



A Manifesto

Priority rural health and wellbeing issues that need to be addressed by government

The Institute of Rural Health (IRH) is a UK-wide academic charity, established in 1997, leading the way in informing, developing and promoting the health and wellbeing of rural people and their communities through its three main programme areas of research, education and training, and policy analysis.

These three academic programmes have enabled the IRH to build up a knowledge base on rural health and wellbeing and develop a wide range of relevant skills and experience. As a UK-wide body it has the capacity to compare the range of health needs, and the provision of health and care services, in England, Wales, Scotland and Northern Ireland, each of which has significant rural populations.

This Manifesto sets out the priorities that IRH believe need to be addressed by policy makers who are serious about providing and enabling rural health and wellbeing.

Equality of health and social care provision

Tackling inequality and disadvantage – Deprivation and disadvantage are often thought of as an urban phenomenon. Rural deprivation is often masked within areas of apparent rural affluence but the use of small area statistics can reveal areas of need. Recognition needs to be given to these pockets of deprivation within rural areas, and to the inequalities of access to services, including the difficulties of accessing cross-border services. It must be recognised that tackling this issue will require targeted resources.

Rural proofing – Any policy which could impact on health and wellbeing should take account of rural circumstances and needs, so that policies or projects do not have any unintended negative outcomes for rural communities. Rural proofing should be a statutory requirement in policy development.

Clinical governance - Clinical governance should be the main vehicle for continually improving the quality of patient care and safeguarding high standards of care. In the rural context clinical governance should be considered simultaneously with rural proofing. Among other things this requires attention to, and resourcing of, continuing education after qualification, and an emphasis on research and the implementation of research findings in order to maintain skills.

Providing appropriate care locally – There needs to be a recognition that rural communities are diverse and different and that care provision therefore needs to be flexible and imaginative. This will require attention to the way primary care teams are structured, the development of the role of the generic “rural health” worker and resources to implement appropriate and evidence-based telehealth initiatives.

The implications of centralisation and specialisation – Where services become increasingly specialised, and hence centralised, they become less accessible to the remote and rural patient. Consideration needs to be given both to transport infrastructure (see below) and to resourcing the rural primary care team to provide more local specialist care. Community hospitals have a vital role as the hub of local community health facilities working with a network of local practices and potentially providing outreach clinics, information and some specialist services. The voluntary sector also has a key role to play (for example the ‘first responder’ teams).

Primary care provision – The recruitment and retention of clinical staff may be affected by worker perceptions of rural practice. Rural placements for (medical) students and specialist rural training modules have been shown to increase career choice of rural practice (1). Providing continuing professional development helps to retain, and to maintain the skills of, rural practitioners. Funding of focussed education and training programmes is therefore vital for rural practice.

The patient's perspective

Access to health services – All patients, irrespective of location, have the right to access good quality healthcare. However good a service is at point of delivery, if a patient cannot access it, it is not available to them. Distance and perceived inaccessibility will determine a person's perspective and experience of health care provision. Provision of services should therefore always be considered in the light of the actual and perceived barriers to access.

Rural transport – Poor or non-existent public transport services and limited car ownership reduce access to health care. Timing of appointments may not take account of the patient's circumstances. 'Distance decay' (decreasing rate of service use with increasing distance from the source of health care (2)), has consequences for health outcomes. (For example there is evidence that in rural areas mortality rates for asthma and cancer are worse than in urban areas (3, 4)). Co-ordination of appointments with available transport, mobile services, or extension of outreach clinics, could address this.

Cultural and social factors – A culture of not asking for help, particularly in relation to stress, depression or mental health; and social factors such as fear about confidentiality in small communities, may prevent people from making use of services. 'One-stop-shops' are an approach that can help tackle stigma associated with being 'seen' attending an appointment since individuals may be attending for health and social care, education, family support, benefit or financial advice (5).

Public health, health promotion and wellbeing

Physical exercise and obesity – The problem of obesity is now viewed as being of epidemic proportions and primary care workers are expressing fears of not being able to handle the level of need. Child anti-obesity drug prescribing is soaring (6) and obesity and weight gain have been correlated with psychological ill health (7) and physical ill health such as diabetes. The loss of playing fields and available play spaces reduces the opportunities for outdoor exercise, rural children may not be able to access distant leisure centres, and many cannot walk to school and therefore are driven or take the bus. Health promotion policies need to address this issue and make use of untapped rural resources.

Rural hazards – There are particular health risks to which rural dwellers may be more exposed, including zoonoses (diseases of animals communicable to humans) and chemical pollution from agricultural sprays or run-off. Health education needs to address this both as regards preventive knowledge for potential victims and diagnostic knowledge for health workers.

