

Issue 4

Rural Health Research Report Series

## Rural Health Intelligence Programme: Main Findings and Recommendations



Llywodraeth Cynulliad Cymru  
Welsh Assembly Government

Prepared for the Welsh Assembly Government by:  
Trish Buchan

## Rural Health Research Series

1. A review of the literature: measurement issues in rural health
2. A review of the literature: access and service models in rural health
3. A review of the literature: social inclusion and rural health
4. Rural Health Intelligence Programme: main findings and recommendations
5. The state of rural health and well-being in Wales
6. Rural health policy review
7. The use of health impact assessment in rural Wales
8. Contemporary rural health issues: intelligence from Wales and beyond

## Rural Health Intelligence Programme (RHIP)

Researchers: Trish Buchan (Researcher)  
Jenny Deaville (Research Manager)

Institute of Rural Health  
Gregynog  
Newtown  
Powys  
SY16 3PW  
[www.rural-health.ac.uk](http://www.rural-health.ac.uk)



Project Manager: Kaori Onoda

Research and Evaluation Branch  
Public Health Improvement Division  
Office of the Chief Medical Officer  
Welsh Assembly Government  
Cathays Park  
Cardiff  
CF10 3NQ  
[www.new.wales.gov.uk/topics/health/ocmo/research/rural-health/?lang=en](http://www.new.wales.gov.uk/topics/health/ocmo/research/rural-health/?lang=en)



© Crown copyright Spring 2005  
ISBN 978 0 7504 4120 9

The views expressed in this report are those of the authors and not necessarily those of the Welsh Assembly Government

## Contents

<b>Executive Summary</b>	<b>2</b>
<b>1. The Rural Health Intelligence Programme (RHIP)</b>	<b>3</b>
<b>2. The main findings of the RHIP</b>	<b>5</b>
2.1 The changing context of rural Wales	5
2.2 The limited evidence base	6
2.3 Measurement issues	6
2.4 Access and service models	8
2.5 Social inclusion in the rural context	9
2.6 Health and well-being policy in rural Wales	9
<b>3. Recommendations</b>	<b>11</b>
3.1 Recommendations to support sustainable health and well-being in rural Wales	11
3.2 Recommendations to improve knowledge about health and well-being in rural Wales	12
3.3 Recommendations for government policy development and implementation	13
3.4 Recommendations for local action	14
3.5 Recommendations for empowering communities and individuals	15
<b>References</b>	<b>16</b>
<b>Appendices</b>	
Appendix I Suggested rural health and well-being research programme for Wales	<b>17</b>

## Executive Summary

The Rural Health Intelligence Programme (RHIP) was commissioned by the Welsh Assembly Government to facilitate the development and implementation of evidence-based policies and programmes on health and well-being in rural Wales. As one third of the population of Wales live in rural areas there is a clear need for a robust evidence base to inform decision making and to target health and well-being issues in rural Wales in an effective manner.

This report provides a summary of the main findings of the RHIP and the key recommendations for rural health research and policy action arising from the programme and through consultation with key individuals involved in rural health and well-being who attended the Expert Seminar and Workshop held as part of the programme.

The key findings include the limited evidence base with regard to the three critical rural health issues in Wales namely: measurement of rural health need, access to rural health services and social inclusion in the rural context. The research indicates that health policy lacks a rural dimension and rural policy lacks a health dimension. It also questions the sensitivity of the Welsh Index of Multiple Deprivation (WIMD) to aspects of rural deprivation.

The key recommendations include:

- the need for an identified lead within the Welsh Assembly Government for rural health issues;
- an independent organisation to act as a rural health advocate and the setting up of a network to facilitate dialogue between rural health and well-being practitioners and policy makers;
- the development of national rural health and well-being research programme for Wales;
- changes in the focus of activity at national, local and community level to address the three critical contemporary rural health issues in Wales.

