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Identifying and Responding to Health Needs in Rural Areas:

A Guide for Commissioners

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Report produced by Dr Simon Kiley,
Research & Policy Officer
Action in Rural Sussex

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1. Introduction

There is a widely held perception that the countryside is a 'healthy' place to live, and for some rural residents this may well be the case. However, it is important that Health Commissioners are aware that significant challenges in accessing healthcare as well as other services, face those living in rural areas. Many of these challenges, individually and collectively, can have a significant negative impact on the health and well-being of rural dwellers.

It is essential that both health policy and delivery mechanisms take full account of the needs of rural residents and lead to fair and equitable outcomes for them. This is particularly relevant given the current shift towards a more localised commissioning process undertaken by GPs.

The very nature of rural areas can give the impression that there are few problems. This impression means that Health Commissioners have often found it challenging to develop appropriate techniques for identifying and measuring rural needs, which has led to them being underestimated and therefore frequently overlooked.

Whilst Joint Strategic Needs Assessments have provided a useful and uniform strategic framework for identifying health needs and outcomes, these have been developed in a relatively one-dimensional way which can underplay the significance of need in rural areas.

The complex range of factors affecting rural areas and people mean that co-operation and joint working across organisations from all sectors are essential to the development of effective, equitable and appropriate solutions.

This Guide sets out to:-

- Provide guidance for Health Commissioners about the key questions and evidence they should examine, in order to fairly meet the needs of the rural communities and people in their constituencies.

In order to do this it provides background on;

- How the health needs of rural populations are currently measured and how these needs may differ from those in urban areas.
- How current policy approaches may affect rural and non-rural populations.
- Alternative approaches for identifying rural needs.

And it offers;

- Help to understand how routinely available mainstream data may be used to support differential analysis and provide recommendations on where rural markers may be required (such as EIA, Health Audit etc.).
- Opportunities for the development of health services which maximise equity of access and quality of care for all

2. Key Rural Questions and Evidence to Guide Health Commissioners

Stage 1: Determine how rural health needs are currently measured.
Do the techniques currently used allow the identification of the actual numbers of people in need in different geographical areas, or do they focus on relative measures of need such as the IMD system of ranking geographical areas?

Relative measures of need provide a somewhat simplisitic and one dimensional view. Whilst useful for identifying the areas with greatest concentrations of need, they do not necessarily identify significant levels of need outside concentrated areas of population. This can only be identified through other contextual data and localised knowledge.

Stage 2: Explore other methods of identifying and quantifying health needs in rural areas
Some simple processes can assist in providing an alternative rural perspective on health needs. These include:

- **Identifying the total numbers of people in need located in rural areas and compare these to those in urban areas.** This can be achieved using the Rural Share of Deprivation Concept along with the government's Rural Definition and mainstream datasets.
- **Bearing in mind that 70% of deprived people do not live in deprived areas, assess how many people in need exist outside of the most deprived 20% of areas compared to those within them.** This may well show that high levels of need exist outside the most deprived areas, offering significant implications for delivery of services.
- **Establish the prevalence of certain health outcomes as a proportion of the population.**
  It is important to determine the prevalence of health outcomes in different areas. Whilst rural areas may have fewer people affected than urban areas, these may constitute a significant proportion of the rural population.

  For example, those experiencing long-term limiting illness in rural areas of the South East (2007) total 256,065 people compared to 981,334 people in urban areas. However, the rate of prevalence is 14.7% in rural areas and 15.7% in urban areas.

Stage 3: **Commissioning: Identifying appropriate delivery mechanisms**

Developing delivery mechanisms for healthcare which completely meet the needs of everyone is a complicated and probably an unachievable goal. However, this does not mean that delivery cannot be developed which meets the needs of the vast majority and puts in place provision for those that are experiencing specific problems or facing certain barriers.

A review of existing delivery methods should always occur as part of the service planning process and where these are shown not to be effectively delivering equitable services in rural areas, other options should be explored.
Commissioners should utilise best practice examples and case studies from around the country to inform their development of services. They should work in partnership with other stakeholders from the public, private and voluntary sector to ensure that mechanisms are both efficient and effective.

Many examples of best practice are available from the Commission for Rural Communities, Rural Services Network and Rural Communities Action Network and the NE Rural Health Commission.

Stage 4: Implementation and delivery
A wide range of innovative methods for providing healthcare provision into rural areas have been developed, as have various schemes for improving transport and travel links to healthcare providers.

Availability of and access to information are extremely important factors which can be easily overlooked. Messages about both preventative health measures and service specific information frequently do not to reach rural people in need, and are often poorly tailored to their circumstances.

Stage 5: Monitoring and scrutiny
It is extremely important that rigorous monitoring and scrutiny of delivery mechanisms is made to really ensure that rural communities are not disadvantaged by existing processes and service delivery plans. Where Health Impact Assessment is utilised, rural communities affected by the proposed plans need to be specifically considered.

