbody>
</table>

**Chapter 1**  
**Rurality and the North West**  

<table>
<thead>
<tr>
<th>Sub-Topic</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Defining rurality</td>
<td>3</td>
</tr>
<tr>
<td>Administrative geography of the North West</td>
<td>3</td>
</tr>
<tr>
<td>Rurality in the North West</td>
<td>5</td>
</tr>
</tbody>
</table>

**Chapter 2**  
**Social and health issues of living in the countryside**  

<table>
<thead>
<tr>
<th>Sub-Topic</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access to local rural shops and services</td>
<td>10</td>
</tr>
<tr>
<td>Access to rural healthcare services</td>
<td>11</td>
</tr>
<tr>
<td>Access to rural public and private transport</td>
<td>15</td>
</tr>
<tr>
<td>Access to housing</td>
<td>16</td>
</tr>
<tr>
<td>The rural economy</td>
<td>16</td>
</tr>
<tr>
<td>Telecommunications infrastructure</td>
<td>17</td>
</tr>
<tr>
<td>Educational opportunities</td>
<td>17</td>
</tr>
<tr>
<td>Hidden rural deprivation and need</td>
<td>18</td>
</tr>
<tr>
<td>Rural community strengths; the expression of rural views</td>
<td>18</td>
</tr>
</tbody>
</table>

**Chapter 3**  
**Impact of rurality on health and healthcare services**  

<table>
<thead>
<tr>
<th>Sub-Topic</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>General levels of health amongst rural populations</td>
<td>21</td>
</tr>
<tr>
<td>The health of rural populations – open to challenge</td>
<td>22</td>
</tr>
<tr>
<td>a. The effect of rurality on the uptake of healthcare services</td>
<td>23</td>
</tr>
<tr>
<td>b. The effect of rurality on health outcomes</td>
<td>25</td>
</tr>
<tr>
<td>Nationally recognised rural health issues</td>
<td>27</td>
</tr>
<tr>
<td>Specific diseases and illnesses found mainly in rural areas</td>
<td>28</td>
</tr>
<tr>
<td>Primary care – differences in rural service provision and workload</td>
<td>28</td>
</tr>
<tr>
<td>Trauma services – differences in rural access to treatment</td>
<td>30</td>
</tr>
<tr>
<td>Secondary care – differences in rural access and services</td>
<td>30</td>
</tr>
<tr>
<td>Patients with specific needs</td>
<td>31</td>
</tr>
</tbody>
</table>

**Chapter 4**  
**National rural health policy and rural policy**  

<table>
<thead>
<tr>
<th>Sub-Topic</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Rural proofing</td>
<td>32</td>
</tr>
<tr>
<td>B. National health policy framework</td>
<td>33</td>
</tr>
<tr>
<td>Tackling inequalities in health</td>
<td>33</td>
</tr>
<tr>
<td>National policy on healthcare reform and modernisation</td>
<td>35</td>
</tr>
<tr>
<td>Historic centralisation of NHS services vs. keeping the NHS local</td>
<td>36</td>
</tr>
</tbody>
</table>
C. Rural Social Services 37
D. National rural policy 37

The 2000 Rural White Paper 37
Additional rural stakeholders 38
Multi agency programmes with a rural dimension 39

E. Funding rural health, social care and public sector services 40

Chapter 5 Local rural health, healthcare and social initiatives 43

Improving access to rural healthcare and other local services 43
Bringing primary care and other services to the community 43
Bringing the community to secondary care services 44
Community-led rural infrastructure initiatives 46
Development of existing community based secondary care services 48
Joint service provision 50
Emergency service responses 50
Rural ICT and telemedicine developments 52
Supporting the needs of GPs and primary care teams 53
Voluntary agency rural health initiatives 54

Chapter 6 Availability of information to assess rural deprivation, health and health needs 56

Poor availability of data on rural health need 56
Local level health profiles 57
Measuring rural deprivation 58
a. Deprivation indices 58
b. Alternative measures offering ‘bundles of disadvantage’ 59
Measuring rural service accessibility and local differences in health using Geographical Information Systems (GIS) 63

Chapter 7 Organisations providing further advice and information on rural health and social issues 65

A. Statutory health agencies 65
B. North West organisations with a health remit 66
C. Organisations with a specific rural interest 67
D. Government departments with a rural interest, remit or data 67
E. Other research and voluntary organisations with a health focus 69

References and reading list 72
Figures

Figure 1  2003 Local Authority and NHS Primary Care Trust boundaries in North West England  4
Figure 2 i&ii Rural local authorities and local authority classifications  6
Figure 3 Rural wards within the North West  8
Figure 4 North West region ward populations  9
Figure 5 i&ii Percentage households living 4+km from a primary school, by ward
Percentage households living 4+km from a supermarket, by ward  12
Figure 6 Percentage households living 4+km from a GP practice, by ward  14
Figure 7 i&ii Indices of deprivation 2000 health domain
Indices of deprivation 2000 access to services domain  19
Figure 8 i&ii Life expectancy (male) and life expectancy (female)  21
Figure 9 Percentage of low birth weight babies  22
Figure 10 i&ii Mortality from motor vehicle accidents. Mortality from suicides  27
Figure 11 Index of Multiple Deprivation 2000 overall deprivation scores for North West wards  60

Tables

Table 1 Example studies on the effect of access on the uptake of healthcare services by rural populations in the UK  24
Table 2 Example studies on how accessibility affects the health of rural populations, and on the relative health of rural populations in the UK  26
Table 3 Eight suggested bundles of rural disadvantage  62

Case studies

Case study 1 The Morecambe Bay PCT ‘Farmers Health Project’  44
Case study 2 Rural transport partnerships  45
Case study 3 West Cumbria Food Co-operative scheme  46
Case study 4 The Cumbria ‘Northern Fells Rural Project’ initiatives  47
Case study 5 Service reconfiguration and modernisation in Kendal  49
Case study 6 North West ‘Community First Responder’ schemes  52
Case study 7 Rural stress initiatives in Cumbria  54
Foreword

The romantic image of the ‘rural idyll’, through a ‘better’ or alternative life spent within the countryside, is popular. It has been generally assumed that living in the countryside is good for your health and well-being. Once traditional rural communities are increasingly being joined by long-distance commuters, more affluent retired people, holiday-home owners and tourists.

In reality, a range of complex issues face those living and working in the countryside. The availability, choice and range of services found within rural areas are often very different to those available in urban towns and cities. Rural communities may face the closure of their village shop, the local pub, post office and primary school. They may not have a doctors’ surgery or pharmacy nearby. Hospital treatment may involve long journeys and emergency care may take time. The range of available jobs and training opportunities are far fewer in the countryside. Housing is often prohibitively expensive and the cost of living may well be higher. In many respects, the contrast between living and working in rural Cumbria and central Manchester, for example, is striking.

Do such sharp differences and inequalities in access to healthcare and other services, their relative availability and range of facilities, have a detrimental effect on the lifestyle, opportunities, and in particular the health of rural communities? Health research has tended to focus on urban environments, where higher levels of deprivation, poor health, social need and inequity may occur. However, rural communities often find the affluent and poor living close by each other. Rural poverty, social exclusion, and levels of ill health and need amongst particular groups (for example, the growing numbers of older people, families with young children and the younger unemployed) are often hidden. Research is required to better understand and help target resources within rural communities.

Locally responsive rural service and access initiatives, involving both partnership work and community ownership, have been shown to be highly successful. The North West has witnessed numerous innovative primary care, secondary care and community led healthcare initiatives.

Rural issues, need, health and healthcare cover a very broad spectrum. This Public Health Information Report, one in a series commissioned by the North West Public Health Observatory, seeks to introduce the range of health, healthcare and social issues facing rural communities within the North West of England (and elsewhere) to a wide audience. It highlights successful rural healthcare innovation, and is designed to appeal to healthcare professionals working within the North West, as well as to teams in partner agencies, academics, students, and to rural communities themselves.
Report structure

The report introduces the concept of rurality in chapter one and describes the administrative and rural geography of the North West. The broad and challenging range of social and health issues facing rural communities nationally is described in chapter two. Such issues include discussion of access to shops and services, healthcare, rural transport, housing issues, the rural economy and educational opportunities. Particular groups, such as older people, the poor and families with young children, face particular problems in accessing services.

On average, residents of more affluent rural areas live longer and lead healthier lives than many of their urban counterparts. Chapter three examines the literature on rural health and healthcare and details how perceived low levels of rural poor health and need are open to challenge. Healthcare may not be readily available or accessible in rural areas and certain groups may either not use health services or will present for treatment at a later stage of illness. The differing workload of rural primary care teams is discussed, along with issues facing rural secondary care. The countryside can be a dangerous place; access to emergency medical treatment is therefore discussed.

Chapter four examines national rural health and rural policy and introduces recent initiatives. ‘Rural proofing’ aims to ensure that rural needs are taken into account when planning services. The tackling of health inequalities is equally applicable to deprived rural populations, yet national plans for health service modernisation and development do not typically consider rural health to require a separate agenda. Is it indeed possible to target resources fairly in rural areas, where deprivation and need are both scattered and hidden? Rural stakeholders and the varied multi agency programmes with a rural dimension are detailed, highlighting how many government and public sector policies impact on health and social issues. The contentious issue of equitable funding of rural services is covered in depth.

Chapter five presents numerous examples of innovative rural healthcare projects, good practice, models of primary and secondary healthcare service delivery, transport schemes and community-led project initiatives. A number of current North West initiatives are detailed. Innovations in technology, support for rural healthcare practitioners, partnership work between agencies and community ownership of projects are discussed. Community-based secondary and emergency care developments present community hospitals with a key role.

Datasets and information that can help inform rural health policy and determine service need are discussed in chapter six, along with the issues faced in trying to determine levels of rural deprivation and ill health. Alternative indicators of deprivation and disadvantage are considered, along with the potential use of geographical information and computer mapping for analysis.

National and regional organisations that can provide further advice and support on rural health and social issues and projects are listed in chapter seven. A comprehensive reference and reading list covering the broad range of rural health and healthcare issues raised concludes the report.
Chapter 1: Rurality and the North West

Defining rurality

What does the term ‘rural’ mean? Whilst dictionaries suggest ‘countryside’, and ‘the opposite of urban’, there is no unambiguous definition of rurality (Moseley, 1979). This uncertainty has resulted in considerable debate (Rousseau, 1995), and numerous issues have arisen where research has sought to measure differences between urban and rural health (Watt et al, 1994). Rural areas are in essence themselves highly diverse and can change over time. In general terms, contrasts have been made between a range of geographies, including urban, suburban and urban fringe areas, rural and remote rural areas, island communities and peripherality (remote rural areas with distinct geographical barriers). In reaching a definition on rurality, researchers have considered a wide range of measures each with their own advantages and rationale (Asthana et al, 2002b). These have including defining rural areas based on:

- population density or sparsity
- measures of settlement size
- remoteness from urban areas, and peripherality
- access to services, and ‘distance to nearest neighbours’ measurements
- land use and main employment groups
- economically active populations
- socio-economic characteristics of area
- local perceptions of whether home is rural or not.
- more complex measures combining multiple elements into one index.

However, it is difficult to introduce cut-off points that conveniently fit rural populations into one group or another. It is argued than ‘an all-embracing definition of the rural is neither desirable nor feasible’ (Halfacree, 1993); an appropriate definition should be used for specific projects.

Administrative geography of the North West

The North West NHS region is comprised of the counties of Cumbria, Lancashire, Greater Manchester, Merseyside and Cheshire¹, and includes a range of urban and rural economies and geographies. Health Service reorganisations through the 1990s, such as Health Authority (HA) mergers, the demise of Regional HAs and the transition from HAs to Primary Care Trusts (PCTs) have brought about numerous changes to the administrative geography in the region. The maps in Figure 1 highlight the current 2003 North West local government and NHS PCT boundaries. Health and local government boundaries may well not be coterminous. This can result in complexity for joint working and understanding, for example, where a PCT has to work with more than one Social Services Department (as in Morecambe Bay), or, in the analysis of rural area health data sets (as with Eden Valley PCT, encompassing parts of three local authorities).

¹ Glossop in Derbyshire (part of High Peak), is additionally within the NHS NW region.
Figure 1: 2003 Local Authority & NHS Primary Care Trust boundaries in North West England

PCTs

1. North Manchester
2. Central Manchester
3. South Manchester
4. North Liverpool
5. Central Liverpool
6. South Liverpool
7. Salford and Walsall
8. Bolton & Wigan
9. Blackburn & Darwen
10. Trafford North
11. Trafford South
12. Ashton, Leigh & Wigan
13. Heywood & Middleton
14. Hyndburn & Ribble Valley
15. Burnley, Pendle & Rossendale

Local Authorities
Rurality in the North West

Whilst the urban conurbations of Greater Manchester and Merseyside dominate the North West economically, and have been key to industrial development, county towns in Cheshire, Lancashire and Cumbria, as well as far smaller rural villages and dispersed hamlets, all add to the region’s character and diversity.

The North West has three distinct rural area typologies, which can be classified as follows (DEFRA, 2000):

- Cumbria, Northern Lancashire and the Pennine uplands, to the north of the region, are predominantly rural, sparsely populated, and contain many outstanding areas of countryside, including the Lake District National Park, Morecambe Bay and part of the Yorkshire Dales.
- Rural Cheshire, to the South, and West Lancashire, present a rich agricultural landscape, which is more accessible, and affluent.
- Urban fringes around Merseyside and Greater Manchester contain significant areas of derelict or degraded land.

The region is fringed by the Pennines to the East, the Irish Sea to the West and the Scottish borders to the North. Much of Cumbria, along with the North Pennines, share similar issues of geographical remoteness and lack of service accessibility to other peripheral areas within England, such as Cornwall, Northumbria and East Anglia. In many ways these areas are similar to much of Scotland, where healthcare is organised with a greater emphasis on rural need.

The Countryside Agency has recognised the diversity, distinctiveness and local nature of England’s landscape through its ‘Countryside Character’ assessment and national map coverage. The North West has been defined by 29 distinct key character areas, which range, for example, from the West Cumbria Coastal Plain, to the Lancashire Valleys, to the Sefton Coast. Each area identifies and describes key local characteristics, landscape, settlement, historical and cultural influences (CC, 1998). These character assessments aim to provide a framework to help shape local and regional policy.

The Government is recommending that policy makers focus on recently defined ‘administrative area’ and ‘urban settlement’ classifications (ODPM, 2002). Based on 2002 Countryside Agency classifications, (produced in conjunction with Oxford University), Figure 2(i) classifies rural local authorities in the North West. However, anomalies do occur using such systems. For example, whilst Carlisle is not classed as rural, most of the district is in reality highly rural. The city population provides a skewed urban classification.

There have been a number of alternative historical classifications of land type and administrative similarity. Figure 2(ii) shows the ONS classification of Local Authorities, as incorporated within the National Compendium of Clinical Indicators (the ‘Public Health Common Data Set’, DoH, 2001b). Cumbria alone is defined using 6 different area classifications. Former West Cumbria coastal mining villages and deprived industrial communities present a strikingly different picture to the popular image of Cumbria as a beautiful county of lakes and mountains.
Whilst a majority of North West residents live within close proximity to the urban centres of Liverpool, Manchester and their neighbouring cities and towns, vast areas of the Region are predominantly rural in nature. 73% of electoral wards in Cumbria are rural, 72% in Cheshire, and 56% in Lancashire; in contrast 1% of Greater Manchester and 4% of Mersey wards are classed as rural (CA, 2000d).

A more local view of rurality removes larger boundary area anomalies. Figure 3 presents the rural geography of the North West at ward level (CA, 2001a). Whilst such classifications provide a basic definition of whether an area is considered rural or not, a wide variety and diversity of countryside is grouped under the one ‘rural ward’ heading. The current Countryside Agency rural ward data makes no differentiation between rural and remote rural areas – there is no ranking of relative levels of rurality (see Cloke, 1977). However, in late 2003, the Office for National Statistics consulted stakeholders over a standard definition of urban and rural areas, which would classify census output areas (a smaller geographical area than ward) into several proposed rural categories, for example, remote rural, and urban fringe (ONS, 2003).

Nationally, using Countryside Agency classifications, some 28% of the population of England (14 million) live in rural wards. Of the 6.73 million living within the North West in 2001, half a million live within villages of less than 3,000 residents. Some 125,000 households in Cumbria live in rural wards, along with 175,000 in Cheshire and 225,000 in Lancashire (CA, 2001e). However, whilst 17.7% of the North West’s population lived in rural districts in 2000, the region still has the second lowest proportion of rural residents of any region in England. Indeed, the North West ‘standard region’ is amongst the most densely populated in Europe, with a variety of economic, social and cultural influences and issues (Flynn and Knight, 1998). Figure 4 shows the region’s ward level population distribution. The major conurbations dominate, with rural wards to the North and South of the region having far smaller ward populations.

Proportionally fewer younger and middle-aged people live in rural areas. Rural areas of the North West are experiencing a rapidly ageing population, with the highest rate of change in the number of older residents occurring in Cumbria and Cheshire (Flowerdew, 2000; Rousseau and McColl, 1997). An ageing population has implications both for the size and range of rural health and social care services required by older residents in future years, as well as on staffing level demands, and the potential for older people to themselves be a beneficial resource in the workplace. Additionally, the in-migration of retired couples, and the outward flow of young people reduces the influence of the ‘extended family’, who could be relied upon in times of need.