## I. The Rural Health Intelligence Programme (RHIP)

The Welsh Assembly Government commissioned the Institute of Rural Health (IRH) to undertake the RHIP to facilitate the development and implementation of evidence-based policies and programmes on health and well-being in rural Wales. As one third of the population of Wales live in rural areas there is a clear need for a robust evidence base to inform decision making and to target health and well-being issues in rural Wales in an effective manner<sup>1</sup>.

The main objectives of the RHIP were as follows:

- to provide a rural perspective to the Welsh Assembly Government on health and well-being issues;
- to provide intelligence on UK and wider European developments on rural health and well-being issues and their implications for Wales;
- to further develop research capacity in Wales on rural health and well-being issues, and advise on future research direction.

The RHIP comprised an innovative and multi-faceted approach to gathering health intelligence. The methods used included:

- systematic search of published literature on mortality, morbidity, deprivation and social determinants of health in rural Wales;
- search of grey and unpublished literature;
- review of mortality and morbidity datasets;
- review of datasets on social issues that act as determinants of health;
- appraisal of a range of health and well-being policies in a rural context;
- case studies;
- surveys of rural health experts within Wales, elsewhere in the UK and in Europe.

There were six requirements to the RHIP:

- Requirement 1: to examine and analyse available data on health and well-being in rural Wales;
- Requirement 2: to examine the evidence on how policies which can impact upon health and well-being are operating in rural areas of Wales;
- Requirement 3: to produce a report on the development of Health Impact Assessment in respect of specific issues facing rural communities;

---

### <sup>1</sup> Definition of rurality

For the purposes of this study the Organisation for Economic Co-operation and Development (OECD) definition of rurality (1994) was adopted (fewer than 150 persons per square km). Based on the population density of the 22 unitary authorities, nine were classified as rural with a combined population around a third of the population in Wales (National Assembly for Wales, 2001): Anglesey, Carmarthenshire, Ceredigion, Conwy, Denbighshire, Gwynedd, Monmouthshire, Pembrokeshire and Powys.

- Requirement 4: to network with relevant organisations and individuals to identify models of good practice that address health and well-being issues in Wales;
- Requirement 5: to identify three key rural health and well-being issues and conduct brief reviews of recent UK and European literature in each of the three areas;
- Requirement 6: to organise and host a workshop with participation from Welsh Assembly Government and connected bodies, the National Health Service and the All Wales Research Health Intelligence Group (AWRHIG) members.

An important component of the RHIP was the setting up of AWRHIG, an expert group on rural health issues in Wales to guide and contribute to the intelligence gathering exercise. The group was comprised of individuals drawn from the spectrum of backgrounds that affect health directly and indirectly and included policy makers, academics, public health specialists, local government officers and representatives from the voluntary sector.

This report presents the main findings of the RHIP and the key recommendations for rural health research and policy action arising from the research and consultation with individuals who attended the Expert Seminar and Workshop (Requirement 6) held as part of the programme.

For detailed findings relating to each requirement, please see relevant reports under the Rural Health Research Programme Series. Relevant reports are referred to in this document e.g. (Report 2 & 3).

## 2. The main findings of the RHIP

### 2.1 The changing context of rural Wales

Unlike Canada, the USA and Australia, where rural health is viewed as a discipline in its own right and there are numerous well-resourced centres, Wales has a relatively undeveloped evidence base for rural health issues. Whilst the scale of rurality and remoteness of communities in countries such as Australia (which leads the way in rural health research) is greater than Wales, less than 20% of the population in Australia lives in rural areas, compared with 32% of the population of Wales. Wales is a rural country with 80% of the land area under agricultural use and the percentage of the population employed in agriculture is over 9% in the most rural county of Powys.