It is often too easy for improvements to be obtained in monitoring data, or for targets to be met in a geographically imbalanced way, through a focus on urban areas. This can lead to a scenario where continuous improvement is obtained from a data perspective, though without any corresponding breakdown of precisely where it is and is not occurring.

To ensure that this does not happen, mechanisms should be put in place to ensure that delivery and outcomes are related back to the initial baseline needs assessments. This can be achieved by mapping outcomes against needs and resources. Such a process would clearly illustrate whether delivery is being effective or not and appropriate action could then be taken in response to this scenario.

Health Equity Audits represent an effective way of assessing whether services are responding adequately to needs. However, the effectiveness of the Audit would itself be dependent on an understanding of rural factors.

The Key Cross-cutting Component: Rural Proofing

Throughout the entire process it is crucial that rural proofing is undertaken in order to ensure that the needs of rural people and communities are treated fairly. From the initial conception of policies and strategies right through to implementation and monitoring, it is important that rural needs are considered and addressed.

Whilst many people regard Rural Proofing as a single generic process, there is clear difficulty in providing generic guidance on how rural communities may be affected by decisions taken by multiple individuals or organisations. A more flexible and effective method of integrating Rural Proofing across the board would be for all employees in an organisation to be directed to 'think rural' in any of their planning of services and establish for themselves how rural communities may be affected by their decisions.

This distributes the responsibility for acknowledging and responding to rural needs to all employees across all stakeholders, rather than focusing it on a few nominated individuals or organisations. This also encourages self-scrutiny as well as scrutiny of 'rural' across and between organisations.

Background to the Guidance

3. How are health needs currently measured?

Summary of important points to consider when assessing health needs:

1. Area-based measures such as the IMD should not be used in isolation. They need to be contextualised with other rigorous data to ensure accuracy and meaning;
2. Not all deprived people live in deprived areas and not everyone in a deprived area is deprived.
3. Indexes and rankings are relative measures for comparing one area with another. Absolute measures highlight the real actual numbers of people affected in each particular locality;
4. Delivery and commissioning require a detailed understanding of local needs and circumstances in order to develop effective tailored solutions.
5. There is a need for local evidence and analyses, rather than an emphasis on comparing local areas using a nationally developed index.

The widely-held assumption that rural populations are 'healthier' than those in urban areas has been developed in response to analyses which are conducted using centrally determined IMD indicators which show that rural health is 'better'. Measures such as average life-expectancy, standardised mortality and morbidity ratios are generally highest in the most deprived urban communities and lowest in the most affluent rural areas[1].

Indeed, the Government has a view of rural areas that largely reinforces this position. The Rural White Paper[2], for example, states that 'the health of rural residents is as good or better than the national average, in terms of birth weight, incidence of long-term limiting illness and longevity' (DETR, 2000). This view largely fails to acknowledge the fact that *"rural populations face broadly the same range of illnesses, health issues, lifestyle choices and medical interventions as those living in urban areas"* (Wood 2004 p21)[3].

In rural communities a 'healthy rural communities effect' may develop, as those with less good health are driven away from rural communities towards areas with more accessible healthcare facilities.

There is currently a clear emphasis placed on examining geographical variations in health in order to allow the targeting of services and resources in those areas where health outcomes appear to be worst. For example, identifying the

[1] Asthana, S. (2006). Equity in Health Provision: a Fair Deal for Rural Areas? *The Rural Citizen: Governance, Culture and WellBeing in the 21st Century.* University of Plymouth.

[2] DETR. (2000). *Our Countryside: the future. A fair deal for rural England*. HMSO: Norwich.

[3] Wood, J. (2004). *Rural Health and Healthcare: a North West Perspective*. Institute for Health Research: Lancaster University.

20% of wards which have the lowest average life expectancy figures within a local authority, county or PCT area.

This and other health indicators are used to examine geographical variations in health, focusing on comparing the health status of one geographical area such as a Super Output Area or Ward with those in others. As such, they are *relative* measures in that they assess the relationship between the 'average' health characteristics of one area's population with that in another.

The main method for monitoring and achieving this change has been through assessing geographical areas on the basis of 'deprivation', using it as a proxy indicator for 'health need'.

Whilst this approach represents a widely-used method for identifying health inequalities, it possesses a number of limitations and can provide a picture of health that does not fairly represent the needs of rural residents. This is because the methods used to analyse and present this data focus on measures of need which are most discriminatory in urban populations.

Assessing health needs in rural areas

Limitations in the evidence and data used to compare the broad characteristics or specific health needs of one area with those in another may include:

Standardised data

Datasets are often standardised (made uniform) to make them comparable. However, this also standardises features such as age and sex characteristics thereby removing the influence of demographic factors on health.

Treating all areas in a uniform way can overlook the unique features and factors of particular areas which may significantly affect the health outcomes experienced there. As Asthana (2006) makes clear, demography can have a more significant effect on morbidity than deprivation.