Road traffic accidents – although the proportion of accidents on non built-up roads is only 28% of the total, the proportion of fatal accidents is 58% (8). This may not just be a factor of speed limits, or of driving habits on narrow roads with expected low traffic density, but of the average emergency response times in rural areas (9); this requires further investigation.

Farm accidents – Those working within the farming sector account for less than 1.5 per cent of the whole working population, but 15 per cent of workplace deaths happen on farms - one of the largest

numbers in all sectors (10). Again this may be a function not just of unsafe working environments (and increasingly of lone worker situations) but of access to emergency services. For both the above issues more public health education is needed for prevention, and ambulance deployment and resourcing of emergency care need consideration in order to bring down response times.

Demographic change – The age balance in rural areas is shifting as increasing numbers of older people migrate in to retire to the ‘rural idyll’ and young people migrate out in search of work or affordable housing. This, together with longer (but not necessarily healthier) lifespans, increases the strain upon health services, particularly for chronic or degenerative disease services and end of life care. Isolation of widowed partners may be more acute in a rural area and will be particularly difficult for the surviving partner of a couple who have recently moved into an area leaving their old support networks behind. Resourcing of chronic conditions management is important and constructive partnerships with the voluntary sector could help fill the gaps in social care provision.

Rural stress, mental health, suicide rates – Normal stresses are magnified by isolation, single-worker situations, lack of knowledge about services and difficulty of access to them. Lack of early intervention services compounds mental ill-health. Death rates from suicide in males were 11 per cent higher in rural areas than in urban areas of England, after allowing for deprivation (11). There are higher levels of depression among farmers compared to the general population and they are consistently considered a high risk group for suicide (12). Dissemination of information about support services may encourage people to ask for help at an early stage, and resourcing of accessible mental health services and voluntary sector support services could pre-empt more serious problems.

Geography – Isolation can compound both physical and mental ill health. Along with the development of outreach services, mobile services and improved access to services, much use could be made of a properly resourced voluntary sector providing, for example, good neighbour schemes and ad hoc transport to services.

A healthy environment

A healthy working environment – Self-employment is higher in rural areas. Small rural businesses, including farms, where the separation between the home and working environment is less clearly defined, are vulnerable to accidents. Farm workers are exposed to agricultural chemicals. Health and safety education needs to reach those not included in the programmes that are routine within larger organisations.

Making use of the rural environment – Rural residents are actually likely to spend more time in the car than walking compared to their urban counterparts, since practically every journey, to school, work or for other services, requires transport. However there is increasing evidence of the benefits of time spent in green space, not just the direct physical benefits from increased exercise but mental and emotional gain also (13). The Walking the Way to Health initiative has been shown to have real health (and economic) benefits (14). Children and adults need encouraging and enabling to make use of the ‘green gym’.

The environmental implications of centralisation – There are environmental implications to the centralisation of services which will increase patient travel. Consideration should be given to outreach services with individual care providers travelling out to a range of patients within a practice area or to the use of Community ‘hubs’ (see above).

Community capacity

Community responsibility – The increasing emphasis on the individual taking responsibility for their own health has now been extended to the concept of community responsibility. However if communities are to be major players in their own community health they need to be given the relevant knowledge, the confidence to make their voice heard and to take action, and adequate resources.

Community sustainability – Small rural communities are vulnerable to change. Declining populations threaten services such as schools and post offices. Where communities have been resourced to provide services (for example running the village shop, developing community horticulture) this gives a boost to both their practical viability and their vibrancy as a community.

Community empowerment – Community capacity is built on both increasing skills and developing confidence. Community development therefore needs to resource training to impart the necessary knowledge and skills building on inherent capacity in the community, to encourage the exchange of good practice and develop a community's confidence in its capacity to make changes and govern its own health and wellbeing. Communities therefore should be consulted in the development of services and taking account of their particular needs and existing capacity will maximise the benefits of service provision.

Volunteering and partnership working – In a time of straitened resources integrated working and the use of the voluntary sector in rural areas are critical to make efficient use of resources and to maximise outcomes. Setting up networks and encouraging cooperation within and between sectors will prevent duplication and enable knowledge exchange. This includes the importance of developing trust between statutory and voluntary providers. This will enable referral on to the appropriate service and a more integrated 'care pathway' for the individual.

Conclusion

The evidence shows that for most people rural areas are a good place to live. However, for the most vulnerable in our communities this may not be the case and this Manifesto sets out the priorities to be addressed that will make the countryside a better place for everyone.

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