The commitment of the Welsh Assembly Government to improving the overall health of the people in Wales emphasises the need to tackle inequalities through targeting of interventions at those in worst health. Better Health Better Wales (Welsh Office 1998a) recognised a need for a sustained and holistic programme of interventions to promote health and well-being in the most disadvantaged sections of the population through partnership work across the voluntary statutory and private sector at a community level. Better Health Better Wales: A Strategic Framework (Welsh Office 1998b), Well-being in Wales (Welsh Assembly Government 2002) reflected this aspiration through an action plan of cross-cutting initiatives aiming to reduce inequalities in the health of the Welsh population.

In order to ensure that the measures to improve health target the most vulnerable, there is a growing need for health and well-being data at a small geographical unit in urban and rural areas. Increasing attention has been drawn to rural health in recent years in Wales as a result of a focus by health and social scientists on health inequalities (Acheson 1998), social exclusion (Chapman et al 1998, Shucksmith 1999) and rural deprivation (Cloke et al 1997, Dunn et al 1998). Crises in the agricultural industry (BSE and Foot and Mouth disease) have brought an additional dimension to the health and well-being of rural communities.

The changing rural context has been identified throughout the RHIP, key components of change being identified as:

- migration patterns;
- the decline of land based industries;
- the loss of traditional language and culture;
- organisational and structural change on health services, such as the moves towards the centralisation of specialist services and development of National Service Frameworks.

The changes, especially those resulting from migration and industrial decline, were perceived to be a challenge for health and well-being in rural Wales at present and in the future. The ability to cope effectively with change is at the heart of a healthy society.

## 2.2 The limited evidence base

The reasons behind the limited evidence base for health and well-being in rural Wales include:

- the lack of readily available robust, small area health and well-being statistics;
- intrinsic difficulties associated with small population statistics;
- the variable and agreed definition of rurality for health;
- the absence of a systematic and strategic approach to rural health research in Wales;
- much rural research is undertaken by rural health practitioners within their own communities and definitions of rurality are often not given. This makes it difficult to compare studies or to build a bigger picture of rural health issues;
- due to small numbers and the logistics of carrying out research in rural settings it is difficult to undertake experimental studies such as randomised controlled trials which are considered 'high quality' evidence. Consequently the evidence base for rural health is largely based on small qualitative studies which limit the extent to which generalisations can be made.

Notwithstanding those limitations, the following three themes were identified as key issues in rural health research in Wales, summarised in the following sections:

- measurement issues;
- access and service models;
- social inclusion in the rural context.

## 2.3 Measurement issues

### 2.3.1 Measurement of health and well-being

Baseline data are necessary to help identify the location and characteristics of health inequalities and deprivation, in order to assist in the development of targeted interventions appropriate to the population and to measure the impact of interventions on health inequalities and deprivation (Report 1, 5 & 6). The difficulties associated with small area statistics are evident when interpreting the significance of trends in health conditions at small area level. Population heterogeneity (mixed types of population) is a characteristic of rural populations at every spatial level from local authority to electoral division. This adds an additional dimension of difficulty in interpreting rural health and well-being data, as the resulting average figure may obscure specific needs of specific groups.

With the caveat about the robustness of the data, the RHIP identified the following issues of rural health conditions which may merit scrutiny through a systematic research programme:

- mortality and morbidity associated with working in land-based industries;
- morbidity in neonates and infants;
- factors contributing higher than expected rates of breast, colon and prostate cancers in some regions of rural Wales.

### 2.3.2 Poverty, deprivation and health inequalities in rural areas

A number of papers highlight urban/rural differences in characteristics of poverty, deprivation and health inequality.

In rural areas:

- poverty may not be geographically focussed in social housing estates;
- the numbers of ethnic minority groups may be low and the proportion of older retired people is likely to be higher;
- those in poverty may be dispersed across a community and living side by side with affluent neighbours with their needs hidden;
- the rural poor may be working and a number of papers highlight low benefit uptake;
- the basic costs of living, food, heating and transport may be higher especially for people living in traditional housing, for those living outside towns and for those who live in remote rural areas;
- many of the rural poor may be in poor health or may be caring for sick relatives;
- the costs of transport to and from hospital and of heating poorly insulated homes with costly heating systems place an additional burden on such families.