The higher number of older people, found in rural areas, may not appear to be significantly deprived, but are likely to have higher absolute levels of morbidity. This is due to the prevalence of heart disease, stroke, arthritis and cancer in older individuals, a need which may not be sufficiently met if health provision is only provided on the basis of IMD relative deprivation measures.

Key drivers of health outcomes such as deprivation are statistically more visible in urban areas than in rural areas. Poorer and more deprived households in urban areas tend to be spatially concentrated and separated from more affluent households. This makes them easy to identify, particularly on indexes, priority lists and maps.

However, in rural areas the poor tend to live side-by-side with the better off. This means that although rural dwellers may possess the same health needs as disadvantaged people in

urban areas, their poorer health outcomes are hidden by the higher and more favourable average deprivation figure of the geographical area in which they live.

Consequently, the use of area based-rankings for deprivation and disadvantage tends to highlight and prioritise urban needs, whilst not giving an adequate or true picture of the extent and nature of rural need. Even an analysis of average scores for geographic areas at a low spatial scale using this approach, tends to emphasise urban-based need.

As a result programmes and resources targeted at those geographical areas possessing high concentrations of disadvantage can overlook and fail to respond to the needs of those living in rural areas.

The fact that rural areas are not prioritised within mechanisms such as the Index of Multiple Deprivation or Health indexes should not be used as a justification that needs in rural areas do not exist or are less significant. This is simply not the case. Many rural areas have significant levels of need; it is just more widely distributed across a larger geographical area and so subsequently less visible using these techniques.

Evidence shows that most deprived people do not live in the areas categorised as the most deprived or disadvantaged in either rural or urban areas. **For example, in West Sussex approximately two thirds of deprived people live outside of the most deprived 20% of areas**. As research by the Oxford Consultants for Social Inclusion (2008) concluded:

"Area based information only tells part of the story - the majority of deprived people do not live in highly deprived areas. Rural areas are substantially more deprived based on the location of deprived people than based on the location of deprived areas."[4] (see page 21 Rural Share of Deprivation)

The use of these area based techniques in determining the distribution of need and correspondingly the distribution of resources, places too much emphasis on where people live, rather than on the actual needs of households and individuals, which is the level at which deprivation takes effect.

Review: Area-based measures

Given that many important decisions are taken at all levels on the basis of area-based needs assessments, there must be a requirement to consider the fundamental limitations of these mechanisms and take steps to address them.

For example, whilst the overall IMD domain shows lower concentrations of deprivation in rural areas, the Access to Services Domain within the IMD reverses this pattern. This domain rather than the overall domain could and should be used as a means for determining issues surrounding accessibility.

[4] OCSI. (2008). *Deprivation in rural areas: Quantitative analysis and socio-economic classification*. OCSI: Brighton.

Joint Strategic Needs Assessments represent the primary means through which health needs and drivers are currently identified. However, they tend to focus heavily on presenting this by identifying where concentrations of needs are located and this tends to be in urban areas. Consequently, the use of these methodologies tends to gloss over rural needs. Changes could and should be made to ensure that these limitations are addressed so that JSNAs provide a fuller and more accurate picture of health needs.

The Commission for Rural Communities has submitted a paper to the government's consultation on the Indices of Deprivation which outlines in detail where the flaws are and where improvements could be made. The CRCs view is that *"the Indices of Deprivation have not provided an effective mechanism for capturing and targeting deprivation in rural areas."*[5]

Health Commissioners should be aware of these limitations and take appropriate measures to ensure that area-based measures such as the IMD are not used in isolation. Instead, evidence needs to be considered in a more holistic fashion which takes account of the wide range of drivers and their potential effects on health outcomes. The development of these approaches requires careful and detailed rural-proofing to ensure that health provision is delivered equitably.

[5] Commission for Rural Communities. (2010). *Submission to the English Indices of Deprivation Consultation*. CRC: Cheltenham.

4. Implications of health policy for rural health provision

Summary of important points:

1. Policy which focuses on narrowing the gap between the health outcomes of those in the most deprived areas with those living elsewhere must ensure all health needs are adequately responded to.
2. The wider factors associated with living in rural areas, particularly surrounding access to services, transport and broadband provision should be acknowledged and incorporated into both policy and delivery mechanisms.
3. Many rural residents, particularly the most disadvantaged, have very limited choice over which health services they can access.
4. Pushing the cost of accessing services on to users can lead to a lower level of take-up leading to later diagnosis, often costing more in the long-term.

The development of health policy over the past two decades has largely focused on narrowing the gap between the health outcomes of those living in the most deprived areas with those in the least deprived areas. Measures used to monitor this gap have focused on life expectancy and infant mortality.

This has often resulted in a pre-occupation with identifying where concentrations of deprivation exist and targeting health resources and services in these locations, rather than seeking to actually respond to the needs of disadvantaged people, wherever they live.