The diversity of landscapes, countryside, economic opportunities and infrastructure within the region, offer extreme contrasts, resulting in wide differences between the varied lifestyles and day-to-day experiences of its population. For example, Eden Valley in Cumbria has the lowest population density in England, with 0.23 residents per hectare. In contrast, Blackpool has the highest density within the region with 40.75 residents per hectare (derived from 2001 census). A remote hill farm and cramped town centre bed-sit offer many contrasts in daily life and health experience.
Figure 3: Rural wards within the North West

Figure 4: North West Region ward populations

Source: NHSE NW mid 1999 population estimates for the former Region (SAD data), 2002 North Cumbria estimates from PCT data. Analysis on 1991 census ward boundaries.
Chapter 2: Social and health issues of living in the countryside

A common and somewhat clichéd image of life in the countryside is one of a ‘rural idyll’, with rural areas offering a different pace of life, beautiful countryside, space to breathe, and fewer stresses. The North West itself has a part to play in the way the countryside is often perceived, with William Wordsworth and the Lakes poets in particular first promoting the ‘picturesque movement’ view of life away from industry and cities during the 18th century (Bate, 2002). In a 1999 survey of both rural and urban residents, 91% of respondents felt that living in the countryside offered a healthier environment to live in, 72% a better place to bring up children, 65% more community spirit, 60% less crime and 33% better schools (National Centre for Social Research 2000, cited in Countryside Agency, 2002b).

In reality, a wide range of issues face those living in rural areas. The closure of local village schools, public houses and sub post offices are emotive local issues. A lack of affordable housing, jobs, training opportunities, and limited public transport services create problems for some who live and work in the countryside (CA, 2002c, 2002b, 2001d, 2000b, 2000c). Sources of information, advice and counselling may not be available locally. Social facilities may be inadequate, along with services for particular groups, such as the disabled and their carers (Mason and Taylor, 1990). Whilst there are wide regional variations, rural areas essentially have fewer services available; those that are offered are likely to be provided at a more basic level. Costs in providing rural services are higher, market forces dictating those offered. Socio-economic, cultural and political influences all play a role in determining local provision.

Marginalisation, or social exclusion – hardship from low incomes, isolation, the lack of a secure home, difficulties reaching essential healthcare and services, powerlessness and the breakdown of social networks – may exist for groups of rural residents, either as a hidden or visible issue (Mullins et al, 2001; CA, 2000a), however beautiful and peaceful the surrounding countryside. A succession of studies have thus questioned the wisdom of viewing the countryside as a rural idyll (Simmons, 1997; Cloke et al, 1997; Woodward, 1996; McLaughlin, 1986). High levels of rural poverty have clear health implications; however, the notion that rural ‘advantages’ make rural areas healthier to live in is still widespread (Clark, 1997).

Access to local rural shops and services

Rural services have been in steady decline over many years. Despite outcries and local press reports on the closure of a village store, post office, or rural police station, ‘change in the countryside is more evolutionary than sudden’ (CA, 2002b). A lack of economies of scale, and poor (if any) profit margins have led to the closures of village general stores and local food shops, rural schools, pubs, post offices, shops and rural bus services. Shops that are available may offer a more basic level of service and a far smaller range of items than their urban rivals. For example, a rural village may have a village store, SPAR or Co-Op, in
comparison to the far wider and potentially healthier range of food found in out-of-town urban supermarkets. Alternatively, the village shop may have multiple roles; if it closes, several services may be lost to villagers. The cost of essential goods is often higher in small local stores than in large chain supermarkets. Fuel costs will be higher too.

Thus, people living in rural and remote rural areas are faced with poorer access to a range of core services than are urban area residents. For example, 70.9% of North West parishes have no general store; 68.8% have no small village shop (CA, 2001e). Issues of poor access may reflect geographical isolation, lack of local provision, or both. Accessibility can be a reflection of whether public transport is available, the frequency and routing of bus and other services, whether linked transport services are available, the ability to own a car, or of the range and quality of local roads.

Geographical access to a service can be measured by the distance or time it takes to travel from home to a ‘service’ along a road network. Using private transport, the time taken will be affected by the available road network, speed limits, road conditions and by the time of day. Travelling by public transport may involve long waits and several buses. Natural features such as rivers, estuaries, hills and winding small rural road networks can appreciably add to travel times and distance. Peripheral communities, living on islands, remote peninsulas, or distant valleys or moors are even more isolated, particularly during winter conditions.

The two maps in Figure 5 highlight accessibility to primary schools and supermarkets within the North West. The thematic shading indicates the proportion of households living over 4 km (approx 2.5 miles) from a service. Access to primary schools is better than it is to supermarkets, reflecting the different emphasis of market forces and the need for essential local services. Whilst Cumbria is worst served by primary school provision, Cheshire, North Lancashire and Cumbria are all limited in their relative access to supermarkets.

It is complicated to measure service access distances using computer mapping, and analysis often measures straight-line ‘as the crow flies’ distances. Indeed, Countryside Agency commissioned analyses (CA, 2003c, 2001a) are based on straight-line distances, which almost certainly under-represent the real distances involved. For example, for communities living in remote rural Cumbria valleys such as Wasdale (see cover illustration), ‘as the crow flies distances’ have little meaning. The nearest main hospital involves a long detour by narrow road using available transport.

Access to rural healthcare services

Rural communities generally face poor access to healthcare services. As with access to a range of essential services in rural areas, primary care GP practices and community health teams are likely to be located at some distance from home. Patients will have limited or no choice as to whom they see for treatment, and may be offered a more limited range of services than available elsewhere.
Figure 5(i): Percentage households living 4+ km from a primary school, by ward

Figure 5(ii): Percentage households living 4+ km from a supermarket, by ward

Source: Countryside Agency ward level geographical availability measures for key services (2001)
87.9% of North West parishes have no GP surgery or branch (CA, 2001e); surgeries are concentrated in small rural towns. Secondary care inpatient, day case and outpatient services are usually located at even greater distances. A far higher critical mass of activity needs to be achieved before such services can be made viable. 41.3% of Cumbria residents live more than 12km from a hospital, in contrast to 3.5% in Cheshire and 1.2% in Lancashire (CA, 2001e). Whilst access to District General Hospital (DHG) based services, A&E, and more specialist care services (such as cancer treatment) remains an issue of accessibility within rural areas, the focus of rural access to healthcare lies with primary care - usually the first port of call when ill.

In a national OPCS survey (Ritchie et al, 1981), whilst only 5% of patients had to travel five miles or more to visit their GP practice, there was a marked urban – rural split, with 12% of patients in rural and only 1% in non-rural areas travelling such distances. Similarly, 36% of rural residents travelled 2-5 miles, as opposed to 15% in non-rural areas. Access to pharmacies also showed high variations.

Such issues over access disproportionately affect particular groups, who are likely to have the greatest need for healthcare. Rural inequity in access to healthcare provision (and other services) particularly affects older people, mothers with young children, adolescents, disabled groups, those at home with no car, and the very poor. The view that accessibility only affects a small minority is false (Moseley, 1979). Such disadvantaged groups may not be able to access health services readily, and therefore make less use of them (Fearn, 1987).

Older people frequently live on a limited income or pension, often do not have their own car, and may well be infirm or in poor health. There is no option of walking to see a healthcare professional, and public transport may be severely limited. Women with young children may have limited or no opportunity to obtain childcare for other youngsters when needing to attend an appointment. They may have no access to a car, if this is used daily by the main employee. People with disabilities are similarly affected. Adolescents suffer similar access issues, and may be reluctant to attend with health problems because of a perceived lack of anonymity, since villagers are far more likely to know their neighbours and surrounding community.

Particular communities may feel isolated through their location or occupation. For example, hill farmers living in isolated communities may not feel able to attend a surgery. Dairy farmers and farm workers may be unable to attend usual surgery hours due to the hours they have to work. Rural services need to be sensitive to rural communities needs, countering issues such as stigma or the issue of ‘cultural access’ where work cultures mean farmers, for example, cannot attend surgery during opening times (during summer silaging and haymaking, or during milking). There are also ‘hidden’ populations who may be potentially excluded from receiving care; these include seasonal workers in tourism and migrant workers.

Figure 6 highlights access to GP surgeries across North West England. Whilst residents of urban wards mostly live within 4km of a GP practice, the rate varies
Figure 6: Percentage households living 4+ km from a GP practice, by ward

Source: Countryside Agency ward level geographical availability measures for key services (2001)
appreciably in rural areas. For example, in many parts of Cumbria, half to all of the residents living within any given ward have to travel over 4 km to a surgery. This pattern extends down through South Cumbria and into rural North Lancashire. Whilst the proportions are smaller, many Cheshire, Pennine fringe and West Lancashire residents also face journeys of 4km and above to a surgery.

This GP practice accessibility data is again based on straight-line distances. 2004 Countryside Agency figures are due to be analysed using road network ‘drive distance’ figures, which may appreciably worsen such accessibility summaries for rural areas. In addition, whilst current Countryside Agency research suggests that 87% of rural households live within 4km of a GP practice (CA, 2003b), this data may be judged as misleading, given it includes branch surgery details, outreach and mobile provision, which may well be limited in availability and only provided for short time periods each week.

Paradoxically, due to urban density in the central North West, regional ‘service access by distance’ summaries are the best of any English region (CA, 2002a). These figures totally mask the differences between urban and rural North West. The 2003 State of the Countryside report recognises that with a higher proportion of older people living in rural areas, there may be greater demand for rural services (CA, 2003b).

Access to rural public and private transport

The extent, quality, type and interlinking of road and other transportation networks affect the relative remoteness of communities. For example, access by road to health and other services varies dramatically for residents of a rural Cheshire village close to a M6 junction, for a West Cumbria community within a valley surrounded by mountains, for a remote farming family high up on the North Pennine Moors, and for a Scottish Peninsula crofting community some 25 miles distant from the nearest services along a winding, partly tarmaced, single track. Rural service access issues are far more pronounced if related to rural America, Australia, NZ, or elsewhere, where distances are measures in hundreds of miles.

Recent research has shown transport to be the biggest concern of rural communities and the issue they most want addressed (CA, 2000b). Rural communities are far more reliant on privately owned cars, and expect to have to travel in order to make use of a range of services (Moseley, 1979). However, running one, or by necessity, more than one family car, is expensive. Fuel costs are appreciably higher. Journeys are far longer, reflected in both costs and time.

Public transport may well be poor, infrequent, not integrated or non-existent in many rural areas. The privatisation of bus services led to rural transport being viewed as unprofitable in many cases. Rail services may be nonexistent. Innovative transportation schemes have been set up as a result. Examples include bus routes and timetables which coincide with specific opening times at nearby towns, and community-led minibus schemes. However, the personal mobility of many rural residents is still severely restricted.
Access to housing

The countryside has witnessed appreciable inward migration in recent years, particularly from more affluent commuters and retired incomers. In many highly popular rural areas, demand for housing easily outstrips supply, and prices have risen appreciably. Unaffordable local housing has become a major issue for families and workers who naturally wish to continue to live in their home area. In the North West, the popularity of the Lake District has made ‘period cottage’, ‘character housing’ or indeed any housing in particular villages prohibitively expensive. For example, in 2002, the average house price in South Lakeland was £122,855, compared to £51,680 in neighbouring Copeland (CA, 2002a). Continued national housing inflation makes the current position far worse. Housing tax discounts on second homes paradoxically make home owning cheaper for second homeowners. The Cheshire commuter belts are another example of where locals have been priced out by town commuters. As more new homes continue to be built in the countryside, implications for rural life and the environment are numerous (CA, 2003a).

Rural populations can become unbalanced in popular areas, where seasonal tourism, employment, and the on-off use of holiday homes, can bring disproportionate changes in the size and age structure of the local population. The privatisation of council housing has made the problem worse, with a chronic lack of social housing in some areas. Private housing that is available cheaply is likely to be of poor quality and health may suffer as a result. In remote areas, virtually no housing may be available. Rural homelessness, whilst unseen in comparison to city problems, is still to be found.

The rural economy

Rural economies tend to benefit from higher levels of employment and self employment. In many rural areas income levels are relatively high. For example, in 2001, 57% of rural wards in the North West had average family household incomes above £25,000, in comparison to 17% of urban wards (CA, 2002a). However, such broad summaries mask rural extremes. Wealth becomes polarised. Rich and poor frequently live in close proximity, with poverty hidden.

Readily available local rural jobs tend to offer lower average incomes or pay. For example, on the island of Harris, 83% of residents were found to have incomes below the national low pay threshold (Shucksmith and Chapman, 1998). Far fewer job opportunities will be available for local residents. Available jobs are less likely to require highly skilled staff. Self employment may result in lower income. Those with very low incomes may either not have a bank account, or find it hard to access a cash machine. Poor rural local incomes are further hit by the higher costs of living and working in the countryside. The health of rural communities is affected by their economic well-being. Initiatives that support the rural economic infrastructure, and provide jobs, benefit health.
In 2000, three broad employment sectors accounted for 71% of rural employment within the North West. These sectors comprise: distribution, tourism and leisure; public sector administration, education and health; and manufacturing. Available work may be seasonally based, for example, within the tourism, leisure and hotel businesses, or other service industries. Rural industries such as farming, forestry, mining and fisheries, whilst dominating the landscape, only account for 1.6% of total employment in the region. However, particular communities, such as the farming community, face particular problems, such as lower returns from milk, meat and crop production, outbreaks of disease such as BSE and the more recent ‘foot and mouth’ crisis, high stress levels, poor incomes and long working hours in difficult conditions.

There has been a trend for commercial companies, which may traditionally have been established within a particular market town, to move to national centres. For example, Kendal has in recent years lost both its insurance and footwear industries, and associated skilled manual and administrative jobs. Market towns are often in decline and surrounding economies hit by uncertainty.

‘Industrial’ rural villages are often associated with one particular industry, such as quarrying, minerals and coal mining. The closure of these can have a devastating effect on the local community. Within National Parks in particular, planners are reluctant to allow industrial development or expansion, which would have a visible impact on the landscape. Potential new jobs associated with such developments are thus affected, leading to conflict between Park aims of supporting both local communities as well as the natural environment.

Telecommunications infrastructure

The telecommunications infrastructure is less developed in rural areas. The ‘digital divide’ between rural and urban areas is becoming more pronounced. For example, Cumbria to date has extremely limited access to broadband Internet services, giving businesses elsewhere a potential advantage. Only one per cent of remote areas are able to receive broadband technology (CA, 2003b, 2003f). Healthcare communication technology, and the potential for telemedicine, are affected by slower access speeds. Such new technologies (as detailed in chapter five) offer access to services that may no longer be physically available locally, and offer the chance for communities of all ages to learn new skills. Rural workers are less likely to have access to information and communication technology (ICT). Small rural enterprises may consequently have fewer IT skills.

Educational opportunities

Whilst people living in rural areas generally have slightly higher levels of educational achievement than their urban counterparts, the data hides hidden levels of poor attainment in remote rural areas (CA, 2003b). For example, neither Cumbria nor Cheshire has a dedicated county-based university. Access to alternative further education, training or ‘night schools’ may be limited, or
based at some distance for rural students. Where further education is readily available, it may well be linked to one particular core industry such as agriculture. Restrictions on educational opportunities may well have staffing implications. This is of particular relevance within the health service, both for the initial training of primary care, community and hospital teams, as well as for longer term continual staff development. Rural service teams may have problems finding and attracting skilled staff.

Hidden rural deprivation and need

The Acheson Report (1998) focuses on the wide ‘gap in health between those at the top and bottom of the social scale’. Ill health is shown to have a variety of determinants (income, education, employment, material environment, and lifestyle). Rurality issues potentially affect all these determinants. Yet rurality has not traditionally been a key focus in health inequality debates.

Using the indices of deprivation 2000 (DETR, 2000a), the maps in Figure 7 contrast health domain deprivation levels (reflecting mortality ratios, receipt of health benefits, limiting long term illness and low birth weight), against service access deprivation (reflecting access to GPs, primary schools, food shops and POs) across the North West. Scores have been divided into five bandings to reflect regional variations. Whilst overall deprivation levels are highest in urban conurbations, as is health deprivation, service access deprivation is highest in rural areas. However, accessibility to services is considered one small part of the overall IMD deprivation index.

High levels of poverty, deprivation, social exclusion and need still exist in rural areas (Chapman et al, 1998). For many, it is difficult to escape from persistently low income, poverty and poorly paid jobs. A problem for the health service is that individual households suffering from deprivation, poverty or social exclusion, and who need help most, tend to become hidden within statistical averages. As the Northern Fells Rural Project comments, ‘when one scratches the surface of an attractive rural area, one finds a significant number of isolated, often stoical individuals, both young and old, who are infirm or caring for others, who do not have access to the range of services now considered normal in most parts of the UK’ (NFRP, 2002).

Rural community strengths; the expression of rural views

Despite the somewhat negative picture portrayed regarding potential service access issues in rural communities, rural life in many aspects highly rewarding. Rural communities may well seek to address local issues themselves, with community action an indication of community vibrancy. Innovative local initiatives, as discussed in chapter 5, may seek to support and help the whole community. There is appreciably less crime, although this may not be perceived as so (CA, 2003b). Rural residents value the special qualities of life found locally. There is some backing to the romanticized view of rural life.
Figure 7(i): Indices of deprivation 2000 'health' domain

Figure 7(ii): Indices of deprivation 2000 'access to services' domain

Source: Indices of deprivation 2000
It is often stated that rural communities are more self-reliant at times of need. This may well be the case in many rural communities, and a strength; however, research has shown that the suggestion that rural communities ‘look after their own’ has at times been used when there has been evidence of severe need amongst some sections of a community (Simmons, 1997).