The intelligence gathered identified the following groups as being most vulnerable in rural areas:

- the chronic sick, people with disability and their carers;
- older people solely reliant on retirement pension (often the indigenous population);
- families with young children;
- the unemployed;
- families and individuals on low income;
- young people especially those leaving the care of local authorities;
- people with multiple needs.

The characteristics of rural poverty were identified as:

- higher costs of transport, fuel and food;
- poor housing with lack of basic amenities;
- low benefit uptake especially amongst older retired people;
- people living with chronic illness or disability and their carers.

While recognising the advances in the small area deprivation data made by the Welsh Index of Multiple Deprivation (WIMD) a number of papers express concern that the index may underestimate rural deprivation (Report 5).

## 2.4 Access and service models

The RHIP confirmed access difficulties in rural areas and indicated that they may arise from physical (e.g. distance, transport, office-opening hours) and non-physical barriers (e.g. culture of self-reliance, stigma and a fear of lack of confidentiality).

There were also problems in the delivery of universal services in rural areas especially those that are remote and sparsely populated. These problems include:

- limited institutional capacity (small numbers of workers and lower skill mix in rural organisations);
- limited critical mass of workers;
- limited number of professional staff;
- dispersed client base with fewer opportunities for group working;
- additional rural costs associated with distance;
- additional costs of partnership working;
- the weak interagency referral network;
- lack of infrastructure to support vulnerable people, including young adults and people with complex needs.

Access to dentists, opticians and distant secondary and tertiary hospitals was also reported to be difficult. The complex regulations governing financial support for patients and their carers to access health services gives rise to concern as such people, especially those with chronic disease, are likely to be vulnerable in a number of respects.

Geographical remoteness was associated with poorer health outcomes in a range of illnesses: the phenomenon of 'distance decay'<sup>2</sup>. This was evident in a range of chronic and acute conditions and appeared to be related to both physical barriers and to cultural differences in urban-rural populations.

<sup>2</sup> The decreasing utilisation of services with increasing distance from the centre of service provision.

Innovative approaches to accessible health services in rural areas result in a patchwork of initiatives with a heavy reliance on enthusiastic local health practitioners. They often involve the voluntary sector, usually retired and older individuals. There was little evidence of these innovative approaches being brought into mainstream service provision which raises concerns over their future sustainability.

Innovative models of health service delivery often involve the use of technology, such as telemedicine, or mobile and outreach services. Although these interventions were evaluated to ascertain patient and practitioner satisfaction, few studies investigated clinical outcomes or assessed the cost benefits of new approaches.

The patchy provision of young people's health services was alluded to in many studies and in the case studies undertaken by the RHIP. The lack of local services was seen as a significant barrier to taking forward policies to promote health and well-being amongst young people in rural areas.

Healthcare provision in rural areas suffers from limited number of professional staffs. There were concerns about the impact of clinical governance on current practice. Linked to these issues are the need for continuing professional development for rural practitioners and the changing balance between local services and the centralisation of specialist services. Recruitment and retaining key health care professionals was proving a particular cause for concern in rural general practice.

## 2.5 Social inclusion in the rural context

The literature review on social inclusion in the rural context highlighted the following issues (Report 3):

- failure to assess the impact of social inclusion programmes in rural areas;
- limited joining up of health and well-being issues in social inclusion programmes;
- the need to balance community development with participation of marginalised individuals;
- failure of rural social inclusion programmes to address the participation of ethnic minorities;
- partnership working needs to occur across traditional boundaries.

## 2.6 Health and well-being policy in rural Wales

The RHIP investigated the impact of policies, programmes and projects to promote health and well-being in rural Wales (Report 6), the specific issue of the use of health impact assessment (Report 7) and the effectiveness of existing policy and administrative structures on rural health and well-being (Report 8).