As outlined previously, the approaches used for identifying the location of deprivation and disadvantage commonly emphasise urban-based concentrations at the expense of more widely distributed rural needs, even though the total need outside of the most deprived areas is generally higher.

Whilst the argument is commonly made that health services are universal and accessible to all, the on-going trend for the centralisation or amalgamation of services in the pursuit of economies of scale and outcome improvements is reducing both the number and geographical distribution of health services.

These developments are shifting costs away from the provider and on to the user. This leaves those in rural and peripheral locations at risk of being forced to take on board the financial, time and other costs associated with accessing services which are now less likely to be locally based.

Whilst rural areas may be healthier in relative terms than those in urban areas, this hides the effects of illness and ill-health on individuals and communities in the countryside. There are significant numbers of vulnerable and disadvantaged people in rural areas who experience a range of barriers which restrict their ability to make use of healthcare services.

As a result they become doubly disadvantaged. With more localised services being withdrawn they are forced to overcome distance, transport and cost barriers. These factors may cause vulnerable people to fail to take-up appointments resulting in later diagnosis, delayed attention and more expensive treatment costs, due to the delay in seeking treatment or advice.

Whilst rural areas are often characterised as being socially uniform, they are in fact very diverse and are made up of individuals from across the wealth, demographic and occupational spectrum. Consequently, whilst it is easy to treat all rural residents in a similar way, there can be significant differences in the health outcomes they possess and the factors which created these.

Rural areas have significantly older populations who are more likely to possess long-term chronic or degenerative conditions. Consequently use of hospital, primary and social care is higher amongst these groups. Evidence has shown that between the ages of 65 and 85 there is a 30% increase in the costs of health provision[6].

[6] Seshamani, M. and Gray, A. (2004). A longitudinal study of the effects of age and time to death on hospital costs. *Journal of Health Economics* 23 (2) pp217-35.

5. Factors affecting healthcare provision

In addition to the issues surrounding the identification of the location and extent of health needs in rural areas, there are an array of factors which impact on the practical delivery of healthcare provision into rural communities.

A review by Woolett[7] summarises the various effects which scattered populations and dispersed settlements may have on service provision and 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 and often not feasible e.g. in Cornwall it has not been possible to introduce telemedicine in many areas owing to poor broadband availability;
- Extra costs are involved in accessing training, staff support or consultancy;
- Rural voluntary organisations may well find greater problems in accessing funds and developing volunteering.

These problems challenge service providers seeking to deliver into rural or more isolated areas. However, these must to be placed in context when set against meeting the needs of the vulnerable and disadvantaged. The 'rural premium' or additional costs associated with delivering rural services must be viewed against the negative impact and actually further increased costs of later treatment.

It is possible to overcome some of these factors by:

- Ensuring need is accurately identified so that resources are not directed into the wrong locations.
- Service providers working together to achieve efficiencies through delivering services in partnership.
- Co-ordinating partnership working between service providers and communities to facilitate the appropriate distribution of information and for raising awareness. e.g. Northumbria County Council- co-located fire service and SureStart.
- Using community-owned or operated facilities to offer a different 'point of service'

[7] Woollett S. (1993). *Counting the Rural Cost: The Case for a Rural Premium*. NCVO Publications: London.

6. Factors affecting access to healthcare

Summary of important points:

1. Transport and access are critical components in providing healthcare provision to rural communities. A shortage of appropriate transport or access to healthcare services is likely to result in poor health outcomes.
2. Social and cultural factors play an important role in dictating how services are accessed by rural residents.
3. Information on service provision needs to be provided in all locations in a form which is widely accessible and does not reinforce social exclusion.

There are a wide range of factors affecting the ability of rural dwellers to access health services. The issue of access is an extra dimension for those in rural areas to deal with and has significant implications for health outcomes.

Physical Barriers: Access and Transport

Rural communities generally have more limited access to healthcare services than those in urban areas. This stems from both the greater distances from services, a problem exacerbated by the lack of cost effective and reliable transport options, and the more dispersed pattern of healthcare services in the countryside.

It is important to acknowledge that it is not solely the distance from services which serves as a major barrier for those attempting to access them. For those in need, a short journey of a few miles, can prove as difficult to undertake as a much longer one due to lack of transport or cost.

This pattern of provision serves to increase the polarisation which exists in rural areas between those able to travel to services and those who cannot, many of whom are the most vulnerable and disadvantaged members of society.

The dispersed population in rural areas often means that public transport options are limited and fail to meet user needs in terms of operating times and destinations as well as being relatively expensive. Such features have placed a further reliance on privately owned transport, creating additional problems for those without access to this.

The lack of timely or affordable transport can be a major barrier to those in society for whom access to healthcare is a priority. This includes the elderly, parents with small children and those with disabilities or long-term illnesses. However, the differences associated with age, sex and social class have been shown to have even greater effects on service usage than distance to services alone[8].