Rural tourism brings considerable income and opportunities to the North West countryside. Wealthy rural residents, or second-home owners, could be viewed as ‘redistributing’ wealth within the local community. There are health benefits from both visiting the countryside on holiday, for weekends and on day trips, as well as from living in the countryside.

Yet, whilst some rural areas have developed into major tourist attractions with significant seasonal variations in population, and others have become major retirement destinations, many others have seen a significant decline or weakening of their economies and social structures. Whilst a range of rural services may be closing over time, as the 2002 ‘State of the Countryside’ report comments, a full range of services are still available within most rural areas, although at a greater distance (CA, 2002b).

There have been numerous indications in the late 1990s that rural populations have felt central government has not been listening to their concerns. The broad debate on ‘Town versus Country’ has resulted in such demonstrations as the national Countryside Alliance protest marches and the 2000 national petrol dispute. Disputes over individuals’ rights to hunt, economic devastation during and after ‘foot & mouth’, floods, effects of rural industry decline on worker stress and mental health, and spiralling costs of living in rural areas have all played a part in this debate (CCC, 2002; RHF and IRH, 2001). Rural communities often feel that they have a lack of political influence and little control over events and resources. The actions indicate real differences are felt between many living within urban and rural Britain.
Chapter 3: Impact of rurality on health and healthcare services

General levels of health amongst rural populations

Rural populations face broadly the same range of illnesses, health issues, lifestyle choices, and medical interventions as those living in urban areas. Unlike other Public Health Information Reports in this series, which have focused on a particular health topic - cancer, mental health, heart disease - this report describes how rurality may affect the health of rural populations and the healthcare provision they receive.

Whilst rural communities may have fewer choices over primary care healthcare and a range of other local services, and are likely to have to travel further to access secondary care and other healthcare services, the key issue is whether such ‘access’ issues impact negatively on their health.

It is widely assumed that living in the countryside is good for your general health, and that rural residents typically live longer and benefit from better levels of good health. The Government supports this claim, the Rural White Paper stating ‘the health of rural residents is as good or better than the national average, in terms of birth weight, incidence of long term illness and longevity’ (DETR, 2000b).

By using national key health measurement indicators, based on commonly used mortality and morbidity data, rural health is indeed shown to be ‘better’ than average. For example, Figure 8 highlights life expectancy for North West males and females by Local Authority. Affluent rural North West local authorities, within Cheshire, South and East Cumbria, and rural Lancashire exhibit higher average life expectancy for both males and females.

Figure 8(i): Life expectancy (male)

Figure 8(ii): Life expectancy (female)
In addition, whilst standardised mortality ratios (SMRs) for the North are the highest in England, the rural North West SMR of 99 contrasts with an urban SMR of 110.

The proportion of low birth weight babies (under 2,500g) born in a given time period is used as a proxy for relative health need and deprivation amongst younger families, and for future service need.

Figure 9 again indicates that rural local authorities in the North West, and their local PCTs, typically show lower rates of low birth weight babies. Factors that can help contribute to a low birth weight include socio-economic status, lack of social support, stress and some aspects of ‘lifestyle’.

However, regardless of whether a community is broadly urban or rural, such summaries merely reflect national trends, whereby ill health and premature death are linked to deprivation and a range of wider determinants of health. In general, deprivation, as well as many of the other causes of ill health, is more widespread in urban environments. In reality, those living in rural areas who suffer from deprivation and poor health, and who have the greatest health need and least opportunity to access services, are hidden amongst scattered communities of the generally affluent and healthy.

The health of rural populations - open to challenge

A number of studies have sought to analyse health, illness and healthcare in rural Britain (Deaville et al, 2002; Cox and Mungall, 1999; Watt et al, 1994; Fearn, 1987), to provide international comparisons (Higgs, 1999), or to specialise in describing specific areas of rural healthcare, for example, rural primary healthcare (Deaville, 2001; Rousseau et all, 1994; Cox, 1995).

Health research has focused predominantly on urban health issues, deprivation and inner city inequalities, reflecting the dominance of urban life on society. The assumption that rural areas exhibit better levels of health is however increasingly open to challenge (Deaville et al, 2002; McKie, 1997; Clark, 1997; Watt et al, 1994; Fearn, 1987; Bentham, 1984), and warrants continued research to develop a better understanding of the health, well being and healthcare needs of rural communities.
a. The effect of rurality on the uptake of healthcare services

Rural communities generally have poorer geographical access to services. Many rural patients, particularly those who are less mobile, face considerable difficulty in getting to essential services. The distance that rural patients live from primary care and hospital services has been found to have a profound effect on their likely use of such services. This ‘distance decay effect’ has resulted in rural patients showing lower levels of health services utilisation than their urban counterparts (Jones et al 1998; Stark, 1997; Jones and Bentham, 1997; Watt et al, 1994; Reid and Todd, 1989; Bentham and Haynes, 1985; Haynes and Bentham, 1982, 1979; Ritchie et al, 1981).

Differences associated with age, sex and social class have shown even greater effects on service usage than have distance to a service (Ritchie et al, 1981). Thus, are rural older people, the infirm, retired, young, poor, socially disadvantaged, and those without transport even more disproportionately affected?

Recent research suggests that some rural patients may be less likely to present with an illness (Watt et al, 1994). This does not necessarily mean that rural populations are healthier, merely potentially reflecting unmet need for services. Rural patients may seek help at a later stage of the development of an illness, for example, as with undiagnosed cancer.

Issues of poor geographical access, as well as community attitudes to health, may bring about such poor service uptake amongst some groups, for example young women and older men (Carr-Hill et al, 1996). Unmet need due to service inaccessibility is a problem in rural areas (Fearn, 1987), presenting a challenge for rural healthcare not only to measure needs more accurately, but also to respond effectively (Haynes and Gale, 1999).

Table 1 summarises a range of studies that have looked at the effect of access on the uptake of healthcare services by rural populations in the UK. For access to be equitable, similar services should be available to all those with equal healthcare needs (Goddard and Smith, 2001), a principle underlying the NHS.

Despite evidence for rural inequity in service provision, research into the range of health problems that may result from poor access have attracted far less attention amongst researchers, policy makers and implementers than other forms of disadvantage, for example, social exclusion, socio economic deprivation and urban health need.

Research has still to confirm whether rural communities make less use of healthcare services because they are generally healthier, stoical in attitude, or cannot readily access such services when in need.
Table 1: Example studies on the effect of access on the uptake of healthcare services by rural populations in the UK


Analysis of 9,764 self reported asthmatics in Norfolk, which used a survey to identify respiratory health, and analysed how far respondents lived from a GP and hospital. Results showed that respondents were less likely to have visited a GP for breathing difficulties if they lived outside an area containing a GP surgery. Thus, their asthma condition might be poorly treated, with fatal consequences.

Effect of access factors on breast screening attendance on two Scottish Islands. Stark, 1997.

Whilst a number of factors can influence whether women attend for breast screening, a small-scale survey on two remote islands indicated that service access has an important effect on uptake. Non-participants lived further from the mobile screening base (whose location was restricted), and were less likely to attend in the afternoon when public transport was limited.


Revisited previous social surveys to show that some of the remoter rural areas in Norfolk have populations with a relatively high need for healthcare. Those with greatest need (elderly, disabled, poor) had the lowest levels of access to transport, and in addition, fewer local services. For them, travelling long distances to centralised services was particularly difficult. Based on health need, those in remoter areas received less healthcare. Demographic trends concentrate need in remote rural areas.


Interviews conducted with 1,603 rural residents across Norfolk, using a questionnaire to investigate varied effects of rural accessibility on patient contacts both with GPs and hospitals in county. GP and outpatient rates declined as relative inaccessibility increased; those with a long-standing illness, disability or infirmity were most affected. Disparity most marked for those with greatest needs for medical care. Inpatients admissions redress balance at a later more serious stage. Services used most by young, mobile, and affluent, who expected more.

Access to Primary Healthcare. An enquiry carried out on behalf of the UK Health Dept. Ritchie, Jacoby and Bone, 1981.

National UK Survey by the Office of Population Censuses and Surveys, looked at factors affecting access to doctors surgeries, home visits, district nurses and health visitor visits, and a range of primary care and other Family Practitioner services. 5,373 personal interviews undertaken. Findings suggested that distance has an effect on physical access to primary care, particularly in rural areas. However, differences associated with age, sex and social class had a far greater effect on physical access.


Research based on a community survey and sample of inpatients in a rural district. Inpatient admissions, visiting rates and outpatient clinic attendances were all affected by relative accessibility to a hospital. Relative accessibility is likely to affect the use made of hospital services by patients and visitors, affecting the less mobile with greatest need.
b. The effect of rurality on health outcomes

The established premise that health is better in rural areas has produced conflicting results and considerable discussion (Cox, 1998, 1995; Watt et al, 1994; Phillimore and Reading, 1992). However, evidence has shown that poor service access can affect health, and that in addition, rural residents can suffer disproportionately from a range of illnesses usually found only in the countryside.

In Scotland, research has shown that patients with common cancers have less chance of diagnosis before death, and/or poorer survival after diagnosis, the further they live from a cancer centre (Campbell et al, 2000). Similarly, for asthma sufferers across England and Wales, a tendency was shown for mortality to rise the further people lived from a hospital (Jones and Bentham, 1997). Research in a rural English county found that localised remote rural areas had higher mortality ratios (Bentham, 1984). In instances where health is shown to be generally better in ‘rural’ areas, the case need not be the same in geographically far more remote areas. For example, limiting long term illness (LLTI) has been shown to display a strong ‘U’ shaped relationship, with the highest rates occurring in urban and ‘remote rural’ areas, and the lowest in suburban and rural fringe areas (Martin et al, 2000).

However research has indicated that people under 65 in rural wards have better health than average, and slightly better health than would be expected according to deprivation scores (Haynes and Gale, 1999). This finding may be less applicable than to those with the greatest health need, for example, ageing rural populations who suffer most from lack of transport. Research from the Northern region (then including Cumbria) indicated that once socio-economic factors had been accounted for, rural health is no poorer than that in urban areas (Phillimore and Reading, 1992). Separately, no relationship was found between the likelihood of dying after a road traffic accident and the time it took to get to hospital (Jones and Bentham, 1995).

Table 2 summarises example studies that have considered how accessibility can affect rural health, and the relative health of rural UK populations.

With poorer access to supermarkets and shops, the limited availability and smaller range of locally available food means that rural communities are not offered the range and choice available in urban centres. In Scotland, both traditional ‘rural’ and ‘island’ diets have mainly been supplanted by limited, unhealthy convenience foods, with health suffering as a result (McKie et al, 1998). Farming communities for example, whilst highly active, may well drink more full fat milk and fatty foods.

An issue with any macro level research into relative differences between urban and rural health is that such studies paint an overall picture, and do not focus on the needs of individuals, whose ill health and needs are hidden in statistical averages, and who at times will be missed by healthcare providers.
Table 2  Example studies on how accessibility affects the health of rural populations, and on the relative health of rural populations in the UK


In a large-scale study, 63,976 Scottish patients diagnosed with common forms of cancer over five years were followed up, in order to investigate whether survival differed for patients who lived in rural and urban areas. Results were adjusted for age, sex, deprivation and distance from a cancer centre. Findings highlighted how increased distance to a cancer centre led to a lesser chance of diagnosis before death for stomach, breast and colorectal cancers, as well as poorer survival after diagnosis for lung and prostate cancers.


All causes of death, as well as self-reported limiting long-term illness, were analysed for people aged under 65, for all wards in E&W. Standardised mortality and illness ratios were calculated and analysed by geographical ward type and deprivation. Rural wards had mean values of mortality and morbidity 12-26% lower than national averages; however, rural areas also had least deprivation. Any relationship between health and deprivation in rural areas was weak, possibly due to the averaging out of poverty in areas with small population size and varied wealth.


Data on suicides (and undetermined injuries) in E&W, over 4 years, was analysed by LA. Male suicides significantly higher in the most rural areas, based on population density. Speculation that rural males had greater access to firearms, were socially isolated, and had few psychiatric services.

Heath service accessibility and deaths from asthma in 401 LA districts in E&W. Jones and Bentham, 1997.

Research examined possible influences on asthma mortality, including the relationship between asthma mortality and geographical isolation from large acute hospitals. Data was studied over 10 years for 401 LA districts. After controlling for social class and lack of private transport, both of which indicated higher rates of death, there was still a tendency for mortality to rise the further people lived from a hospital. Remote rural asthma sufferers may not receive optimal treatment.


Study of serious and fatal road traffic accidents over five years in Norfolk. Use of GIS to estimate time taken to reach A&E, and odds of dying from a particular accident. No relationship was found between health outcome and the estimated time taken to reach victims and get them to hospital.


Research examined whether health was intrinsically better in rural areas of the North given comparable deprivation levels. Data on under-65 deaths, low birth weight, sickness and economic census data, from a study on health and poverty re-examined. Inequalities in mortality found to be higher in urban areas. In localities with similar deprivation levels, low birth weight little different in mainly former industrial rural areas. Distinct mortality health advantage was apparent in rural areas.

Mortality rates in the more rural areas of E&W. Bentham, 1984.

Investigated relationship between mortality and rurality in E&W using standardised mortality ratios and data on rurality. Findings indicated that remoter rural districts had higher and more rapidly increasing mortality rates than less remote rural areas.
Nationally recognised rural health issues

A very few health issues are recognised nationally as being a greater problem in rural areas. For example, road traffic accident (RTA) rates are higher in rural areas. Figure 10(i) highlights mortality from ‘motor traffic accidents’ within the North West. Rural Cumbria clearly shows higher RTA SMR mortality ratios. Eden Valley PCT has the second highest RTA SMR nationally (DoH, 2001b).

Isolation, occupational stress, economic crises, and unforeseen events can contribute to mental health problems (Read and Hughes, 1997). Foot and Mouth disease brought considerable distress to entire rural communities in 2001 (Bailey et al, 2003). Suicides are higher in rural areas, as in particular are farm suicides. Farming communities, and farmers and vets in particular, have ready access to firearms and drugs if seeking to take their own lives. Figure 10(ii) highlights suicide rates across the North West. The picture is more mixed, showing how urban ‘isolation’ in parts of Manchester and Liverpool is associated with suicide.

![Figure 10(ii): Mortality from Motor Vehicle accidents](image1)
![Figure 10(ii): Mortality from suicides](image2)

Particular accidents result from rural employment, including for example, major trauma injuries from farm vehicle and machinery accidents, as well as forestry injuries and drowning amongst fish farmers.

Teenagers in remote communities have fewer opportunities for entertainment. Whilst rural areas are viewed as good places in childhood, they can be constraining for young people (Glendinning et al, 2003). Limited opportunities leave the young vulnerable to alcohol, smoking and drugs (Mullins et al, 2001).
Specific diseases and illnesses found mainly in rural areas

There are a number of illnesses that are particular to rural populations, and more likely to be seen and treated only by rural practice teams (Mungall, 1999). These include tick-borne diseases from sheep, hypersensitive systemic reactions to insect stings, reactions to horsefly bites, the risk of poisoning from adder bites, and inflammatory tick borne Lyme disease.

Zoonoses are infections that are passed on from animals to people. Whilst there are many illnesses within this category, they may remain undiagnosed, or rarely seen. Pregnant women who come into close contact with sheep during lambing may be risking their health and the health of their unborn child. Infections such as chlamydirosis, toxoplasmosis and listeriosis can be passed on, leading to the potential risk of miscarriage. Ringworm, orf and cowpox may affect farmers and farm-workers. Helicobacter pylori may be acquired from animals, as may liverfluke. Weils disease, passed on from rats and cattle, is an occupational risk. Tetanus can be picked up from contaminated soil (Mungall, 1999).

Farming in particular is associated with a number of health conditions. Farmers have an increased incidence of osteoarthritis, may suffer from dust diseases such as farmers lung, organophosphate poisoning (with concerns over chemicals used in sheep dipping), psittacosis from bird farming, and so on. The potential risk of Bovine Spongiform Encephalopathy (BSE) or ‘mad cow’ disease, and Creutzfeldt-Jacob Disease (CJD) have brought restrictions on farming, as the Government has sought to eradicate diseases from herds.

Primary care – differences in rural service provision and workload

Popular television and radio series such as ‘Peak Practice’ and ‘Dr Finlay’ have presented an idealised view of rural medical care to the public, where a doctor can give unlimited ‘hands-on’ time to patients, and follow personal crusades (Phillips et al, 2001). Rural practices may or may not offer greater levels of personal care, through long-term knowledge of patients. However, small or single-handed practices may only be able to offer a limited range of medical services (Cox, 1995).

General Practitioners (GPs) are the focal point for rural healthcare, and indeed treat the vast majority of episodes of ill health within the NHS. Their role is key. The distance a patient lives from a GP surgery has frequently been shown to be negatively related to primary care consultation rates, one of very few rural issues recognised within the Acheson Report (1998). The picture is similar for out-of-hour’s co-operative services (O'Reilly et al, 2001), with implications for new GP contracts. However, it is unclear whether this represents unmet need for healthcare, with distance patients unable to reach treatment, or, if patients living near to a GP practice attend for ‘lesser’ reasons.

If rural patients cannot get to a practice, the alternative is to bring primary healthcare services to these rural and more remote communities, for example
using branch surgeries, home visiting, and mobile services. Whilst older patients in particular like branch surgeries, they are not popular with GPs, where opening hours, facilities and privacy are limited and required notes may be unavailable. Mobile services are intensive in staff and can be costly. Despite this, branch surgeries bring in a significant number of extra consultations (Bentham and Haynes, 1986). Whilst innovative opportunities for nurse practitioners to work with rural communities and undertake many of the roles of a GP have been shown to work well, as shown in the Morecambe Bay Farmers Health project, they are costly.