A number of the rural issues identified in policy review had already been recognised by the Welsh Assembly Government and the external agencies responsible for the implementation of policy. Although steps had been taken or were being planned in many instances to strengthen the rural dimension to policy, the barriers to the delivery of health and well-being policy, programmes and projects relate not only to individual policies but also to their interaction (or lack of interaction) in a rural setting.

The difficulties in delivering specific policies, programmes and projects to promote sustainable health and well-being in rural Wales should be seen in the context of the literature review (Report 2) which highlights the difficulties of mainstream and universal services in reaching remote and rural communities.

The key issues were identified as:

- policy decay: the tendency for activity on health and well-being policies to tail off with increasing distance from the centre of activity. This may occur at a national, local, or community level;
- policy overload: at a local level, the plethora of policies, programmes, projects and strategies proved challenging for small rural authorities with limited critical mass and institutional capacity. Furthermore as the majority of programmes are targeted at areas of high deprivation, small rural communities identified as being deprived may experience an array of health and well-being programmes addressing different issues but targeting the same population;
- there are low cost benefits associated with interventions in small communities;
- preparing funding bids proved challenging for small rural communities;
- although there is an expectation that there will be a joining up of health, social and economic policies and programmes at a local level, different parts of the Welsh Assembly Government were not always seen to be acting in a joined up manner.

### 3. Recommendations

At the heart of the following recommendations is the need to strengthen the evidence base regarding the rural dimension to health and well-being in Wales. This will assist in the identification of health priorities, contribute to an equitable basis for resource allocation, and inform the development of accessible and sustainable health care provision in all parts of Wales.

It is also recommended to establish policy leadership for rural health issues in Wales to ensure joined up approaches at national, local, and community levels. The rural policy agenda needs to consider health and well-being of the rural population, and equally, health policies should as a matter of course take account of the needs of the rural population in Wales. This process should be mediated through mechanisms to facilitate two-way dialogue both horizontally and vertically from individuals in the community to policy makers in the Welsh Assembly Government. This will enable the rural dimension to health and well-being research to be identified and investigated, now and in the future.

#### 3.1 Recommendations to support sustainable health and well-being in rural Wales

1. To establish a policy lead for rural health and well-being within the Welsh Assembly Government. This lead may be based within health or rural policy, but should be supported by a formal mechanism to facilitate dialogue, cross cutting working across the Welsh Assembly Government.
2. To set up a strategic body in Wales that has an overall responsibility for rural issues including health and well-being. It should have a remit to:
  - act as an advocate for rural issues to the Welsh Assembly Government;
  - support the integration of health dimensions into rural policy initiatives;
  - conduct rural proofing of health policies, programmes and projects to ensure that rural issues are considered in the delivery of policies and in resource allocation;
  - promote fair and equitable access to health services in rural areas;
  - facilitate consultation with rural agencies;
  - identify examples of best practice and advising on the future practice.

The AWRHIG were divided as to whether this body should be a new organisation or whether the remit of an existing organisation should be strengthened for this purpose.

3. To set up a health and well-being network to facilitate dialogue between the key stakeholders, health researchers and policy makers. This would provide a mechanism by which rural concerns can be presented in decision-making on health research priorities and policy development. This network may also provide a vehicle by which research findings, good practice and policy information may be effectively disseminated to those working in rural settings.

The network should be inclusive and cross-cutting, and should involve statutory and voluntary sector organisations, long-standing and new organisations, policy makers and health practitioners. During the RHIP, the AWRHIG proved to be an effective model for gaining rural health intelligence in Wales.

There are clearly a number of options on the lead agency and structure of a rural health and well-being network in Wales. The final decision should be based on the principles of maximising effectiveness and co-operation while minimising duplication of activity. Resources will need to be provided to co-ordinate and administer a network.