In rural areas, even where services are locally based, issues surrounding access can arise with some residents

[8] Ritchie, J. Jacoby, A and Bone, M. (1981). *Access to Primary Healthcare. An enquiry carried out on behalf of the United Kingdom Health Departments*. The Stationery Office: London.

experiencing significant problems in getting from outlying households to a village or market town location. Rural areas often have dangerous roads with no provision for pedestrian access, fewer pavements, poor engineering, less traffic calming and limited lighting.

Distance decay

The barriers to accessing healthcare services can lead to distance decay. Distance decay is where there is a decreasing rate of service use as the distance from the service location increases[9].

This distance decay means that those in rural and isolated communities with further to travel to access health services are less likely to use them than those living in urban areas. This leads to delayed intervention and treatment and consequently poorer health outcomes.

Those most affected by distance decay are typically women with young children, older people, farmers, ethnic minorities, the disabled and those on low incomes.[10] However, it is important to be aware that distance decay can have an impact on any individual or community in rural areas.

Access and transport are key factors in distance decay, as these generally dictate the ability of individuals to get to health services from their homes. It is important to note the role of existing public and voluntary transport schemes in facilitating journeys for those that would otherwise be unable to undertake them.

A range of solutions exist which can serve to mitigate the effects of distance decay. These include: the co-location of services; outreach clinics and community hospitals; mobile clinics and greater use of telecommunications, although this latter is dependent on good Broadband provision and the use of ICT by service users.

Social and Cultural Barriers

Other social and cultural influences may also affect individuals' ability or desire to access services. The take-up of services and support mechanisms from those in rural areas tends to occur at lower rates than in urban areas, partly due to distance decay but also due to independence and a culture of self reliance.

Research has indicated[11] that while people in rural areas may be geographically further apart, they are in fact socially closer. Consequently, the stigma associated with certain conditions often leads to certain illnesses and conditions being kept

[9] Commission for Rural Communities. (2008). *Distance Decay*. CRC: Cheltenham.

[10] Defra. (2006). The quality and accessibility of services in Rural England. A survey of the perspectives of disadvantaged residents. www.defra.gov.uk/rural/pdfs/quality-accessibility-services-rural-eng-report-pdf

[11] Parr, H. Philo, C. and Barns, N. (2004). Social geographies of rural mental health: experiencing inclusion and exclusion. *Transactions of the Institute of British Geographers* Vol. 29 No. 4 pp401-419

secret for fear of being labelled in a particular manner, for example, access to mental health and sexual health services.

Access to information

Another issue commonly overlooked by those investigating health service take-up by rural residents, is individuals' awareness of services, particularly what those services are for and where they are provided. Ensuring that people can access the right services in the right places can go someway to alleviating pressure points.

The is sometimes the assumption made by those delivering services, that because accessing services is need driven potential users will automatically be able to identify those services which are applicable to them. But many users face difficulties in determining what to access and where.

A lack of relevant and applicable information can hinder those on low incomes, those with dependents, older people and the disabled from accessing basic health provision or obtaining advice.

The past decade has witnessed an explosion in the quantity of web-based information. This has not necessarily resulted in those in need in rural areas being able to access appropriate guidance. This stems from the fact that broadband access in many rural areas is particularly poor. Users who experience physical access barriers (the elderly, infirm and those low incomes) are often those least able to make use of on-line services.

Problems related to web-based and other technological solutions can also hinder healthcare service providers and restrict their ability to provide information and innovative services where it is required.

The introduction of web-based and technological services has often occurred at the same time as the reduction of physical services. Consequently, this process has left some vulnerable groups without either direct access to physical information services or their web-based replacements.

Determining whether low levels of take-up stem from poor access or poor information provision can be difficult, but is key to establishing the most appropriate approach for service providers. Ensuring that provision is both accessible and widely publicised is essential in achieving positive outcomes.

7. Rural access to healthcare provision in the SE

Summary of important points:

1. Access to healthcare provision is generally worse in rural areas than in urban areas as households tend to be further away.
2. Matching up healthcare provision with health needs must ensure that services are too heavily focused in urban areas. This can be assessed by mapping out the location of healthcare services in order to view their distribution.
3. Access to healthcare needs to be rural proofed to ensure that it meets rural needs and does not unfairly affect rural residents. Where access is affected, alterations to service provision must be developed.

Given the importance of access to healthcare facilities in dictating health outcomes for rural residents, it is appropriate and important to consider how these facilities are distributed across the region and what impacts this distribution pattern may have.

Evidence for the South East region shows that as one would expect, rural households are on average further away from healthcare services such as GPs, Dentists, Hospitals and Pharmacies than those in urban areas.

However, it may be surprising to some that whilst the impression of the SE is largely one of a densely populated region that such a small proportion of its health services are accessible to households, both rural and urban, when compared to other regions of the country.

