Poor access to care:
rural health deprivation?

The White Paper *Our health, our care, our say: a new direction for community services* should offer something for rural health care.[1] 'Rural' merited five mentions; lay responses about poor health provision to the citizens' summit are mentioned twice. Two innovative approaches developed in rural areas deserved reference but the Paper only once referred to the need to develop rural services. It failed to focus on how to address rural health issues. Whether this is our fairy godmother speaking remains a big question for rural GPs.

The Kerr report for Scotland[2] had a section on health inequalities that mentions 'rural' only once. The recommendations made by the BMA[3] in 2005 remain undelivered, and it is not clear how they can be delivered as the BMA has disbanded its rural committee.

In England (the least rural country of the UK) the rural population comprises 19% of the total. These 9.5 million people equate to the population of London and the West Midlands. In Wales and Scotland the figure is nearer 40%. It is inconceivable that any national plan would fail to take into account the specific needs of a population of this proportion. Perversely, changes are occurring in both primary and secondary care that actually reduce the health resources available to the rural population.

Mortality rates for road traffic accidents,[4,5] asthma,[6] and cancer are worse in rural areas.[7] Cancer is diagnosed at a later stage[8] and intervention rates for coronary artery disease (key government targets for health improvement) are lower.[9] Rural patients are admitted to hospital less frequently than urban patients.[10] Neither the NHS improvement plan[11] nor NHS cancer plans[12,13] make specific mention of rurality or access, yet if overall healthcare gains are to be achieved, national planners should take note of such a large subset of our population.

Rural healthcare needs are not inherently different. Poverty, deprivation, social isolation, drug and alcohol abuse are all features of rural practice, but are compounded by poor access to secondary and tertiary care. The illusion of a rural idyll[14] prevents acceptance of rural practice as an arduous and challenging job, where all aspects of medical and social problems co-exist, often concealed by a stoical and uncomplaining public. Furthermore, rural and remote patients are less likely to have the opportunity to exercise choice, a central tenet of government policy.[15] This reduced range and number of service providers, in both primary and secondary care, is a main difference between urban and rural health care. The erroneous assumption of policy makers that a wide range of specialised services is accessible leads to difficulties for rural practice.

The relationship between socioeconomic deprivation and ill health is accepted by policy makers who propose solutions delivered through primary care initiatives.[11,16–18] Few studies have looked at how much deprivation affects rural health, but it is reasonable to assume a similar effect.

Specialist care for the rural patient involves travel and inconvenience unless local services are provided or care is declined or modified. Promoted as potentially higher quality, the centralisation of services distances care from rural patients. Health and social inequalities further compound this issue, and are erroneously considered to be a largely urban problem. The need to travel disproportionately affects the most vulnerable, the elderly, the infirm and those with socioeconomic disadvantage, particularly those without cars.

The inverse care law[19–21] applies as much to geographical access as it does to other forms of deprivation. The travelling burden of rural patients applies to all who receive specialist care.[22] The development of new treatments, examples being angioplasty for acute coronary syndromes and thrombolysis for stroke, may well be outside the reach of all rural patients with current referral pathways. While geography inevitably creates problems, rural GPs need to maintain and develop their roles as local providers either in health centres or in local community hospitals. An attempt to offer equitable access will inevitably lead to measurable healthcare gains.

Access to secondary and tertiary care for rural patients struggles against policy changes based on centralisation. Increasing pace of change not only has the potential to improve care but also adds a risk of doing harm, albeit unintentionally. A policy that benefits the urban majority, unless designed and implemented with care may reduce the availability of service to rural and remote patients. Resource allocation already discriminates against rural NHS trusts.[23] There is no transparency about how complex decisions on resource allocations are made: perhaps this is hardly surprising given the lack of agreement about what constitutes 'rural' and the lack of research in, among other things, fundamentals such as deprivation.[24]

A simplistic view of the determinants of ill health being solely due to genetic, environmental or behavioural factors is no longer credible. Social determinants of ill health are the most likely and certainly the most easily remediable causes of poor health. It is accepted that unequal distribution of resources can compound ill health in less advantaged groups.[27] The distributing of resources is a challenge faced by the UK and other industrialised nations, with social change widening rather than reducing social inequalities. In order to achieve equity, distribution of resources should be proportionately weighted towards health services in rural areas, by a combination of sustaining or developing more local services, and adding in mobile or peripatetic facilities.

The new GMS contract is founded on a population-based approach to specific disease areas. The contract is heavily capitation-based, and the provision of essential rural services such as minor injury clinics, immediate care, management of acute illness, terminal care and dispensing have been ignored or left to local negotiation. Many remote practices still

provide these services, often unpaid and in addition to their own out-of-hours cover. Such a wide range of services can only be delivered with a low list size.

A combination of poorer health outcomes and fewer resources demands action by any just society. The solution lies in a combination of actions, the first of which is recognition of the problem. The idea that primary care can deliver services traditionally delivered in the secondary sector is a central theme of the English White Paper and there is good evidence that quality will not suffer as a result.[26] The Kerr report[2] introduces the concept of 'clinical peripherality' refining the measurement of rural access to medical care. It produces unexpected findings with many island populations having better access to care than substantial mainland communities. While requiring further evaluation and research, this tool promises to enable managers and politicians to better understand the health implications of rurality based on reality rather than perception. In turn, this should help to distribute healthcare resources more equitably and allow local rather than centrally imposed solutions to develop. The countryside agency has produced guidelines for 'rural-proofing' government policy.[27]

Rural general practice can take on some of the work. It needs support from secondary and tertiary care organisations that may not see this as their role. Community hospitals are an under-used resource.[28] Mammography screening, however, is successfully delivered to rural communities, showing how much can be done if the cost of mobile services is accepted, and there is a political will. Mobile imaging units are widely used to augment urban services throughout the UK, and yet inexplicably they are not used to reduce travel for rural patients. Chemotherapy can be safely and effectively provided at home or in a community hospital, and would significantly reduce travelling, potentially enhance uptake of treatment and improve survival if it were widely available in this form in rural areas.[29,30]

Political and managerial structures to develop these proposals do not exist ,or if they do, are ineffective. The need for good advocacy is both urgent and overdue. Arguably, our political system is driven by a largely urban agenda, and there can be a tendency to think that technology such as video-links and other new developments will solve all rural problems.

The challenge for the future is for rural primary care to engage at a national level with fellow clinicians, managers and politicians to achieve improvement. In the past the NHS was built on a willingness and ability to address health inequalities. Failing to join together to develop care pathways relevant to rural communities, or further marginalising rural communities by centralising policy, is to miss an opportunity to improve the health of the nation.

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