### 3.2 Recommendations to improve knowledge about health and well-being in rural Wales

4. To establish a research programme to support the development of policies and programmes to address health inequalities in rural Wales. Four key themes identified for such a programme were:
  - rural specific health issues;
  - defining rurality for health research;
  - clarifying the link between poverty, deprivation and health inequalities in rural areas;
  - social inclusion.

Further detail on the suggested research issues under each theme are outlined in Appendix I.

5. There is a need for an informed debate as to what may be considered 'robust' evidence. This is particularly the case for the 'softer' evidence and for research into issues where it is not possible, practical or appropriate to undertake randomised controlled trials, for example in rural Wales. This debate should involve dialogue with other academic disciplines such as sociology and anthropology that have a greater expertise in research methodology into the determinants of health. This debate should assist in formulating a consensus to identify robust evidence and will inform the rural health research programme.
6. To introduce robust small area statistics to inform decision-making. There is also a need to identify optimum sizes and time frames for capturing health data for common and low incidence diseases. The data should be made available at the smallest geographical level for which robust data may be obtained.
7. More effective use of routinely collected data on health and the factors that influence health such as prescriptions, primary care and community data, income and tax, to enhance our understanding of health, well-being and social care issues for small areas. This may be achieved through an agreed common format for the reporting of key datasets for different spatial levels.
8. To improve compliance, consistency and quality of recording of health information in outpatients departments, community based services and in primary care services to inform the development of community health profiles. In particular, there is a need for improved availability of health data at small geographical units for the following population groups:
  - children and adolescents;
  - for children and young people leaving care and for those with multiple health needs;
  - older people;
  - occupational groups such as agricultural workers.

9. To identify appropriate indicators of health need and poverty at household level. This should be informed through research as outlined under Recommendation 4. With decreasing population size, the confidence intervals surrounding summary data (such as averages) increases. Consequently it is more difficult to show statistical significance for data based on small numbers. The use of averages may obscure need especially in rural communities with a mixed (heterogeneous) population while the cost benefits of obtaining data for very small populations may be limited. Under these circumstances, the assessment of poverty, deprivation and health need for households or for individuals within households may be more a rurally sensitive option.

### 3.3 Recommendations for government policy development and implementation

10. To make Policy documents and the associated guidance from the Welsh Assembly Government easily accessible with the status and time frame of the documents being clearly specified. Any additions and amendments should also be catalogued, kept up to date and easily accessed through the publications department or on the Welsh Assembly Government website. There should be greater clarity in the documentation on policies, programmes and projects that emanate from the UK government as to their status in Wales.

Where major programmes and projects are funded by the Welsh Assembly Government, it would be helpful if information about the location of the programme, the awards and outcomes are in the public domain and in an agreed common format that facilitates area based analysis using GIS mapping.

11. To amalgamate and consequently reduce the total number of policy initiatives, programmes and partnerships to promote sustainable health and well-being generated by the Welsh Assembly Government. There is also an onus on local authorities to reduce partnership and programme duplication.

The use of common assessments such as health impact assessment, common standards, performance indicators and outcomes across agencies would be a significant step towards rationalising activity. This should be done in consultation with the statutory and voluntary agencies that form the core of the partnerships to support health and well-being in Wales. Welsh Assembly Government should work in conjunction with these agencies to produce a common set of assessment frameworks, performance indicators and outcomes for cross cutting programmes to promote health and well-being.

12. To establish a range of people-centred initiatives to counterbalance the practice of targeting initiatives at defined geographical areas. These people-centred initiatives should sensitively assist vulnerable individuals living in a mixed rural population e.g. carers, older people and families on low income, and ethnic minority groups to access support for issues such as fuel poverty, smoking cessation, access to health services, poor literacy or employment skills, that contribute directly and indirectly to health inequality.
13. The resource allocation received by statutory agencies such as the health service and local government in rural areas should take full account of the travel and transport costs, time taken to reach clients and the limited economies of scale associated with delivering services to small rural populations. This resource allocation should be based on equity of rural services with urban services

and calculated on actual costs. The costs may be different in different types of rural area though are likely to be greatest in the most peripheral and sparsely populated rural areas. If the evidence of additional rural costs is not currently available to inform this resource allocation, research should be undertaken as a matter of urgency.