Table 1 shows, the South East as the region with only 17 % (the fourth highest proportion) of rural households within 4km of a GP surgery.

Table 1 - Percentage of households within 4km of GP surgeries (by region)

GP surgeries (All sites) (4km)			
Region	**Rural**	**Urban**	**All**
East Midlands	23.4%	71.0%	94.4%
East of England	23.4%	69.3%	92.7%
London	0.1%	99.9%	100.0%
North East	17.3%	80.6%	97.9%
North West	9.3%	88.4%	97.7%
South East	**17.5%**	**78.5%**	**96.0%**
South West	25.4%	66.2%	91.7%
West Midlands	10.8%	84.6%	95.4%
Yorkshire and The Humber	16.3%	80.4%	96.7%

Source: CRC (2010)[12]

[12] Commission for Rural Communities. (2010). *Geographical availability of services by region.* http://ruralcommunities.gov.uk/wp-content/uploads/2010/06/allregions.xls

Whilst 22% of the SE population reside in rural areas, Tables 1 to 4 show that healthcare services provided in the South East are not accessible to a comparable proportion of the rural population. Indeed, for access to Hospitals and NHS Dentists the figures are much lower.

Table 2 shows that the South East has only 12 % of rural households within 8km of hospitals.

Table 2 - Percentage of households within 8km of Hospitals (by region)

Hospitals (8km)			
Region	**Rural**	**Urban**	**All**
East Midlands	13.4%	67.3%	80.7%
East of England	14.1%	63.9%	78.0%
London	0.1%	99.8%	99.9%
North East	13.3%	75.6%	88.9%
North West	6.9%	85.7%	92.7%
South East	**12.6%**	**75.9%**	**88.5%**
South West	19.9%	64.8%	84.7%
West Midlands	8.2%	82.5%	90.7%
Yorkshire and The Humber	9.4%	77.6%	87.1%

Source: CRC (2010)[13]

[13] Commission for Rural Communities. (2010). *Geographical availability of services by region.* http://ruralcommunities.gov.uk/wp-content/uploads/2010/06/allregions.xls

Mapping the location of healthcare services can be a particularly useful means of assessing access as this allows geographical gaps in provision to be observed. Such maps can also be analysed in relation to needs assessments and other datasets which can determine the most appropriate location and method for delivery.

Table 3 shows that the SE has only 12 % of rural households within 4 km of an NHS dentist.

Table 3 - Percentage of households within 4km of an NHS Dentist (by region)

NHS Dentists (4km)			
Region	**Rural**	**Urban**	**All**
East Midlands	15.2%	70.2%	85.3%
East of England	15.4%	69.1%	84.5%
London	0.1%	99.8%	100.0%
North East	13.9%	80.6%	94.4%
North West	8.1%	88.3%	96.4%
South East	**12.7%**	**78.1%**	**90.8%**
South West	17.3%	65.9%	83.2%
West Midlands	7.8%	84.3%	92.1%
Yorkshire and The Humber	11.9%	80.3%	92.2%

Source: CRC (2010)[14]

[14] Commission for Rural Communities. (2010). *Geographical availability of services by region.* http://ruralcommunities.gov.uk/wp-content/uploads/2010/06/allregions.xls

Table 4 shows that the SE has only 14.7% of rural households within 4km of a pharmacy.

Table 4 - Percentage of households within 4km of a Pharmacy (by region)

Pharmacy (4km)			
Region	**Rural**	**Urban**	**All**
East Midlands	19.6%	70.9%	90.5%
East of England	18.6%	69.2%	87.9%
London	0.1%	99.9%	100.0%
North East	16.5%	80.6%	97.0%
North West	8.8%	88.4%	97.2%
South East	**14.7%**	**78.5%**	**93.2%**
South West	20.0%	66.3%	86.3%
West Midlands	8.8%	84.6%	93.4%
Yorkshire and The Humber	14.0%	80.4%	94.3%

Source: CRC (2010)[15]

[15] Commission for Rural Communities. (2010). *Geographical availability of services by region.* http://ruralcommunities.gov.uk/wp-content/uploads/2010/06/allregions.xls

8. Determinants of health in rural areas

Health outcomes in rural areas result from the same determinants as those in urban areas. These focus on overarching factors such as:

- Education and skills
- Employment and jobs
- Housing affordability and availability
- Transport and access to services

However, there are an additional range of trends and drivers which although they also occur in urban areas, have a particular relevance and significance for healthcare in rural locations.