The availability of prescriptions and off the counter medications is more limited in rural areas. Pharmacies are located for commercial reasons, and rural dispensing practices are required where no pharmacy provision exists. Dental, ophthalmic and chiropody services can be irregular and non permanent, resulting in relatively little preventative work being achievable (Williams, 1980).

As well as seeing more specific rural health conditions, rural primary care teams may experience a different workload to that of their urban counterparts. Doctors and nurses are often the first to be called to rural emergencies to undertake intermediate care, whereas in urban areas a patient would be more likely to visit an A&E department, minor injuries unit, or to call an ambulance. Staff carry a wider range of resuscitation and other equipment than is usual (RCGP, 1999). Primary care teams are likely to see more minor injuries and undertake more minor surgery. Teams may not be specifically trained for such reactive care.

Rurality affects GP practice structures and staffing, as well as the range of services offered. Primary care teams are likely to have a better local knowledge of their area, and of the individual patients in their care. Patients are more likely to have lived locally for many years, and seen the same healthcare professionals. Rural GP practices tend to be smaller, with lower list sizes. Rural GPs may be happier to work in single-handed or small GP practices. Rural practices in popular tourism areas may well see far higher numbers of out of area patients, where medical histories are unknown and notes inaccessible.

However, doctors are on call for longer, and face a greater out-of-hours workload, as they have fewer opportunities to be part of evening, night time and weekend co-op schemes. Doctors may have responsibility for a higher number of rural based nursing home patients, who need continuing care and present funding issues. Domiciliary visits to patient homes involve far longer journeys, with GPs away from their surgery for longer periods. In some areas, 4-wheel drive vehicles may be essential in winter.

Community based nursing teams are more dispersed. In very sparse rural areas of the UK, where there is not enough work for whole time nurse teams, there are a number of triple-duty nurses, who are trained as district nurses, midwives and health visitors (Whyte, 1997). Such multi-skilling, for example where district nurses carry out multiple assessments in one visit, has been considered successful in Scotland (Hogg, 2000). Part of the community, highly skilled, and working to flexible boundaries, such posts have unfortunately become hard to fill.
Recruitment and retention of staff can be an issue in rural areas (Swindlehurst, 2003). Fewer trained primary care professionals are available to be employed. Whilst attractive rural areas (for example National Parks) do not have problems recruiting GPs, nurse, doctor and support staff recruitment can be an issue elsewhere. Rural areas can be perceived as a backwater, with professionals feeling isolated in terms of career development and opportunities (DoH, 2001a). In particular, hospital consultants are more likely to be drawn to major urban centres where greater technical backup, facilities, academic training and peer support opportunities are found. In the autumn of 2003, Morecambe Bay Hospitals placed Consultant post adverts in the National Trust Magazine, stressing the lifestyle advantages of living in the area. Primary care teams need to be better supported in obtaining lifelong CPD training. Specific ‘rural track training’ would be beneficial.

Trauma services – differences in rural access to treatment

A quick response time is considered essential in treating trauma and medical emergency cases. Those in immediate need of urgent trauma care, for example, following an accident, or after suffering from a heart attack, may have to wait longer in rural areas before receiving initial medical care.

The principle of equity of treatment for all, regardless of where a patient lives or falls ill, means that effective triage needs to be available at the scene of an accident or emergency, wherever it occurs, as well as within a distant District General Hospital. High quality transport systems are needed to both get paramedics to the scene, and to take patients to trauma centres for treatment.

In responding to incidents such as agricultural accidents, rural RTAs, cardiac arrest, and drowning, paramedics, medical teams, equipment, support services and volunteer teams may be required. In rural areas, the distance involved in reaching a casualty usually means response times will be slower. As paramedic, ambulance, police, and fire service team responses typically involve longer journeys, innovative services such as fast response cars, as well as air ambulances, have come into service.

Secondary care – differences in rural access and services

There has been a consistent trend in recent years towards the regional centralisation of specialist secondary and tertiary care hospital services. Within rural areas, many of the services offered by larger urban District General Hospitals have traditionally been provided by locally accessible cottage or GP hospitals, now referred to as community hospitals. Community hospital coverage varies by rural county, with substantial numbers having been closed over past decades. Whilst popular and well supported by the community, such hospitals offer fewer services than their District General counterparts, particularly with regard to specialist services. However, a surprisingly varied range of services can be offered, with local examples highlighted in chapter five.
The GP is the first point of contact in primary care, and controls access to other services, particularly secondary hospital care. Lack of rural access to a GP could be reflected in secondary care usage levels. For example, a threefold difference has been observed between a ratio of the use of GP services to need for urban residents with a car and telephone, to usage by remote rural residents without (Bentham and Haynes, 1985). However, once a patient is seen by a GP, rural residents as a general rule, receive equitable levels of hospital care to urban counterparts (Fearn, 1987).

The personal cost of accessing distant secondary care services is not evenly distributed amongst rural populations. As with access to primary care and other services, those who may well have the greatest need – older people, the disabled, parents with young children, adolescents – cannot as readily travel for treatment. The Rural White Paper acknowledges that rural residents often face ‘difficulty in accessing more specialised hospital services’.

Policy decisions on service location affect patients (Haynes and Bentham, 1979). Campaigning by local residents over recent proposed closures of rural hospital maternity units have led to the establishment (and survival) of locally based, responsive and successfully run midwife led maternity units and obstetrics care. The proposed closure of local A&E or minor injuries units brings a similar public response. Indeed, research indicates that the provision of locally based outpatient appointments can increase attendance rates when compared to a centralised service. It is local residents who predominantly make use of A&E departments.

Patients with specific needs

Families with specific needs may face considerable unmet health need in rural areas. For example, those with mental health problems often face stigma in rural areas, with psychiatric healthcare often poorly resourced, inaccessible and misunderstood. Whilst people may live at a physical distance from their neighbours, paradoxically they are socially closer (Parr and Philo, 2003). It can be hard to keep secrets, and families, patients and carers can ‘soldier on’ in quiet. Alcoholism in isolated Scottish communities is a particular problem. Distant specialist services may not be routinely used. To maintain confidentiality, community psychiatric nurses have been known to leave their cars some distance from a patient’s home (Parr and Philo, 2003). Informal care from family and friends may be heavily relied on, with carers given little support and communities not intervening.

Families of children with disabilities are often under enormous stress, and may have less social contact with other children (Mullins et al, 2001). The range of professions allied to medicine, for example, speech and language therapy, physiotherapy and occupational therapy, may be poorly resourced if staff cannot be appointed, with recruitment and retention recognised problems. Services such as hospice provision, locally provided for in urban areas, may only be available at great distance for rural communities.
Chapter 4: National rural health policy and rural policy

A. Rural proofing

Government has introduced the policy of ‘rural proofing’, namely that policy should consider the likely impact of decisions on the particular needs of those who live in, work in or enjoy the countryside (CA, 2003d). Developed by the Countryside Agency, rural proofing seeks to ensure that rural needs are not overlooked, but are at the heart of policy making, particularly given the distinctive features of rural areas with their scattered populations and service issues. If particular rural issues or needs are identified, rural proofing should ensure that a proper assessment is made of how policy will impact on rural communities, and where appropriate, policy adjusted to meet local circumstances.

Regionally, Government Offices work with the Countryside Agency to implement rural proofing. National, regional and local level versions of a policy makers rural proofing checklist have been developed for use by Government agencies, strategic partnerships and local authorities (IRH, 2003). Checklists provide a listing of questions that should be addressed to ensure policy meets rural need. Checklist considerations include establishing whether policy would bring about closure or centralisation of a service, ensures rural residents can access services, will allow for higher costs of rural service provision, and adequately considers travel needs and the ease and cost of travel (CA, 2002d). Rural proofing provides a motivation for health and partner agencies in rural areas to think and plan laterally and across organisational boundaries.

The perception that rural residents do not suffer the social and health problems found in cities has resulted in a lack of consistent policy over rural health. Current NHS policy, as well as the 2000 Rural White Paper, could be considered to be at an early stage in terms of the tackling of rural health need and rural healthcare planning as a distinct issue. For example, in 1992, the Rural Voice Health Group commented how the Department of Health ‘barely has a rural dimension to its policy making and considerations’ (Fennel, 1992). Health policy and service delivery models for rural areas may be indistinguishable from those proposed for urban areas. PCTs with a rural heartland and large urban centre may well focus on issues facing deprived urban communities, to the detriment of rural areas. Rural proofing should ensure rural needs are considered.

Promisingly, during 2003, the Institute for Rural Health (IRH) has been undertaking a ‘Rural Proofing for Health’ project, whose main aim is to develop a toolkit that can be used by PCTs and other agencies involved in healthcare delivery to identify rural needs and incorporate these needs into policy making. By using such an approach, the proposed toolkit should help PCTs ‘deliver services that are appropriate for rural areas and which may help to address inequities in service provision’. Findings from an initial IRH project questionnaire to 60 rural PCTs in 2003 reaffirm current PCT views on rural healthcare issues detailed within this report (Swindlehurst, 2003). South Lakeland Local Health Group, part of Morecambe Bay PCT, has become one of three trusts nationally to agree to become more involved in piloting the IRH toolkit.
B. National health policy framework

Current NHS policy sets out the vision and mechanisms for improving the health of the population and for the development of the health service, and represents a clear framework for action. Policy makes little if any distinction between rural and urban health and healthcare needs. However, locally managed healthcare organisations working in partnership with their communities, the public, private and voluntary sectors, have the opportunity to develop innovative rural healthcare services according to local need.

Tacking inequalities in health

The 1998 Acheson Independent Inquiry into Inequalities in Health highlighted how wide differences, or inequalities, are apparent in both the health of different communities – by socio-economic group, ethnicity and sex – as well as in a range of wider influences that can have an impact on health. Two key issues contained within the Acheson Report are the requirement to focus on supporting disadvantaged communities and social groups, and the need to make strenuous efforts to ensure equity in access to services based on need (Acheson, 1998). Whilst distance from primary, secondary and specialist services is considered as a supply-side issue of concern, rural access to health services and the needs of deprived rural socio-economic groups are not given separate consideration.

In reducing future health inequality, the Acheson report recommended, ‘all policies likely to have a direct or indirect effect on health should be evaluated in terms of their impact on health inequalities, and should be formatted in a way that by favouring the less well off they will, wherever possible, reduce such inequalities’. Whilst rural and urban populations may face similar health and social issues, rural issues over access, lack of choice and remoteness may well require national policies to be adapted, or innovative schemes to be introduced locally, according to need. The recommendation that priority be given to interventions that help younger women, expectant mothers and young children is particularly apt for deprived rural families.

The White Paper, Saving Lives: Our Healthier Nation, the national strategy for Public Health, followed Acheson in July 1999. Saving Lives offers an action plan for improving the health of everyone, particularly the health of those at greatest disadvantage, and for tackling the main killer diseases (DoH, 1999). The joint working approach it promotes links individual action on healthy lifestyles, community partnership working and government policy in together reducing factors that influence poor health.

A key aim of strategy is to ‘improve the health of the worst off in society and to narrow the health gap’. Whilst people can do little about their sex, age and genetic make-up, all of which play a role in determining an individual’s health, a broad range of circumstances - wider determinants of health - can be influenced.
In a socio-economic model of health and inequalities, layered factors that impart on personal and community health include (Dahlgren and Whitehead, 1992):

- Individual Lifestyle – diet, physical activity, smoking, alcohol, drugs, behaviour
- Social & community factors - culture, poverty, unemployment, social exclusion
- Living and working conditions - housing, air & water quality, service access
- General socio-economic factors - economic and environmental issues

Rural communities face particular issues over many of these broad layers that influence health. Distance acts as an added layer or barrier for many factors.

Health inequality runs throughout life, from before birth to old age (Bartley et al, 1998). It is apparent by sex, age, social class, and by geographical area. However, on average, rural populations live longer than those in deprived urban conurbations. For example, male average life expectancy in rural North Dorset is 79.6 in contrast to 69.7 years in Manchester – a gap of 10 years. Deprived urban populations are thus perceived as suffering from by far the greatest health and social inequalities (Benzeval et al, 1995). However, such headline summaries mask the inequity faced by deprived, isolated rural households.

*Tackling Health Inequalities - A Programme for Action*, published July 2003, details ways in which national strategy to cut inequalities in health can:

- support families, mothers and children
- engage with communities and individuals
- prevent illness and provide effective treatment and care
- address underlying determinants of health

In seeking to improve the health of the 30-40% of the population where the greatest burden of disease exits, this policy provides an agenda by which all public sector bodies – whether NHS, local authorities, social services, education, employment or planning - can to be guided (DoH, 2003b). In providing the basis for meeting health inequality targets by both geographical area and by social class, local level work needs to focus on the poor in affluent rural areas.

Health is an important dimension of social exclusion, itself a national priority. A distinction made between poverty, deprivation and social exclusion suggests poverty results from an inability to share in the everyday lifestyles of others because of a lack of resources (taken to be disposable income). Deprivation or disadvantage is a broader concept than that of poverty, and deals with the outcomes arising from both lack of resources and a range of additional social and economic conditions. Social exclusion relates to a wider breakdown in the social integration of a household within society and the resultant exclusion from society (Shucksmith and Chapman, 1998).

Where a range of social problems are compounded, for example isolation, unemployment, poor incomes, and lack of transportation, health can suffer disproportionately. Research has been unclear as to whether many rural people suffer short spells of poverty, or alternatively, a small minority experience long spells, from which they cannot escape.
National policy on healthcare reform and modernisation

The NHS Plan, published in July 2000, set out the national priorities for the health service, and presents the vision of a health service ‘designed around the patient’ (DoH, 2000). The Plan sets out core principles for the NHS, based around free access at the point of delivery to a comprehensive range of services on the basis of clinical need. The Plan seeks to develop the NHS so that it produces more effective, faster and fairer services that deliver better health and tackle health inequalities. Investment in the NHS and a programme of modernisation and reform is bringing about considerable change, for example, funding new hospitals, modernising GP practices and in providing additional staff, hospital beds and modern technology. Greater local level management of the NHS, national service frameworks (NSF), institutes for excellence and best practice, the views of patient being heard, new staff contracts, and evidence based treatment are all developing rapidly. National policy needs to recognise local variations in access to both healthcare and essential services.

Shifting the Balance of Power (the next steps; securing delivery) highlights how newly established PCTs have been able to take the lead in developing, redesigning and commissioning both primary care, hospital and community based health services, as well as tackling local public health issues (DoH, 2002b). Locally led and managed PCTs have taken over from HAs and have far greater control over budget allocations. In developing partnership led health agendas, Local Strategic Partnerships (LSPs) have a key role in linking local priorities and themes together, and in ensuring joined up action in tackling a range of health and health related issues in an integrated way. Local strategic partnerships and local health groups are held to be key partners for the development of rural healthcare services and interventions that meet local need. Health improvement and modernisation programmes (HIMPs) provide the strategic plan for improving health and healthcare between PCTs and partner agencies, and in linking into neighbourhood renewal and regeneration programmes.

PCTs are charged with being truly representative of their resident population. However, there is the risk that where rural PCTs are dominated by urban ‘town’ voices, the rural heartland may well be forgotten. Small, distant rural communities may well perceive that their needs are ignored, with development focusing on county towns. Rural communities may have different perceptions of what services are required locally, than that of healthcare planners. The economies of rural county towns and villages are interdependent, and not always competitive; short-term troubles or economic decline have consequences for general health. The working practices of rural industries, such as agriculture, do not always sit comfortably with national agencies’ statutory monitoring duties.

Improvement, expansion and reform: the next three years, published in September 2002, identifies national health and social care priorities – around improving service access, quality and outcomes, and in reducing health inequalities - that will have to be built into local plans to 2006 (DoH, 2002a). Priority areas are as relevant for primary care as for hospital services, and require close co-operation between health, social services and a range of local
agencies. Policy recognises that local communities have local needs – rural communities thus represent one set of local needs. However, rural healthcare planning, capacity building in terms of staffing, building, equipment and improvements in services, are all affected by access issues. The organisation of services for dispersed rural populations is important, otherwise modernisation agenda choices such as patient choice, GP contracts and assertive outreach may have little meaning for rural communities (Moore, 2003).

Historic centralisation of NHS services vs. keeping the NHS local

The NHS has consistently chosen a route of centralising secondary care (and other) services within conurbations and regional centres (Watt et al, 1993; Fearn, 1987). ‘Biggest is best’ has underpinned many of the changes in the NHS. However, in concentrating acute hospital services without sustaining local access, particularly in rural areas, services have increasingly been perceived as more remote from many communities. As a result, rural residents have faced inequality in accessing local services, with issues over the time, distance and difficulty it takes in obtaining specialist healthcare. Such distant urban centralised services include A&E departments, obstetrics, a range of specialist hospital services and regional cancer centres. Remoteness and access to services is essentially a political decision regarding priorities, and the issue of whether barriers can and ought to be overcome.

*Keeping the NHS Local – A New Direction of Travel*, published in February 2003, offers guidance and a new approach on designing local health services, and through the proposal of developing high quality, effective care in smaller hospitals, a means of consultation in promoting rural health services, and through the proposal of developing high quality, effective care in smaller hospitals, a means of consultation in promoting rural health services (DoH, 2003a). Whether or not some may feel *Keeping the NHS Local* to represent political expediency following political backlash from the closure of the Kidderminster A&E Unit, it offers a positive view and approach regarding how accessibility could be improved for rural communities. In particular, through its promotion of the role of smaller hospitals, it offers rural based community hospitals (formerly cottage or GP hospitals) a key role in providing a range of services tailored to local needs.

Community hospitals vary considerably in size and function, and can offer ‘ambulatory care’ such as outpatient consultations, investigation and diagnostics, some surgical procedures and low dependency inpatient care. Community hospitals are seen as a major future player in supporting rural intermediate care, in particular, in preventing bed blocking. Both local and specialist regionally based teams can readily hold some outpatient clinics in community hospitals, considerably benefiting patients who would otherwise have to travel long distances. However, there are still many tensions over the wide range of additional services that centralised hospitals can offer patients. Community hospitals are run by PCT teams; acute trust teams could provide added input. Rural geographies can leave patients isolated. There is a misperception that patients living close to the boundaries of two rural PCTs will have option of receiving treatment from alternative sources. In reality, primary care teams in neighbouring Trusts may each miss such patients.
C. Rural Social Services

Rural social service teams have a key role in supporting vulnerable, often isolated people, through home support and within the community in day-care centres. Care In the Country, the first comprehensive inspection of rural social services, was published in 1999 (Brown, 1999). The kinds of services offered to people in rural areas are not markedly different to those offered in urban areas. As with rural health services, the greater distance from resources, neighbours and others in need differentiates urban and rural communities (DoH, 1996).

In the case of home care services, the report found that rurality issues brought about such problems as staff recruitment and retention, limitations on service choice, confidentiality, travelling times and costs, the provision of back up support, changes in who delivers care, and the efficient use of staff time. Day care services are generally based in larger centres. Issues here revolved around how to transport people economically and efficiently to such services, and what can be done when transport is not available. As the population of rural areas continues to grow older, provision of a range of home care services may increasingly become an issue.

Legislative opportunities for flexible working between the NHS and local authorities have led to the development of more formal partnership work, for example through mental health and community trusts, and via the recent establishment of Care Trusts. PCT based Care Trusts offer a possible way forward for modernising social and health care, and could potentially provide a more cost effective and comprehensive service in rural areas.

D. National rural policy

The 2000 Rural White Paper

The Government Rural White Paper, Our Countryside: the future - A fair deal for rural England, published in November 2000, sets out the challenges and key goals facing the countryside and rural policy makers (DETR, 2000b). With a vision of a ‘living, working, protected and vibrant countryside’, the White Paper details national policy around these headline topics. The report concedes that basic core services are overstretched in rural areas, and that the countryside faces considerable development pressures. However, the Paper suggests that any generalisation of rural issues is dangerous given wide regional variations in economies, infrastructure, and relative remoteness.

In supporting a living countryside, the White Paper focuses upon support for key rural services, the modernisation of rural services, provision of affordable rural housing, and an improvement in rural transport services. Initiatives include renewing the rural post office network, rate relief for village shops, development of primary care ‘one-stop centres’, internet learning and access points, increasing the housing association programme, providing regular rural bus services, and offering community initiated transport scheme grants.
To promote a working countryside the Paper offers funding for the rejuvenation of market towns and sets out aims to support and reform farming and related industries. In supporting local rural Parish and Town Council community initiatives, the Government seeks to promote a vibrant countryside. Rural proofing, as discussed, should take rural need into account in planning.

The White Paper recognises communities may face ‘isolation, lack of information, and high travel costs’, whilst service providers will face ‘sparsity, extra costs and scattered clients’, in providing core services. In regard to health and social care it states, ‘the challenge for health services in rural areas is to provide good quality accessible care to an often scattered population, and to ensure that people living in the country with particular needs have the same opportunities to benefit from targeted help as those living in towns’.

Action over rural health is typically highlighted by the perceived benefit for all of national developments, as opposed to the development of specific rural health initiatives. For example, NHS Direct is seen as a gateway to rural healthcare, rural areas will benefit from national hospital building and modernisation programmes, the NSF for older people sets out the standards needed to improve care for the elderly, and rural ambulance response times are set to improve.

One-stop rural primary care centres or mobile centres are considered by the Paper to be a major development in supporting the majority of rural people. As of September 2003, 61 of 265 new primary care centres are being established in rural areas (IRH, 2003). However, the definition of these rural primary care centres could become blurred when contrasted with the remit of community hospital services, out of hours GP services, and GP led minor injuries unit rural developments. Indeed, primary care centres could be perceived as applying an urban solution to rural areas.

Additional rural stakeholders

There are a number of rural stakeholders with a health remit or interest. In particular, the Countryside Agency has the key lead in maintaining, developing and protecting the countryside, with a range of rural area regeneration projects - as set out in the Rural White Paper. The Department for Environment, Food & Rural Affairs (DEFRA), has both a role in improving accessibility of services to rural people, as well as a public health remit. National policy on tackling social exclusion cuts across many public sector organisations, with the aim of removing inequity in society equally valid in rural areas. Initiatives include minimum income guarantees, the new deal for jobs, and investment in housing.

The Rural White Paper aims to further involve local communities more in decision making so that rural voices can be heard. Rural communities have representation through their parishes, district councils, transport authorities, and county councils. A wide range of health, community, voluntary sector, rural service, local council and welfare groups have a rural interest, which can be voiced through local health groups, partnerships and discussion (CPRE, 1999).
Rural economies are served by a range of agriculture, tourism, food processing, rural development, and land management interests. Local authority, national park, Area of Outstanding Natural Beauty (AONB), and various national charity interests (for example the National Trust and RSPB) provide management of the rural environment, and for whom rural health may or may not be an issue.

Regional Rural Forums have been established to enable the exchange of information between rural interest groups and to advise regional and national policy makers on local issues. The North West Rural Affairs Forum represents a rural voice for the Region, with 200 organisations and individuals invited to its twice-yearly full meetings. A steering group of 30 key organisations meets four times a year and has an ongoing work programme, although health has not to date been represented separately on this group (CNWRS, 2002). Findings from a 2003 IRH national survey indicate that only 10% of rural PCTs (who responded) are currently working with a Rural Affairs Forum (Swindlehurst, 2003). Whilst PCTs have strong links to local strategic partnerships, rural health links to regional partnerships could be developed further.

Multi-agency programmes with a rural dimension

Multi agency commitment and partnership are considered an over-riding feature of successful health and social care schemes in rural communities (RHF, 1998; DoH, 1996). These may result from formal links with partner organisations, joint initiatives with community groups, service users and carers, or with a range of voluntary organisations (for example, Women’s Institutes, Parish Councils, Age Concern and church societies).

A range of multi agency programmes have been established to tackle deprivation, social exclusion, and health and social need in those areas with greatest need. Such programmes have established rural models, for areas where deprivation and need may be scattered, or population numbers small. For example, Health Action Zones (HAZ) bring together the health service, local authorities (including social services), the voluntary and private sectors and local communities in tackling major local health problems and inequalities in health. Part rural or rural HAZ have been established, for example, in North Cumbria.

Whilst neighbourhood renewal funds (NRF) are available for projects that tackle deprivation in the most deprived local authority neighbourhoods, such funding is not available to tackle the needs of deprived people who do not live in so called deprived areas. As such, national public policy may fail to offer either a rural strategy, or essentially even a national strategy. In contrast, the New Opportunities Fund has funded innovative projects in health, education and the environment, which are additional to core governmental expenditure. The development of healthy living centres, or as in the Peak District rural ‘healthy living networks’ (PDHLN, 2003), has offered a holistic approach to address issues that affect health. Such centres have offered activities and services such as outreach work, health education with young people, welfare advice, citizens advice bureaus, crèche facilities, parenting skills courses, local food co-ops,
credit schemes, home safety equipment schemes and free exercise schemes. Rural ‘one stop’ shops could more effectively bring together numerous agencies.

Sure Start programmes for families with children aged under four seek to improve the health, education and emotional development of young children in disadvantaged areas, develop childcare availability and support parents. Pilot ‘mini Sure Start’ programmes are being established in rural areas, where there are pockets of deprivation, yet, the number of disadvantaged children living locally is considerably less than required by conventional Sure Start (Sure Start, 2003). A small number of rural schemes, for example in West Allerdale in Cumbria, are developing innovative ways of delivering services that characterise urban Sure Start. For example, it has been suggested by the DoH that rural Sure Start schemes could offer mobile playbuses, access to rural childcare, access to advice centres on health and financial issues, and mobile clinics.

E. Funding rural health, social care and public sector services

To fund high quality healthcare or other services adequately, it needs to be recognised that the cost of running equivalent services can be higher in rural areas than in urban ones. Woolett (1993) highlighted how scattered populations and dispersed settlements in rural areas bring about increased service costs:

- Low numbers of service users prevent economies of scale from being achieved; service quality may be restricted, and basic service costs higher
- Rural services face additional transport, travelling and communication costs; these are compounded by the higher cost of fuel in rural areas
- Staff may be less ‘productive’ as they have to spend far more time travelling between patients or clients
- Added costs are incurred in providing transport for rural service users
- New services often develop at a slow pace due to the difficulties in communicating over long distances and unproductive time spent travelling
- Different methods of delivering services may have to be introduced to ensure access; implementing communication technologies is expensive
- Extra costs are involved in accessing training, staff support, or consultancy
- Rural voluntary agencies may well find greater problems in accessing funds

Rural costs are often hidden, with rural local authorities seen to be low overall spenders, and with urban-rural unit cost comparisons difficult to calculate. In contrast, urban areas may also face higher costs, through property prices, wage levels, and city based costs of living. As a generalisation, rural areas provide smaller service ‘units’, which may result in lack of choice, limited specialised services, restricted opening times, and higher unit costs.

Health Service providers face a range of rural costs, which result from the need to maintain more District General Hospitals, additional smaller community hospitals and healthcare sites, as well as from lower bed occupancy rates, higher prescribing costs, higher travel costs and long term staff pay grades. Rural PCTs need to provide community hospitals, minor injuries units and clinics, within
The complex formulae used to allocate funding to former English Health Authorities for hospital and community health services (HCHS) have not included a rurality or sparsity factor. England is thus the only region of the UK not to significantly adjust healthcare resource allocation funding to compensate for costs that result from rurality (Asthana, 2003). Ethical issues are at stake (Rice and Smith, 2001). Differing approaches to rurality funding have been taken to allocate healthcare funding in Scotland, in Wales, in England for General Medical Services (GMS) allocation, and for local government Standard Spending Assessments (SSA) – now replaced by the Formula Spending Share (FSS).

Two recent reports (Asthana et al, 2002a; White, 2001) review the issues, history and methodologies surrounding UK NHS allocation formulae. They argue that current allocations hinder rural areas in several ways. For example, the current English formulae fail to compensate for the extra costs faced by healthcare providers in rural areas, for example, in running several hospitals, and community sites with lower bed occupancy rates. Adjustments for unavoidable variations in the cost of providing rural services take insufficient account of time, travel and transfer costs, and the duplication of roles. The use of census variables such as unemployment as formulae indicators of poverty may misrepresent rural disadvantage and deprivation. Funding factors that adjust for notional need are considered flawed and inappropriate, with the poorest areas receiving less than the most affluent. Services that show higher levels of need amongst older people, such as for district nursing, show inequitable distribution of funding, discriminating against areas with higher numbers of older people; often these are rural areas. Assumed levels of use of health services, by age band, may again weigh against rural older people. Particular services, such as psychiatry, are disproportionately funded towards urban centre utilisation. The NHS pay formula is weighted to reflect salaries within local communities, ignores the fact that staff are on national scales, and thus results in a skewed allocation for London and affluent areas.

In contrast, the Scottish Fair Shares Model of hospital, community and general medical services allocation weights heavily towards, and distinguishes between, rural and remote areas. Extreme isolation, whether on an island or remote mainland, is seen as requiring levels of health service that cost significantly more (SEHD, 1999). Thus, whilst the landscapes and accessibility issues of Scotland may be perceived to be very different to those in England, thus justifying different allocation formulae, in reality areas such as Cumbria, the Pennines, North Yorkshire, Northumbria, Cornwall and East Anglia offer similar issues of peripherality.

The formula used to allocate GP funding in England weights for different health measures, such as limiting long-standing illness, and better represents health need. Indeed, within primary care, some recognition is given that costs are
higher in rural areas, with GP practice funding linked to the proportion of patients living beyond a set distance of a surgery. Emergency ambulance services receive a minor funding adjustment for rurality. Rurality is a significant factor in local government non-health allocations.

Funding allocations for English hospital and community, GMS and prescribing services are given directly to PCTs. This may highlight even greater distortions in locally available funds, should allocation formulae be found to be systematically biased.

Irrespective of how health, social services and other rural agency funding is allocated, the question remains as to whether rural PCTs and other agencies are able to use the resources they are allocated to provide equitable levels and quality of service and care, and in particular, to provide an equitable service based on rural need. One approach is to target all health funding and programmes towards the most deprived wards in an area. However, if PCTs target resources to areas (wards) with highest concentrations of health need, which are typically found within larger towns, they can miss out the rural poor, scattered across dispersed communities, who comprise the middle level deprivation groups in terms of both socio-economic status and social class. The targeting of rural communities who are suffering from deprivation and need, yet remain hidden using standard indicator measures, such as the index of multiple deprivation, needs to be considered and resourced.

Morecambe Bay PCT, with 310,000 residents, has the 5th largest resident population in the country, neighbouring Eden Valley with 69,000 residents the 3rd smallest. Covering neighbouring rural districts, how can staffing and funding levels fully compensate for such size differences? Morecambe Bay in some respects benefits from its size, in that rural residents can make use of large urban acute hospital services (IRH, 2003). However, a far smaller rural PCT may have a relatively smaller resource allocation.
Chapter 5: Local rural health, healthcare and social initiatives

Improving access to rural healthcare and other local services

Issues of concern to local communities are often similar, regardless of whether a locality is urban or rurally based. However, potential solutions to such issues may well require recognition of their rural context, and in addition, how a given area or community is distinctive from others elsewhere. By undertaking a careful and sensitive comparison of local needs against existing service availability, gaps can be identified, and new resources potentially funded and brought to the area. A wide range of innovative rural health improvement, healthcare and community support initiatives have been established nationally, as well as in the North West. Such schemes demonstrate how access to rural services and healthcare, and the promotion of health, can be developed according to local circumstances. Examples are considered throughout this chapter.

Bringing primary care and other services to the community

Chapter three has highlighted how evidence indicates that reduced access to care can have adverse effects on the health of rural residents. A number of models of good rural primary care healthcare practice and services have been developed, and improved over time, which help to address this key issue. Such service delivery models include branch surgeries, mobile services and home visiting services, which seek to be sympathetic to the particular circumstances of rural patients.

Branch surgeries, as previously discussed, can vary appreciably in scope and size, and are much less common than a generation ago. In remote communities however, even a very limited service, such as a once weekly GP session at a local branch surgery, may be of particular help to the frail, older patients, terminally ill, the farming community, and to those without transport.

Where transport is poor, and a patient has problems in getting to health services, home visiting may be more common. Domiciliary services are likely to be determined by both geography and clinical urgency, although a patient may receive an irregular service. There has been a long-term decline in both home visiting and the use of branch surgeries (Fearn, 1987; Bentham and Haynes, 1985). GPs are deterred from making long distance visits that involve considerable time. However, in remote rural areas this may be the only option for a patient.

Outreach working enables healthcare workers to work in non-healthcare environments, for example, in pubs and auction marts, which may well appeal to those who see healthcare as less relevant to them or who would not typically wish to visit a GP practice team. Case study 1 details the Morecambe Bay ‘Farmers Health Project, an innovative example of rural outreach working.
Case Study 1: The Morecambe Bay PCT ‘Farmers Health Project’

Whilst farmers are perceived to lead healthy outdoor lives, in reality they face numerous hazards, illnesses, hard physical conditions, and work practice changes, and may suffer from a range of stress related and mental health problems. Farmers and farm workers work long hours, in demanding jobs, and it is often difficult for them to take time off to visit a doctor. When surgery hours clash with milking, harvesting and daily schedules, attending surgery can be a non-option. Many feel let down, both by the health service, and particularly post foot and mouth, a range of other Government agencies.

The ‘Farmers Health Project’ has been an innovative, and internationally recognised example of outreach work within the farming community. Primarily based within Morecambe Bay PCT, which covers South Cumbria and North Lancashire, it has been an initiative closely involving both the PCT and the Institute for Health Research at Lancaster University.

The urgent need for a mobile farmers health service had been identified in an earlier research study, which had looked at the issue of why farmers were not using mainstream health services (Gerrard, 1998). Funding was provided for two nurse practitioners, themselves from rural backgrounds, along with support workers, to use a mobile healthcare unit to visit the range of venues where farmers meet – for example, auction marts and agricultural shows - and provide support, care and a first line for treatment.

After overcoming initial reticence amongst farmers to get on board, the local farming community have become highly supportive. The nurse practitioners acted as a key link between patients using the service and other healthcare services, and complemented GPs, who may not have been visited by the patient. A range of diagnostic equipment was carried, and farmers felt they were being seen privately. The nurse practitioners understood both the range of conditions which farmers are susceptible to, and how to prevent or treat them. If serious problems were found, appointments could be made straight away.

The service was widened to include rural people, and during the foot and mouth epidemic additionally worked as a support helpline. Despite the projects undoubted success, reputation, and local support, its role is currently being adapted; its continuation is uncertain without long term commitment and funding.

(Holmström, 2002; Burnett and Mort, 2001; Gerrard, 1998).

There is considerable potential to develop the role of the nurse practitioner in rural areas. Nurse practitioners have a level of skills, training and experience which enable them to diagnose and manage commonly seen diseases in collaboration with a patient, giving them a degree of autonomy and independence from the need to refer a case directly or indirectly to general practitioners and other members of their primary care team.