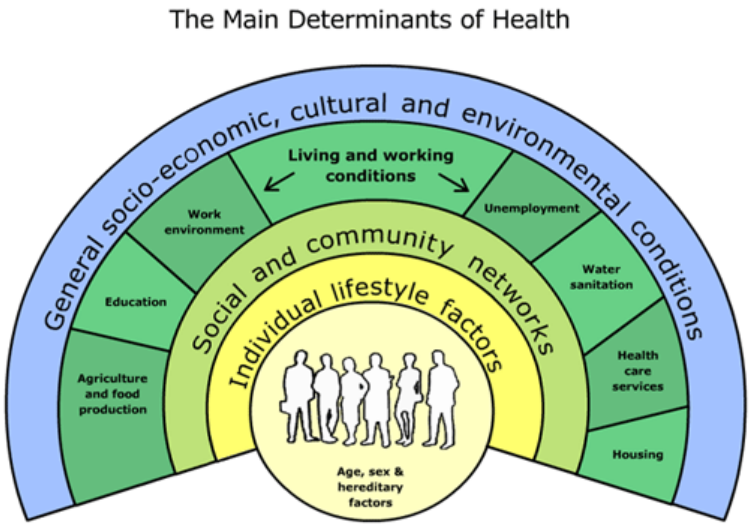
Access to services is obviously a key difference between urban and rural locations, due to the longer distances that most rural residents are forced to travel. This can result in higher financial and social costs, which can hinder people's ability and willingness to travel, resulting in lower take-up of services.

Demographics also have a significant impact on rural areas. Many parts of the countryside have become characterised by the out-migration of younger people and the in-migration of older people. This leads to a social imbalance with large numbers of vulnerable elderly people in isolated rural locations.

Accidents resulting from road and traffic incidents are both more frequent in rural areas and more likely to result in serious injury. Similarly, machinery related accidents are also more common in the countryside, especially in agriculture.

The lack of after care services also means that vulnerable and elderly people from rural areas experience longer and more costly stays in hospital than their urban counterparts.

Figure 1 - The Main Determinants of Health[16]



[16] Dahlgren, G. and Whitehead, M. (1991). *Policies and Strategies to Promote Social Equity in Health*. Stockholm, Institute of Futures Studies

9. Methods for ensuring rural health needs are equitably identified and assessed

Summary of important points:

1. Needs assessments must ensure that they accurately take account of rural health needs. This can be achieved by focusing on absolute measures of people in need using tools such as the Rural Share of Deprivation.
2. Rural Proofing is the key process which should be followed to ensure that rural is appropriately responded to at every stage from policy development through to commissioning, delivery and monitoring.
3. Health Equity Audits, Equality Impact Assessments and Health Impact Assessments represent three key methods through which the inclusion of rural into strategy and delivery may be assessed.
4. Developing monitoring systems which can integrate fully with the needs assessments is a crucial component in ensuring that what is delivered matches the identified need.
5. Monitor innovation and identify successful approaches employed elsewhere.

Ensuring that the needs of rural communities are met in a fair and equitable way is often portrayed as a complex, time consuming and difficult process. However, there are a wide range of tools and processes which can be used to ensure that rural needs are identified, acknowledged and appropriately responded to.

9.1. The Rural Share of Deprivation Tool

The Rural Share of Deprivation tool was developed by the Oxford Consultants for Social Inclusion as an analytical approach for evaluating the extent and nature of deprivation and disadvantage located in rural areas compared to that found in urban areas.

This approach utilises standard mainstream government datasets, such as those from the Census, and breaks the data down into rural and urban components for fixed geographical areas such as a county or local authority.

This allows, for example, the number of individuals claiming Job Seekers Allowance in the rural portion of an area to be compared with that in the urban portion, and offers an analysis of whether the take-up of such benefits is higher as a proportion of the population in rural areas than it is in urban areas.

This technique allows analyses to be undertaken which may present an alternative picture to that developed through other relative data measures such as the Index of Multiple Deprivation. It is particularly applicable to health-related services, given that they are founded on the principle that all people should have equal access to services on the basis of equal need, rather than on the basis of where they happen to live.

An example of this would be where an urban area is surrounded by a large rural hinterland. A traditional IMD-based approach is likely to identify the most deprived Wards or Super Output Areas as being located within the urban centre. However, the rural share of deprivation approach may illustrate that, whilst concentrations of need are indeed located in the urban centre, the rural areas have both a higher proportional and absolute level of need.

This approach has been adopted by a wide range of bodies including the Commission for Rural Communities, Action for Communities in Rural England (ACRE) through the Rural Community Action Networks and other county-level organisations, in order to explore the extent and nature of need in rural areas.

9.2. Rural Proofing

The concept of rural proofing was introduced in 2000 following the publication of the Government's White Paper entitled *'Our countryside, the future – A fair deal for rural England.'* [17]

The Rural White Paper outlined a view of rural proofing as a means of ensuring that policy is developed and implemented by government and other statutory bodies in a systematic manner.

[17] MAFF & DETR. (2000). *Our countryside: the future – A fair deal for rural England.* HMSO: London

Rural Priorities focus on three main elements:

1. Firstly, to determine whether a policy would have any significant detrimental impact in rural areas.
2. If any impacts on rural areas can be identified, to assess what these are and how significant they might be.
3. To consider whether policy changes are required or whether mitigation for rural areas can be developed.