Bringing the community to secondary care services

Public transport is one of the most critical issues of concern in rural areas (Moseley, 1979). For those who do not have access to a private vehicle, or who cannot drive, public transport offers the main means of accessing services and maintaining a quality of life. Transport is a key element in supporting vibrant
rural communities. Numerous rural transport services have either been lost in recent years, or severely reduced. However, more recently, a number of rural transport models have been introduced which help rural populations, including patients, to access a range of health and other services, whether for a hospital outpatient appointment or operation, GP appointment or day care session. Case study 2 highlights joint agency partnership work.

Local bus services and community transport schemes play a vital role in many rural areas for those without ready access to a car. Where a bus route is established, timetables may however be restricted to certain times of the day or even only to occasional days. By working in partnership to improve public transport, services can be increased and adapted, for example, more effectively linking established routes, providing more frequent and site based access to hospital and other community services, and matching timetables to shop opening times, railways and alternative transportation.

Case Study 2: Rural transport partnerships

An example of rural transport innovation is the Worcestershire integrated transport partnership. In a partnership between the NHS, bus operators, Worcestershire County Council, the voluntary sector and a range of additional partners, transport services have been developed to tackle a number of rural issues, for example, in improving access to health services, employment and education, and in seeking to reduce social exclusion and improve social opportunities.

Funding from the main agencies was first directed to develop urban services between the three main acute hospital sites based across the County. The partnership is now investing in rural transport initiatives, which serve local population centres and link community hospitals and GP practices. Initiatives include a mixture of fixed route bus services and demand responsive services.

The transport group is working closely with existing community-based groups, offering the potential for better integration between different rural transport schemes. ICT is being used to promote better information on route and journey timetables and travel opportunities, for example, showing how journeys can be linked, rather than just presenting the timetable for one transport company.

(Deaville et al, 2002).

Community transport schemes, such as voluntary community minibuses, dial-a-ride and car share schemes, have been developed where public bus provision is limited and not cost effective (CA, 2001c). Through its Vital Villages initiatives, the Countryside Agency offers rural transport partnership funds. Rural Transport Partnership grants offer funding for larger scale transport initiatives that involve partnership between several organisations (for example, transport operators, local councils, tourism and health groups). Parish Transport Grants offer funding for smaller scale projects where communities seek to meet local needs. As each local community has different requirements, projects can be highly flexible. For example, funding can help with the purchase of minibuses for community use, or to support car clubs, the diversion of an existing bus service through a village, to help with taxi sharing schemes, to provide information on transport options, and
so on. ‘Rural wheels’ schemes in Cumbria, and elsewhere, offer a variety of volunteer led transport options (CA, 2001b, & Vital Villages ‘updates’).

Royal Mail Postbuses, operating along some 200 routes in remote areas across Britain, can be hailed at any point along their route (Royal Mail, 2003). They offer subsidised daily transport in remote areas, although trips have to be planned carefully as buses follow mail delivery routes. The Countryside Agency ‘wheels 2 work’ moped loan scheme has helped teenagers in remote areas use mopeds to get to work or college, and travel without dependence on timetables.

As an ideal, patients should, where required, be offered appointment times which fit in with existing public transport timetables, through consultation with either the patient themselves or their practice. NHS patient transport services might learn from other rural services, for example, rural school mini bus or taxi services, in how to best support patient travel needs or in making joint use of transport.

Community-led rural infrastructure initiatives

Partnership working, strong local community involvement and ownership of projects, and the establishment of networks are all viewed as essential for healthy and vibrant rural communities to develop local service and access initiatives. Innovative local self-help schemes, which run a range of services from lunch clubs, to food co-operatives, to minibuses, are being promoted as possible models for others to follow. Case study 3 provides an example of how community based food co-operatives have been introduced in North Cumbria.

### Case Study 3: West Cumbria Food Co-operative scheme

Parts of North Cumbria suffer from high levels of deprivation, and their isolated communities have significant problems with heart disease and cancer. In a successful partnership between the Health Action Zone, the Countryside Alliance, the local councils and auction mart, food development workers are helping to supply affordable and quality fruit, vegetables, meat and fish to disadvantaged local communities.

27 food co-operatives, each serving 40 to 100 families in West and North Cumbria, have gained national recognition for their innovative community scheme. Food is bought from local producers, and has linked farmers, market gardeners, egg producers, fish farms and small businesses to their communities. Volunteers then divide up the fruit and vegetables and put them into carrier bags for each family. The cost of buying from the food co-op is a fraction of what a supermarket would charge (a large bag of local produce typically costs only £2), families with limited means receive a variety of fresh food, transport costs are low for producers and income is guaranteed. Food is seasonal, fresh and full of fruit and vegetables.

A number of initiatives have followed, for example, promoting ‘five a day’ healthy eating, ‘ready steady cook’ sessions for hard pressed single parents, mini gardens in schools where children can grow their own food, farm visits, and possible development of public sector supplies. The scheme demonstrates how deprived communities can work with rural agriculture to the gain of both. The idea of healthy eating is promoted and communities have an opportunity to get to know each other more.

(Taylor, 2002; Beenstock, 2001).
Such community ‘bottom up’ schemes can support locally expressed needs for access to a range of services, and the development of locally based projects and clubs, for those at greatest need. For example, a local initiative could help develop the village pub into a shop, post office and community base. Minibus schemes in particular help local residents to get around when needed. Case study 4 shows how a number of health related, as well as other rural initiatives, have developed from the Northern Fells Rural Project in Cumbria.

Case Study 4: The Cumbria Northern Fells Rural Project initiatives

The Northern Fells Rural Project provides self-help schemes to seven small communities scattered around the northern fells of Cumbria. Based around Caldbeck, these communities have a combined population of 3,600, who live within 200 square miles of remote countryside.

The project started as one of three Prince of Wales Rural Revival Initiative pilot projects, which sought to highlight some of the problems facing rural areas. It has now developed into a community managed and volunteer led limited company that runs a range of services the community need.

In 1999, the project initially had a specific health focus, seeking to identify unmet local health and social needs, to map existing support services and identify gaps, and to develop services that used healthcare as an entry point. Needs of the elderly, young, people with disabilities, carers, young parents, the unemployed and those on low incomes, and people without transport were all considered. A wide range of funding was guaranteed. The remit of the project has since become far wider.

Local knowledge highlighted how flexible, local transport would be key to service provision. A minibus with wheelchair access was provided from the outset of the project to help residents get to doctors surgeries, dentists, and optometrists, as well as to visit people in hospitals, nursing homes and residential homes. Volunteer drivers work Mondays to Saturdays to offer a flexible and responsive service for any journey, or any need, at highly subsidised rates. The minibus sought to complement existing services, such as the infrequent bus services, and existing voluntary and hospital car services. By year two, only 60% of bus bookings were medically related; it is booked in advance for many uses.

Initial findings confirmed how modest funding streams, which built on the skills, resources, enthusiasm and experiences of local people, can be used to help a community support itself to fill in service gaps. Minibus driver recruitment was found to be surprisingly easy, indicating how rural areas can have a great sense of community. In addition, the project has supported older people, for example, through referrals to agencies where additional help could be provided, in obtaining state benefits, and on organising monthly social lunch clubs. Young people’s initiatives, undertaken in conjunction with teenagers through group and other discussions, have focused on involving the teenagers themselves in finding solutions to issues raised.

Now, as a limited company, the community is providing a ‘lend a hand’ support scheme for those who are ill, have disabilities or who are carers. A youth development worker is leading activities for young people including short training courses, workshops and trips. The door-to-door minibus is well established, along with the lunch clubs. Benefits awareness and advice are being developed. Part-time paid co-ordinators make best use of local volunteer time and skills, for the community.

(Northern Fells Rural Project, 2002; CA, 2003e).
Community schemes work best in partnership with existing national organisations where there is common ground. Whilst many communities have developed their own transport schemes, there is concern that these self-help voluntary schemes are being used by government as a means of free delivery of welfare services (Sherwood and Lewis, 2000). Whilst local interest can produce volunteers, and funding support, such schemes may however suffer from problems of long-term recruitment and retention. In addition, failure to find sufficient funding can be a dispiriting experience, and the time co-ordinators and volunteers provide needs to be recognised and respected. It could be argued that voluntary community services may in time exacerbate the problem of access for remote rural settlements, enabling public sector agencies to downgrade or continue with lesser services. However, community enthusiasm for such initiatives, from those who take part, cannot be doubted.

Development of existing community based secondary care services

The provision of care in rural areas can be seen as a compromise between accessibility and required levels of quality of care. Patients in rural areas cannot expect rapid access to specialist secondary or tertiary care centres for a range of treatments and medical emergencies (Baird, 1999). The gap can be filled by cottage, or community hospitals, which can have a major role in offering selective services. These can include acute, diagnostic, therapeutic and chronic care, mental health service provision, ambulatory care, and locally based outpatient consultations, as promoted in ‘Keeping the NHS Local’ (DoH, 2003a). Whilst only accounting for a tiny proportion of patient beds, they offer initial hospital care for a far higher proportion of the population (Fearn, 1987).

Case study 5 details how Westmorland General Hospital, in South Cumbria, has developed its midwife led maternity unit and services to meet the needs of women in rural areas, as well as integrated emergency and minor injuries services with the local out-of-hours Co-op scheme. These service changes show what could be achieved in smaller community hospitals.

The safeguarding and redevelopment of local minor injuries units, closer links to GP out of hours Co-ops, midwife led maternity units, intermediate care bed provision, and the establishment of healthy living centres all provide examples of how rural healthcare can be adapted to meet patient needs, staff skills and willingness, financial constraints and technological and medical advances.

Whilst many community hospitals have closed over time, there are still several within the North West, for example, at Alston, Brampton, Cockermouth, Keswick, Maryport, Millom, Penrith, Wigton, and Workington in North Cumbria, Accrington, Clitheroe, Pendle and Ramsbottom in Lancashire and Congleton and Knutsford in Cheshire. Each will offer a range of locally responsive services, and could develop under the guidance of Keeping the NHS Local.
Westmorland General is a small, recently built, rural District General Hospital located in Kendal, South Cumbria, and offers a limited range of inpatient, day case and outpatient services. Serving the needs of a widely dispersed, rural and affluent community, it is somewhat precariously located between two far larger (though distant) Morecambe Bay Hospitals NHS Trust DGH sites at Lancaster and Barrow. Maternity and emergency services have been adapted to meet the need for modern, accessible services for the mixed market town, tourist and rural based community. Whilst facing considerable financial and staffing constraints, and regular threats of closure, services have been innovatively developed.

a. Maternity services

The continued availability of high quality, locally accessible healthcare services is an emotive issue in rural areas. Health service professionals, and communities alike, care passionately about the services they manage or receive. In 2001, a vociferous local community campaign helped 'save' Helme Chase maternity unit from possible closure. The previously consultant-led maternity unit had been moved and then downgraded. The unit was re-established as an integrated midwife led service, remaining a base for community midwife antenatal services and including a 'birthing centre'. Prospective mothers, at low risk of complication, do not have to travel to Lancaster or Barrow, some 30 to 60+ minutes from home.

The success of the unit was demonstrated in 2003, when Helme Chase was voted one of the best places in the country to give birth, winning the National Childbirth Trust midwife led unit better birth environment award. Whilst there is a delicate balance between social and medical factors in providing maternity care, and safety may be compromised given the range of potential obstetric complications, women in rural areas should be given a choice of locally accessible birth, or consultant led hospital delivery with a full medical team.

b. Integrating emergency and minor accident services and out-of-hours GP Co-op schemes

The Kendal Emergency and Minor Accident Unit (EMAU) has also been threatened with closure. A public consultation over service options was held during 2002, to determine how best to respond to local 'unscheduled hospital attendances, admissions and out of hours services'. By not having emergency surgical facilities, intensive care or unscheduled out of hours services, Westmorland General is more like a community hospital than a full DGH. Training posts are not recognised, making 24 hour medical staffing a challenge. Nurse practitioners have proved a valuable resource. 12 million visitors to the area each year dwarf the local population. If the unit closed, 18,000 new patients would have to travel to Lancaster.

At night, the GP out-of-hours Co-op scheme has been based independently, next door, in outpatients. When junior doctors could no longer be used in the EMAU, assessment and treatment was totally led by nurse practitioners and on call GPs. There may at times have been confusion over who was actually treating a patient. As significant trauma cases go straight to Lancaster, the caseload is manageable. However, high season visitor numbers, and unexpected peaks brought problems, with no clear sense of where the unit's future lay.

A short-term plan has been agreed whereby the Westmorland GP Co-op will pilot a core general practice type service for emergency and minor accidents between midnight and 8am, in conjunction with nurse practitioners. Paramedics may become more involved if patients arrive unexpectedly who could be better dealt with by using paramedic skills. A commitment to keeping the unit going, 24 hours a day, prepares for the long term, which will seek to further integrate all out of hours provision, emergencies and minor injuries, with one entry point, one base, a common pathway of treatment, and the removal of traditional barriers to joint working.

(National Childbirth Trust, 2003; Morecambe Bay Hospitals NHS Trust, 2002; MBHA, 2000).
Joint service provision

Innovative ways of organising medical care and social care are required to make full use of limited resources in rural areas. With the increasingly proactive role of the emergency services, retained fires stations in remote areas could for example be used on occasion as a community health base. Whilst a rural fire station is ideally located as a base for a community defibrillator, there is no reason why, when an IT infrastructure is in place and first aid equipment already available, health and emergency services could not share such bases.

‘One-stop shops’ are another example of joint service provision. Rural one-stop shops are being introduced to provide personal advice, help with benefits and access to training. The first such rural one-stop shop was opened in Shropshire in 2003, and includes a post office, a village shop, an ATM cash machine, an ICT access centre, a community office and regular police ‘surgeries’ (DEFRA, 2003). The rural White Paper promotes the development of similar ‘one stop shop’ primary care centres, or mobile centres. The role of these centres in rural areas is still to be fully established, and offers considerable potential for innovation. For example, a one-stop primary care centre could improve GP practice communications, providing internet and tele-links to local hospitals. The booking of hospital appointments could be linked to transport schemes. Such centres could additionally support community led food co-op schemes, offer safe buy health promotion services, and link to rural ‘mini Sure Start’ crèche facilities.

In many remote and isolated areas, there is no local pharmacy from which medical prescriptions can be dispensed. In such cases, the local GP practice is often a dispensing practice. This has advantages where costs do not justify the employment of a professional pharmacist. Whilst dispensing payments are made to GPs for providing such a service, there is concern over future funding. The RCGP Rural Doctors’ Group has stated that general medical services in rural areas should be funded equitably without the need to rely on this extra source of income (RCGP, 1999). The one-stop shop aim could be applied.

Emergency service responses

Casualties suffering from a suspected heart attack or major trauma injury may well face longer waits to receive care in rural areas, due to the distance involved in reaching them from central ambulance stations or stand by locations. Rural ambulance services are required to reach a patient suffering a life-threatening event (category A calls) with a 1st response, within 8 minutes in 75% of cases.

Rural ambulance services have introduced rapid response paramedic schemes. Cumbria Ambulance Service have introduced fast response paramedic vehicles, enabling paramedics who are held on standby at callout hotspots to arrive quickly at the scene, stabilising a patient prior to the arrival of an Ambulance. Cumbria had previously introduced fast paramedic motorbikes, with some media interest, which were intended to beat long summer traffic queues in the Lake District. However, health and safety laws restricted the use of these bikes to fine weather, and they proved costly. This scheme was unsuccessful and dropped.
After a cardiac arrest, it is vital to give a patient thrombolytic drugs as soon as possible, preferably prior to hospitalisation. With the centralisation of district A&E Departments, at distance, how can such services be provided 24 hours a day, 365 days a year? In August 2003, Cumbria paramedics successfully administered the first clot-busting pre-hospital thrombolysis on a rural heart attack victim. Some 160 paramedics in the region are undertaking highly specialised training, enabling them to administer such drugs to rural patients prior to arrival at hospital (Broomby, 2003).

Ambulance services, and others, can waste considerable time trying to find rural patients. This applies where a property may have no house number, be located up a long isolated track, or become lost in darkness. In Kentmere, Cumbria, the Women’s Institute are in the process of giving every household in the valley a laminated card which includes their full home grid reference, house name, postcode and important telephone numbers, and which can be used when the emergency services need to be called (Westmorland Gazette, 2003). Such simple innovative local solutions show the power of community initiatives.

The region can call on the use of the North West Air Ambulance helicopter service, operational since 1999, for major trauma incidents. Based at Blackpool, and part funded by public donations, its effective area of use is still restricted, and of less use to rural communities in Cumbria. In the autumn of 2003, fundraising was started by the North East based Great North Air Ambulance to purchase a new air ambulance to serve Cumbria, the Scottish borders and parts of North Yorkshire. If successful, the service may be based at Penrith.

Rural fast response service initiatives, whether ambulance, fire or police, are generally county based responses, and not specifically for rural communities. An exception to this generalisation is the ‘Community First Responder’ scheme, promoted by many Ambulance Services for rural areas (Nelson, 2002). North West ‘Community First Responder’ schemes are discussed in Case study 6.

A number of doctors are members of the British Association for Intermediate Care (BASICS) and work closely with Ambulance Services, Cumbria included. Several volunteer Mountain Search & Rescue Teams (and cave rescue) are established in the North West, and in the Lake District in particular. The Royal National Lifeboat Institution offers similar support for coastal emergencies. Mountain rescue team members are trained in search, first aid, survival and rescue techniques, and provide immediate care for mountain accident victims prior to hospitalisation. RAF and Royal Navy helicopters can be called out in emergencies, though their bases are currently under review. Whilst such rescue services have particularly close links with the police and armed forces, and many units have doctors attached, their role supports a mountain environment. Paradoxically, where a farmer injured on his own fell side may be reliant on the ambulance service, a nearby walker may receive alternative support. Given the increasingly proactive role of the emergency services, could not greater use be made of Forces helicopters for remote rural trauma and emergency NHS support?
Case Study 6: North West ‘Community First Responder’ schemes

All North West Region Ambulance Services have promoted the establishment of community led, volunteer, ‘First Responder’ Teams, who are trained to attend certain (non trauma) emergency 999 calls within their neighbourhood, 24 hours a day. Such basic life support and early defibrillation potentially offers a significant improvement in the chances of surviving a cardiac arrest. For example, as of May 2003, some 26 Cumbria community groups have established first responder teams, using defibrillators based at 33 sites. Teams may be called out to incidents within three or more miles of their base.

Standard 5 of the National Service Framework for Coronary Heart Disease (2000) requires that ‘people with symptoms of a possible heart attack should receive help from an individual equipped with and appropriately trained in the use of a defibrillator within 8 minutes of calling for help, to maximise the benefits of resuscitation should it be necessary’. However, in rural areas, it is often not possible for a paramedic ambulance team to reach such cases for some time. Equity in access to vital healthcare, when needed, is a key principle of the NHS.

Each First Responder team has to form, fundraise, train, purchase defibrillators, bleepers and other equipment, and to develop in its own way and learn from their own successes and mistakes. Community team volunteers are increasingly being called out to more calls, typically to offer care, and at times arriving just before, or at the same time, as an ambulance. First responder arrival times count towards rural ambulance service response time monitoring targets. Whilst a valuable community based initiative, which saves lives, supports those in distress, and may influence community cooperation for the good, they are nevertheless providing a free, goodwill, voluntary service that benefits the NHS.

Rural ICT and telemedicine developments

Information communication and technology (ICT) and telemedicine developments have the potential to present information and exchange ideas rapidly amongst NHS teams. Telemedicine can be described in general terms as being medicine practiced at a distance, and can be used for diagnostic purposes, treatment and medical education. Telemedicine has been introduced into rural regions of Scandinavia and Australia with some success. Its uptake in the UK has been far less. The driving force for its use is to reduce costs and increase service quality, though some have argued it is ‘not as good as the real thing’ (Wootton, 1999).

Advances in telecommunications technology enable video images of patient test results to be passed electronically down a phone line or digital cable, between local GP practices or community hospitals, and major hospital centres. Data and images can be sent to a specialist team within a major hospital for response. Telemedicine has been successfully used for diagnostic services, for example in analysing dermatology, ECG cardiology recordings, ultrasound and minor injuries tests. Diagnostic hospital-to-hospital uses include the diagnosis of neonates with congenital heart disease, fetal ultrasounds, orthopaedic clinics, radiology advice, head injury diagnosis and psychiatric consulting. Tele-care can be used to monitor older people, or the vulnerable at home, and in providing teaching aids and continuing education for GPs and practices, where ongoing professional training is required and training difficult to access.
Telemedicine is being used within cottage hospitals in Cornwall to offer fast consultation and diagnosis for minor injuries patients (Jackson, 2001). Such technology has the potential to improve access to specialist services from remote areas elsewhere, to offer near immediate diagnosis, to be cost effective, decrease professional isolation, to reduce waiting times when dealing with test results, and to save both patient and staff journeys and time. In isolated rural communities, telemedicine could prove particularly effective in improving access to secondary care from primary care bases. It can be used to identify patients who require immediate transfer to an acute centre. In addition, it has the potential to enhance the role of nurses and nurse practitioners in rural areas.

Live teleconferencing and wireless PCs can enable clinical and managerial staff to contribute scarce time to project meetings, from a distance, whilst saving on group travel time and cost. Teleconferencing is used in the NHS in North Cumbria. Video links have additional community benefits in remote rural schools, where, for example, children can be taught specialist subjects without having to move school or live away during the week.

The ‘NHS Direct’ telephone helpline service offers patients the chance to discuss their symptoms with a trained health professional, without having first to travel to a practice. E-mail and the Internet have rapidly offered an additional means of direct communication between teams. IT and PC development, and modern information systems have brought several advantages to working lives. In South Cumbria, GPs in one picturesque tourist area publicly supported the introduction of additional mobile telephone masts; current provision means they can be out of reach of their teams when visiting rural patients.

Supporting the needs of GPs and primary care teams

Primary care teams in rural areas have additional roles to their urban counterparts, and are likely to undertake far more minor surgery and emergency work. Rural GPs may be called out to provide immediate care at the scene of accidents and emergencies. GPs in remote areas are more likely to work alone. Close involvement within a community brings about long continuity of care, lasting personal relationships and many benefits (Hamilton et al, 1997). However, the opportunity for doctors to leave their practice or the local area may be limited, when offering 24 hour care. The GP Associate Practitioner scheme has proved very successful in remote areas, for example on Scottish islands, where it is difficult to get a break (Marshall, 1999). The scheme recognises the particular difficulties of being single handed with many on-call commitments, and allows the deployment of an additional doctor between two single-handed remote practices. At no cost to the practices concerned, the scheme allows isolated doctors time away from their practice (17 weeks can be taken flexibly).

The rural GP Inducement Scheme has been in operation since the NHS was founded and guarantees a minimum salary for GPs in rural areas where the population is too small to make a practice viable under normal financial terms and conditions. Without the scheme, many small rural communities would face real problems in accessing any medical services (RCGP, 1999).
The doctors’ retainer scheme provides an opportunity for doctors who have left the NHS, or who have other commitments – for example a young family - to continue to undertake a modest amount of medical practice. Such flexibility has advantages in rural areas. Whilst traditionally aimed at doctors aged under 55, as rural populations and NHS staff grow older, it could offer a means of providing additional part-time cover in rural areas (Marshall, 1999).

Voluntary agency rural health initiatives

Mental health is a particular issue of concern that faces rural communities, as demonstrated by the ‘Farmers Health Project' findings (Burnett and Mort, 2001) and through such traumatic events as the foot and mouth epidemic in 2001, BSE and various financial crises facing farmers in recent years. The National Association for Mental Health has established Rural MINDS to help promote better mental health for people living and working within the countryside, to develop training and education for those providing emotional support in rural communities, and to seek to influence the development of rural mental health services. Similarly, the Rural Stress Information Network has been established to be an authoritative source of information and advice concerning the causes and extent of rural stress, to develop initiatives intended to help alleviate rural stress, and to encourage the development of practical solutions to help people living in rural areas who feel distressed or suicidal. Case study 7 considers initiatives in Cumbria which seek to help those in stress; Chapter 7 provides contact details and information links for these organisations.

Case Study 7: Rural stress initiatives in Cumbria

The Cumbria Stress Information Network is a website based initiative, which has been set up in response to the need to support people who live and/or work in Cumbria who suffer stress. The overarching aim of the project is to help to bring together rural people in distress and to put them in touch with people who can offer help and support.

The website includes information on the symptoms, reactions to and causes of stress, and looks at potential relief mechanisms. A wide range of national and local organisations that can provide support are detailed, from stress and mental health helplines, the Samaritans rural outreach project, to countryside and farming organisations, alcohol and drug services, the Citizens Advice Bureau and social services. Advice is given for different groups of people and communities, for example, farming families, those with young children, people with disabilities, the elderly and ethnic minorities. A wide range of advice can be sought.

The project has been supported by a large number of voluntary and statutory organisations, both nationally and within Cumbria. News and events, useful links, a discussion forum, and contact detail sheets are available on-line.

(http://www.cumbriastress.org.uk)
A range of voluntary agencies support those facing problems in rural counties. Rural Community Councils in the North West, such as Voluntary Action Cumbria and Community Futures in Lancashire seek to enable rural people to take positive action to enhance their community, and provide advisers and access to information. Responsive initiatives have been developed. For example, from late 2002, the Cumbria Rural Citizens Advice Bureau offered a new Money Advice Service to individuals and small businesses whose financial circumstances had been affected, directly or indirectly, by the recent foot and mouth disease epidemic. Credit Unions have been set up across West Cumbria to help those with financial difficulties get back in control. Empowered with information, and supported by professionals skilled to help, many problems and stresses - with potential health implications - that face individuals living in the 'rural idyll' can be addressed.
Chapter 6: Availability of information to assess rural deprivation, health and health needs

Poor availability of data on rural health need

Rural communities are widely dispersed and small in population size. Poor and affluent households often live side by side, in small groups of houses. For example, a major landowner’s home may be next door to several former estate cottages, in which a mixture of retired, farm workers with young children, casual workers and commuting professionals live. Each household and family may have very different income levels, lifestyles, opportunities and chronic and acute healthcare needs.

Thus, it is difficult to characterise or compartmentalise scattered rural communities, and even more difficult to bring together information detailing their location, relative means and likely healthcare needs. However, PCTs, local government, regional and national policy makers, voluntary agencies and community groups alike, require accurate and relevant information on those living within a given area, in order to better understand, plan for, request, provide, manage and develop responsive public services.

A wide range of health service, local government, and national agency information can be analysed to assess local demography and health need, as well as to determine whether services are provided equitably. Such datasets include NHS public health data on births and deaths, hospital data detailing the care patients receive, GP practice patient registers, cancer registry data, local authority data on service clients, national compendiums and National Statistics data such as the 2001 census and ‘neighbourhood statistics’.

Data on a particular illness, or for a specific geographical area, is usually made public at an aggregated level, for example, summarising information on all residents or patients who live within a given local authority electoral ward, or, who have been treated for a particular type of illness. Indeed, many datasets are only available as aggregated summaries, showing data counts for a ward, PCT or LA area, or in summarising a particular service. Most datasets make no differentiation between rural and urban patients, residents or clients.

Analysis of health data has traditionally had an urban focus. Potential differences in rural health have often not been considered. Indeed, it is extremely difficult to look at scattered pockets of need, as opposed to better-understood urban concentrations of households. Commonly used data are insensitive in picking up rural trends. Importantly, small population numbers do not make an impact on aggregated data. Those in need are ‘lost’ amongst more affluent rural residents. Data aggregated to ward level, or to LA or PCT level, is insensitive in highlighting local variations and extremes of need. Small populations are susceptible to statistical variation, with health data potentially relating to a very small number of identifiable patients (Deaville et al, 2002). Statistical averages hide localised differences or inequalities in rural health, and ultimately service inequity.
Local level health profiles

Locality profiles and equity audits help primary care teams to better understand key issues within their catchment areas. Quantitative data supports team information needs, particularly when only intuition and personal knowledge about community health has previously been available. Chapter 7 provides information for such teams on organisations, and their web sites, which offer a wide range of local level health, deprivation, demographic, benefit uptake and other datasets at various geographical levels. In addition, PCT Public Health teams hold a wide range of data. Other North West Public Health Observatory information reports provide detailed data on specific illnesses and conditions, for example on cancer. The web search engine Google (http://www.google.co.uk/) is an invaluable resource that can be quickly used to find a range of potentially useful information.

Given the limitations of information that is aggregated to a set geographical area, how can data be presented in alternative ways to support rural healthcare planning? It has been suggested how important it is to look at very small areas (i.e. individual households) when considering health need in rural areas (Cox, 1998, Carr-Hill et al, 1996). Many health service datasets, as well as other public sector data, contain information on individuals. There is the potential, if data is available and in a useable form, to identify where current users of health services, potential users, the unemployed, poor, and deprived live. Unfortunately, given small numbers of potentially identifiable rural residents, and confidentiality issues, access to or presentation of such data is often severely limited.

Where a health database contains information on individuals, and includes details of a person’s full home postcode, it is possible to link the data to a variety of other datasets which can for example describe the ward in which a person lives, the approximate location of their home on a street, and whether the area is classified as rural or not. Using spatial analysis and computer mapping, such information can then be summarised for any geographical area, for example, to look at just those living within a particular housing estate, or to focus on every household where a particular group of interest live. In this way, very localised rural data could be presented.

However, many PCTs do not allocate funding to buy computer mapping software and additional specialised datasets, may lack high level management support for such information development, have limited knowledge of potential data sources, time constraints and varied skill levels for undertaking such analysis. Government agencies typically will not provide individual level data, for example on those in receipt of benefits, which could complement health service data. Thus, analysis of rural health need will continue to be affected by the aggregated spatial level at which data can be readily obtained and presented, hiding localised extremes of need.

The local knowledge held by community based health teams has great potential to inform planning, and could be better harnessed by PCTs. In-depth local research and surveys, for example on all patients who use or could use a service, though time consuming, offers an alternative to quantitative analysis.
Measuring rural deprivation

Whilst the advantages of looking at individual person data has been discussed, data summarised at ward level is usually the lowest level of geographical area at which the health of communities is presented. Despite its limitations, ward level analysis usually remains the best available local measure and approach for rural service planning. In order to better provide for the health and other needs of local populations, PCTs and partner organisations need to understand where deprivation and poverty is greatest.

a. Deprivation indices

Deprivation indices are commonly used to measure differences in poverty and disadvantage at ward level. A wide variety of indices are currently in use (DoH, 2002c). Ward level health indicators have included Jarman, Townsend and Carstairs scores, which compare GP workload and relative need for health care, as well as a range of government datasets that have sought to measure relative deprivation levels for specific policy objectives. However, current deprivation indices have been frequently criticised, with two main areas of concern emerging. Firstly, such indicators use data that measures urban and not rural deprivation. Secondly, deprivation is more dispersed in rural areas and indicators fail to measure need (Farmer et al, 2001; Haynes and Gale, 2000; Hodge et al, 2000; Martin et al, 2000; Noble and Wright, 2000; Dunn et al 1998). Thus, deprivation indicators are poor at measuring rural health variations (Barnett et al, 2002).

For example, lack of car ownership has been included as a deprivation factor when determining relative poverty. However, in rural areas, where a car is essential, communities have been incorrectly portrayed as being less poor and facing less need than similar urban areas which show lower levels of car ownership. In reality, transport costs may well leave less disposable income for rural car owners. Rural poor and rich households are found in close proximity; data on each group averages out. The rural poor may be less likely to take-up available benefits. Access issues are not included in more traditional deprivation indices, nor are issues surrounding the often prohibitive cost of local housing. Thus, different factors are required to best measure a rural dimension to disadvantage.

The South West Public Health Observatory have recently compared different methods for measuring rural deprivation (Asthana et al, 2002b), and have concluded that the latest Index of Multiple Deprivation 2000 (IMD2000) exhibits the closest overall association with mortality and morbidity data, and in addition, offer the strongest association in rural areas. They are thus considered the best currently available measure of deprivation. The indices of deprivation 2000 consist of an overall deprivation score for a ward, as well as six domains of deprivation (DETR, 2000a). These domains measure inequity of income, employment, health deprivation and disability, education, skills and training, geographical access to services and housing need. Each domain is itself made up of a number of datasets indicating need.
An advantage of the indices of deprivation is that individual deprivation domains can be contrasted, as presented in chapter two. Figure 11 highlights overall deprivation scores for wards across the North West. Whilst rural wards show by far the lowest levels of deprivation (based on quintiles within the North West), IMD2000 scores highlight severe deprivation levels along the West Coast of Cumbria, as well as in groups of wards in towns and cities surrounded by Cheshire, Lancashire and Cumbria countryside. However, the vast swathes of rural green, or lesser deprivation on the map, highlight how localised pockets of need and deprivation are hidden by any aggregated measure and level of geography. The real variations in rural deprivation are at individual household level, within rural areas.

The indices of deprivation 2000 ‘service accessibility’ score can be seen as an attempt by rural agencies to bring service access issues to the national policy agenda. If previous deprivation measures of rural need have been inaccurate, through their potential urban skew, rural areas will have suffered through poor allocation of resources. Future more versatile deprivation indices could offer separate refined urban and rural measures.

An additional advantage of indices such as the ID2000 service access scores is their relative ranking of ward scores. Current rural ward indicators, highlighted in chapter one, do not differentiate between relative levels of rurality. A particular advantage of an earlier ‘Cloke index’, though at district level, was that it did differentiate between degrees of rurality, highlighting extreme rural areas (Cloke, 1977). Recent complex multivariate deprivation indices, which use a range of socio-economic data, seek to measure deprivation using such scaleable measures. A basic issue remains regarding how local areas can be ranked as rural, or remote rural, or whether they should be given any scaleable ranking. ONS consultation may provide nationally agreed definitions (ONS, 2003).

Whilst ward level data is currently used within the indices of deprivation 2000, proposals for a revised set of multiple deprivation indicators include the analyse of deprivation at a sub-ward level, using 2001 census ‘super output areas’ (SOA). SOA will offer a more local geographical picture, and will combine similar output areas, the smallest geographical area found within the census (ODPM, 2003).

b. Alternative measures offering ‘bundles of disadvantage’

The ID2000 indices still do not fully reflect rural deprivation. As awareness increases regarding urban bias in current deprivation indicators, alternative approaches have looked to identify better rural measures.

A number of alternative indicators of rural deprivation have been proposed. For example, the Rural Voice Health Group (cited in Cox 1997) proposed 14 broad indicators of rural deprivation, namely, lack of local services, high costs of living, public transport problems, housing cost and quality, information deprivation, low income levels with a seasonal component, limited job opportunities, limited adult education, inadequate social facilities, lack of facilities for particular groups, lack of political influence, lack of control over local resources, stigma associated with certain groups and lack of anonymity when using local services.
Figure 11: IMD2000 overall deprivation scores for NW wards
Lack of opportunities and limited access are common themes running through these suggested indicators. However, many are difficult to measure using available data.