This is a simple concept, which demands that policy makers think about possible impacts in rural areas throughout the process of developing and implementing policies. It focuses on providing policy-makers with a mechanism that allows them to assess the potential impacts of their policy on rural areas when it is implemented, thereby allowing modifications to be made that will negate or mitigate any negative impacts.

The purpose of rural proofing is to ensure that activities meet the needs of a community. It is a process of assessing how policies work for rural people and places, thus ensuring they are implemented successfully across the board. Preliminary assessment of how policies will affect both rural and urban areas is an important way to work out how what precautionary measures may be needed to bring a policy to all areas.

Rural Proofing should be treated in exactly the same way as other diversity issues. It is not a separate process, but an integral part of developing and delivering policies, and it is mandatory for all central government departments to undertake this task. Guidance on how to undertake Rural

Proofing is available from the Commission for Rural Communities.

However, there are currently no systems for assessing how effectively the process of rural proofing has been undertaken as evidenced in the RFSE Mainstreaming Report which can be downloaded from www.rfse.org.uk. This lack of monitoring or assessment is one of the greatest limitations of the system as it currently stands and has the potential to impact on how 'rural' is mainstreamed.

9.3. Equality Impact Assessments

In order to maximise the effectiveness of rural proofing, the process needs to begin at an early stage in developing a new policy or delivery mechanism and should be continued through into monitoring and evaluation.

One way of ensuring that rural proofing is undertaken is to embed this process within an Equality Impact Assessments (EIA). EIAs are evaluations undertaken during the development of new projects or policies which seek to ensure that equality, social inclusion and community cohesion are acknowledged and addressed. They assess the likely or actual effects of any new developments and should outline the steps required to mitigate such impacts.

However, it is important to ensure that the questions included in the EIA are effective at determining how significant the need is in rural areas, the effects of the policy or delivery decisions for rural people (especially in terms of accessibility) and how outcomes will be monitored to ensure that rural people are not unfairly affected.

Limitations in the identification of rural need can be addressed by using similar principles to the rural share of deprivation concept, requiring a rural/urban breakdown of 'need' figure with the information provided both as rural/urban totals for the entire area as well as with a Ward or Super Output Area level breakdown.

The process through which needs are identified should then be incorporated into service delivery and monitoring mechanisms, so that delivery can be compared with the initial needs assessments. This allows progress to be monitored with a spatial dimension which in turn ensures that any disparity between rural and urban areas can be identified.

9.4. Health Equity Audit

Health Equity Audits are designed to identify how fairly services or other resources are distributed in relation to the health needs of different groups and areas with the objective of providing services relative to the identified needs. The overall aim being to ensure that needs and service provision are aligned and will not themselves become imbalanced, which may in turn lead to greater health inequalities. This would include an analysis of need assessment, resource allocation, commissioning, and service provision or outcomes.

This approach emphasises the need to address health inequalities across the social gradient and respond to needs

across the whole socio-economic spectrum rather than those most in need or the most susceptible to certain outcomes.

These audits allow local level issues to be identified and assessed with regard to the impacts which they may have on individuals' health. They also emphasise the need to monitor the entire 'care pathway' which can provide some insight regarding improvements need to be made in primary prevention, secondary prevention, acute and chronic care.

The Department of Health has issued guidance http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4084138 on the role of Health Equity Audits which includes advice on how they can be carried out.

9.5. Health Impact Assessments

Health Impact Assessments (HIAs) assess the potential health impacts of a policy, which take into account not only the direct determinants of health, but the wider determinants too. This may include factors such as poverty, unemployment, educational attainment and social exclusion. Other policies should also be assessed, particularly those with a direct relevance to rural areas such as those relating to transport and agriculture.

The aim of these assessments is to consider the impact on the health of the population as a whole as well as to determine whether a particular group is disproportionately affected. These assessments may also be informed by other processes such as Equality Impact Assessments.

Whilst the linkages between wider policies and health outcomes may not always be apparent, it is important that due consideration is given to these issues so that health and well-being is not unduly affected. The Department of Health has issued guidance http://www.dh.gov.uk/en/Publicationsandstatistics/Legislation/Healthassessment/Browsable/DH_075622 on the role of Health Impact Assessments which includes advice on how they can be carried out.

9.6. Monitoring and Evaluation

It is very important that the effectiveness of delivery mechanisms or take-up of services by rural communities is regularly monitored and assessed, both to ensure equity and efficiency.

The most effective monitoring is that which is designed and put in place when the needs assessment is developed as this will ensure that subsequent reviews can easily align themselves with the initial baseline data.

One of the recurring problems for the effective evaluation of the effects of service delivery on rural areas is found when rural needs are not integrated at the outset. Retrospectively analysing outputs from a rural perspective can be difficult.