University researchers have recently proposed ‘bundles’ of indicators of rural disadvantage, which aim to identify the number of people in a given area who are at disadvantage from a particular set of circumstances (Hodge, et al, 2000; Dunn et al, 1998). Bundles have been developed to show how rural areas can differ from urban areas (Midgley et al, 2003), to compare the concentration of disadvantage in rural areas, and in helping to better understanding the relationships between different types of disadvantage.

Bundles bring together individual datasets into groups of indicators, which are considered to be closely associated with rural disadvantage. Eight possible bundles of indicators have been suggested, which give some indication of the number of rural people affected by specific circumstances. Table 3 details the suggested bundle measures. Examples of their potential use have been demonstrated using case studies for the counties of Lincolnshire, Suffolk and Durham (Dunn et al, 1998).

As each bundle indicates the number of households or individuals suffering from a particular set of circumstances, they do not need to show the average experience of all households in an area, and thus offer a method of reducing ambiguity regarding rural disadvantage. Each bundle would be relevant to different policy areas. Summaries ranked by ward quartiles highlight where disadvantage or deprivation is greatest. Potentially, PCTs could use this approach to define their own local interest health bundle(s), and in addition, to present data at a smaller area than ward, for example, using recently proposed census ‘super output areas’.

Whilst health need was not included as a bundle in initial research, 2001 census data, Countryside Agency data on access to GP and other services by ward and locally held PCT datasets could be used to create such health need bundles. The 2001 census will provide the opportunity for proxies of several of the bundle indicators to be presented at census output area (part of a ward). Output areas seek to maximise the homogeneity of local populations. Indicators could certainly be combined with a range of small area data extracted from NHS datasets to be presented at ward level.

The idea of bundles emerged from an initial review within the same project of rural data sources, which categorised datasets by key issue and linked them to policy use (Dunn et al, 1998). Of potential use by PCTs, the data sets reviewed were grouped into demographic, economic/incomes, household surveys, education, housing and social indicators. However, whilst many of these datasets are available at ward level, others only go down to a district or other large administrative area level.

Thus, a challenge remains for PCTs to develop locally sensitive rural health indicators to meet particular planning needs, which can present data at ward level, or at even smaller geographies. Aggregation of individual patient or client
level data potentially enables new data to be included in customised indicators, which could focus on the dispersion of rural disadvantage and healthcare need and on data that is sensitive to measuring how rural areas differ from urban ones. Overall, such rural indicators have a number of potential uses, focusing debate, making a case for support, identifying priorities, establishing targets and measuring progress.

Table 3: Eight suggested bundles of rural disadvantage

- **Access to employment**
  Measuring numbers of unemployed + hidden unemployment + outwards migration

- **Quality of employment**
  Number of people working long hours for low pay + seasonal workers + excess in part time work where only type of work available

- **Vulnerability of employment in the local economy**
  Numbers employed in a dominant ‘unbalanced’ sector + new employment

- **Low incomes**
  People in low income standard occupational classifications (SOC) + weekly earnings by occupation + number unwaged + unwaged incomes

- **Access and affordability [of housing]**
  Cost to earnings ratio of renting or buying a home + low earnings + numbers in social housing

- **Housing quality**
  Households with more than one person per room + households in temporary accommodation + households with no central heating

- **Access to services**
  No local food shop + no doctors surgery + no daily bus service + households with no car

- **Physical isolation**
  Pensioners living alone + households with dependents and no earners + second residences and holiday homes + sparsity

An alternative way forward is to look at single measures of need by service, both by local geographical area, and by interest group (for example, older people or lone parents). For example, counts of housing benefit and council tax benefit claimants offer crude measures of poverty (Noble and Wright, 2000).

One way of improving healthcare and other local services is to identify local need and to show how it can be translated into action. Pressure is thus brought on service providers to consider innovative ways of meeting community need. Clear, relevant, information, openly shared between public and planners alike, plays a key role in supporting and shaping change.
Measuring rural service accessibility and local differences in health using Geographical Information Systems (GIS)

Geographical Information Systems (GIS) are specialised computer software packages that can store, analyse and present information using maps. GIS have a range of applications in health service planning (Gatrell and Senior, 1999; Gatrell and Löytönen, 1998). When combined with statistical spatial analysis techniques, a wide range of health data can be analysed to show the incidence of disease within a population, inequalities in health need, and inequity in service provision across a geographical area.

A particular advantage of GIS over traditional ‘relational’ databases is in their ability to summarise information regarding people living in any given area (for example, an estate boundary rather than a ward), who live within a set distance of a site or interest (for example, a GP practice), or who are linked to a particular location (for example, who have been involved in a road traffic accident).

Geographical access to services was the greatest issue of concern raised by rural PCTs in a 2003 IRH rural proofing questionnaire (Swindlehurst, 2003). Using GIS software packages such as MapInfo, it is straightforward for PCTs to both highlight where rural populations live, as well as to summarise the distance that proportions of registered GP patients live from primary or secondary care health services. Such analysis is likely to be a fundamental part of a future ‘rural proofing toolkit’ (IRH, 2003). GIS software is increasingly being used by PCTs, in conjunction with a range of boundary data and reference maps. When used in conjunction with health, partner agency and nationally available datasets, mapping becomes a powerful tool for geographical analysis and presentation on local populations and their relative health and service needs (IHR, 2002).

GIS can equally be used to analyse and highlight rural data at an aggregate level, for example showing ward level deprivation using ‘thematic mapping’, or in selecting data on individuals with particular illnesses. Even where individuals cannot, for confidentiality, have their home addresses shown as points on a map, data for such individuals can be readily captured for use in planning.

The key difference in mapping data for rural, as opposed to urban PCTs, is in the size of geographical area being mapped. Rural data are better presented at the locality level, highlighting information on a set group of mixed rural/urban wards, as opposed to attempting to present data for an area that may cover several hundred square miles. Locality level data should if possible be mapped at a lower geographical level than ward. Rural PCTs could present data for a locality by new census ‘output area’. Other GIS users, such as the police, may alternatively present data that summarises activity within 1km, or other size, grid squares.

PCT use of GIS typically focuses on straightforward presentation mapping of data, for example looking at the location of services, and in displaying counts or rates as coloured thematic areas on a ward map. However, GIS have the ability to undertake more complex health service analysis, for example measuring...
distance to primary care services (Jones et al, 1998), and in analysing demand and supply for services (Higgs and White, 1997). Supply can be measured by looking at the size and distance, or ‘attractiveness’, of a service from population centres. Demand measures the population requiring a service in each geographical area of interest. Within each ward, relative demand and supply can be linked to deprivation levels, and inequity in service provision highlighted.

Such analysis has recently been used to demonstrate inequity in the provision of hospice services for the terminally ill within the North West (Wood et al, 2003; Wood and Gatrell, 2002). Those facing a terminal illness, along with their families, friends and carers, may live too far from hospice care to be able to make ready use of such services. Within the North West alone, there are rural areas with high demand for hospice care (based on local deprivation, cancer incidence and population size), yet who face poor geographical access to care.

The same approach has recently been applied in looking at service provision in rural Wales, measuring the accessibility and ‘attraction’ of doctor’s surgeries, dentists, banks, primary schools, post offices and petrol stations (Higgs and White, 2000). Countryside Agency data presented within this report measured rural distance to services. GIS drive-time analysis could support transport issue initiatives. In addition, GIS can be used to determine the optimal location for regional centres, such as specialist cancer centres, and to undertake epidemiological investigations.
Chapter 7: Organisations providing further advice and information on rural health and social issues

A wide range of national and regionally based organisations have a health remit. The following contacts provide a selective list of agencies that could be approached for further information on rural health and social need.

A. Statutory health agencies

Department of Health

The Department of Health is responsible for improving the health and well being of the people of England. Its website offers the latest on the Department’s work, health and social care guidance, publications and policy.

The Department of Health
Richmond House
79 Whitehall
London SW1A 2NS

tel: 0207 210 4850
e-mail: dhmail@doh.gsi.gov.uk Website: http://www.doh.gov.uk/

North West Healthcare Organisations

Primary Care Trusts

NHS Primary Care Trusts have been established to improve the health of their local population, to work jointly with a wide range of partner agencies, to commission hospital and community services and to develop primary and community care services. The Public Health team within the local PCT is a useful first point of contact for information.

Strategic Health Authorities

There are three Strategic Health Authorities within the North West, which cover Lancashire & Cumbria, Greater Manchester, and Cheshire & Merseyside. The remit of these Authorities includes ensuring that national priorities for health are integrated into local plans and strategies, building the capacity of the health service, and ensuring high-quality performance is found within the NHS.

Cumbria & Lancashire Strategic Health Authority
Preston Business Centre
Watling Street Road
Fulwood Preston PR2 8DY

Tel: 01772 647000 website: http://www.clha.nhs.uk/
Cheshire and Merseyside Strategic Health Authority  
Quayside, Wilderspool Park  
Greenalls Avenue  
Stockton Heath  
Warrington  WA4 6HL  
tel: 01772 647190    website: http://www.cmha.nhs.uk/

Greater Manchester Strategic Health Authority  
Gateway House  
Piccadilly South  
Manchester   M60 7LP  
tel: 0161 236 9456    website: http://www.gmsha.nhs.uk/

B. North West organisations with a health remit

North West Public Health Observatory (NWPHO)

Public Health Observatories are regionally based and provide an extensive intelligence resource to local agencies, populations and health networks. The North West Public Health Observatory (NWPHO) website offers access to a wealth of public health information, including research reports, bulletins, and online data.

North West Public Health Observatory  
Centre for Public Health  
8 Marybone  
Liverpool   L3 2AP  
tel: 0151 231 5834    website: http://www.nwpho.org.uk/

North West Health Development Agency

The Health Development Agency has been established to ‘identify the evidence of what works to improve people’s health and reduce health inequalities’. It works alongside professionals to get evidence into practice.

Health Development Agency North West Regional Office  
Public Health Development Unit  
C Floor, Bowland Tower East  
Alexandra Square  
Lancaster University  
Lancaster   LA1 4YT  
tel: 01524 593 936    website: http://www.hda-online.org.uk/html/about/north-west.html
C. Organisations with a specific rural interest

The Countryside Agency

The Countryside Agency sees its responsibility as one of ‘making life better for people in the countryside, and improving the quality of the countryside for everyone’.

It has two North West Offices, which are based in Manchester and Penrith.

The Countryside Agency
7th floor
Bridgewater House
Whitworth Street
Manchester M1 6LT
tel: 0161 237 1061

The Countryside Agency
Haweswater Road
Penrith CA11 7EH
tel: 01768 865752

The head office of the Countryside Agency is based at:

The Countryside Agency
John Dower House
Crescent Place
Cheltenham
Gloucestershire GL50 3RA
tel: 01242 521381
e-mail: info@countryside.gov.uk
website: http://www.countryside.gov.uk

D. Government departments with a rural interest, remit or data

Office for National Statistics (ONS)

The Office for National Statistics is responsible for producing and disseminating a wide range of key economic and social statistics. The national statistics online website provides a valuable resource, and source of data and information, for numerous themes, at a range of geographical levels.

Website: http://www.statistics.gov.uk/

Data includes local level neighbourhood statistics, and results from the 2001 census.

Website: http://www.neighbourhood.statistics.gov.uk/
Website: http://www.statistics.gov.uk/census2001/default.asp
DEFRA aims to ‘enhance the quality of life through promoting: a better environment; thriving rural economies and communities; diversity and abundance of wildlife resources; a countryside for all to enjoy; and sustainable and diverse farming and food industries that work together to meet the needs of consumers’.

Department for Environment, Food and Rural Affairs
Nobel House
17 Smith Square
London SW1P 3JR
Helpline tel: 08459 33 55 77
e-mail: helpline@defra.gsi.gov.uk website: http://www.defra.gov.uk/

The Environment Agency
The Environment Agency is the leading public body for protecting and improving the environment in England and Wales. The EA has a North West Regional Office and area offices in Penrith, Preston and Warrington.

Regional Office
Environment Agency
PO Box 12 Richard Fairclough House
Knutsford Road
Warrington WA4 1HG
Tel: 01925 653 999 Website: http://www.environment-agency.gov.uk/

North West Development Agency
The North West Development Agency is responsible for the sustainable economic development and regeneration in the North West through the promotion of business competitiveness, efficiency, investment, employment and skills development. The NWDA has several area offices within the NW.

Tel: 01925 400100 website: http://www.nwda.co.uk/

The Government Office North West
The Government Office North West represents Central Government in the region, supports the delivery of a range of services and programmes, and seeks to assist regional partners and local people in helping increase the prosperity of the region, promoting sustainable development and tackling social exclusion. Policy on rural and ‘food chain’ issues focuses on their NW context. The GONW has offices in Liverpool and Manchester.

Tel: 0161 952 4179 website: http://www.go-nw.gov.uk/
E. Other research and voluntary organisations with a health focus

The Institute of Rural Health (IRH)

The Institute of Rural Health aims to improve the health of rural communities. Established in 1997, the work of the Institute seeks to understand issues surrounding the causes of rural inequalities in health, the needs of these populations, and the delivery of high quality healthcare to rural populations. Core IRH research looks at definitions of rurality from the health service perspective, mental health, specific rural health issues, individuals and groups at risk, the healthcare work force, and issues for service delivery.

Institute of Rural Health
Gregynog Hall
Tregynon, Newtown
Powys SY16 3PW tel: 01686 650800
e-mail: IRH@rural-health.ac.uk website: http://www.rural-health.ac.uk/

The Institute’s booklet, ‘Think Rural Health’, published in September 2002, sets out to answer a number of rural health questions for PCTs, namely:

- Can equity of access be achieved for rural patients?
- Is it possible to target resources fairly in rural areas?
- Are rural health professionals adequately supported?
- Can the health service facilitate joined up working on rural issues?
- How can rural health needs be assessed?

The Rural Health Forum (RHF)

The Rural Health Forum is a UK wide initiative that acts as a focal point for those involved in rural health and social care. The Forum works to promote good health and well being in rural communities, supports networking and partnership work, and brings together aspects of rural health and social care. In 2003, the RHF is developing a rural proofing toolkit, to help healthcare agencies develop policies that take into account the needs of rural communities.

The Forum Co-ordinators may be contacted via the Institute of Rural Health.
Website: http://www.ruralhealthforum.org.uk/

The National Primary Care Trust Development Programme (NatPaCT)

The National Primary Care Trust Development Programme is establishing a virtual web forum to help rural Primary Care Trusts to address rural issues (Summer 2003).

Website: http://www.natpact.nhs.uk/news/index.php?article_request=512
Royal College of General Practitioners Rural Practice Group.

The Rural Practice Group of the RCGP was founded in 1993 to raise the profile of rural medicine in the United Kingdom through education, research and the dissemination of good practice in rural healthcare.

Website:  http://www.rcgp.org.uk/rcgp/clinspec/ruralgr.asp

Action with Communities in Rural England

Action with Communities in Rural England (ACRE) is a national charity that supports sustainable rural community development. ‘It provides a national platform for Rural Community Councils, other bodies and individuals who work at local, county, regional and national level to alleviate rural disadvantage in England’.

ACRE
Somerford Court  Somerford Road
Cirencester
Gloucestershire GL7 1TW
Tel: 01285 653477

e-mail: acre@acre.org.uk  website:  http://www.acre.org.uk/

Rural Community Councils in the North West

Voluntary Action Cumbria seeks to enable rural people to take positive action to enhance their community, providing access to information and advisory networks, advocating rural needs, enhancing community confidence about bringing change, and enabling communities to access resources.

Voluntary Action Cumbria
The Old Stables
Redhills
Penrith
Cumbria  CA11 0DT

tel:  01768 242130

e-mail: vac@dial.pipex.com  website:  http://www.ruralcumbria.org.uk/

Community Futures is the Community Council for Lancashire, and represents the interests of rural communities in the County. Cheshire Community Council has as similar remit in the south of the region.

Community Futures
15 Victoria Road  Fulwood
Preston  Lancashire  PR2 8PS

tel:  01772 717461

Cheshire Community Council
96 Lower Bridge Street
Chester  CH1 1RU

tel:  01244 323602
Rural Stress Information Network

The Rural Stress Information Network was set up to be an authoritative source of information and advice concerning the causes and extent of rural stress, initiatives intended to help alleviate rural stress, and to encourage the development of practical solutions to help people living in rural areas who feel distressed or suicidal.

Rural Stress Information Network
The Arthur Rank Centre
Stoneleigh Park
Warwickshire, CV8 2LZ

Tel: 024 7641 2916
Email: enquiries@rsin.org.uk
Website:  http://www.ruralnet.org.uk/~rusin/about.htm

Similarly, the Cumbria Stress Information Network was set up in response to the need to support people who live and/or work in Cumbria who suffer stress. The overarching aim of this project is to help to bring together rural people in distress and offer them help and support.

http://www.cumbriastress.org.uk/

ruralMinds

RuralMinds was set up to support people with mental health problems who live in rural communities in England. RuralMinds promotes better mental health for country people, developing innovative support and care networks, providing information and training for rural community volunteers and professionals, and influencing rural mental health services.

ruralMinds
The Arthur Rank Centre
National Agricultural Centre
Stoneleigh Park
Warwickshire CV8 2LZ

tel: 024 7641 4366
cemail: ruralMinds@ruralnet.org.uk
website:  http://www.ruralnet.org.uk/~ruralminds/
References and reading list

The following list of references provides a detailed reading list for many of the issues considered within this rural health, healthcare and social issues report.


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