14. The Welsh Assembly Government to take capacity into consideration when planning partnership work in a region, and to consider core funding for voluntary organisations that contribute to health and well-being partnerships in rural areas.
15. To address concerns about recruitment and retention of general practitioners, dentists, and other health professionals in rural areas as a matter of urgency. The issues appear to be related to professional isolation and terms and conditions of employment including the provision of out of hours cover. It requires co-ordinated action at national and local level.
16. To consider options to integrate a generic health and well-being programme into rural regeneration programmes in order to support rural initiatives becoming more sustainable. This would provide a joined up approach that reduces segmentation and policy overload. However, if this approach were adopted there will be a need to ensure that local decision-making is inclusive of individuals and groups such as young people and ethnic minority groups, that have historically been excluded from decision making in rural areas.
17. The Welsh Assembly Government to provide flexible funding opportunities for cross cutting bids that meet the needs of small local communities. Funding bids should also take account of outcomes such as community participation in decision-making.

### 3.4 Recommendations for local action

18. Local authorities to identify clear local priorities for action and support the development of locally appropriate cross cutting programmes that work across traditional service boundaries. Where such interventions are shown to be effective in addressing health inequality deprivation or health need, sustainability should be promoted through mainstream funding.
19. Community strategies to have a higher degree of input from the National Health Service generally. In addition, there is a need for Local Health Boards and ambulance services to liaise more closely with patient organisations and with regional transport providers to ensure that there is accessible public transport from rural areas to hospitals with a time schedule that enables rural inhabitants to attend appointments, visit sick relatives and return home. The current complex system of providing transport or financial support to take individuals and their carers to hospital should be thoroughly investigated and simplified. Regulations should be consistently applied and should be transparent to users and those responsible for funding the service.
20. Local service providers to provide an ongoing programme of training and education for generic rural practitioners and service providers in health, youth work and social services, to ensure that they develop and maintain the skills and competencies that are required to support the specific needs of vulnerable client groups.

### 3.5 Recommendations for empowering communities and individuals

21. To empower individuals and communities to help them acquire the skills to participate fully in decision-making. This may be achieved through social inclusion programmes and through the rolling out of the current structures to empower young people, to other age and interest groups.
22. To develop one-stop shops for people with multiple needs. It might be done by providing the training to the key people in the community such as the clergy to equip them with knowledge and skills to offer advice and information to such people.
23. Community development in rural areas to balance the interests of marginalised groups. There is a need for rural social inclusion programmes to enhance opportunities for participation of individuals from minority ethnic groups, refugees and Gypsy Travellers that tend to be excluded from decision-making in rural areas.

## References

Acheson D (1998) *Independent inquiry into inequalities in health report*. London: The Stationery Office.

Chapman P, Phimister E, Shucksmith M, Upward R and Vera-Toscano E (1998) *Poverty and exclusion in rural Britain: the dynamics of low income and employment*. York: Joseph Rowntree Foundation.

Cloke P, Goodwin M and Milbourne P (1997) *Rural Wales: community and marginalisation*. Cardiff: University of Wales Press.

Dunn J, Hodge I, Monk S and Kiddle C. (1998) *Developing indicators of rural disadvantage (Research report number 36)*. Salisbury: Rural Development Commission.

Shucksmith M (1999) *Poverty and social exclusion in rural Britain*. Section I in the Rural Group of Labour MPs Rural audit: a health check on rural Britain. Hereford: The rural media company.

Welsh Assembly Government. (2002) *Well-being in Wales*. Cardiff: Welsh Assembly Government.

Welsh Office. (1998a) *Better Health Better Wales: A Consultation Paper*. Cardiff: Welsh Office.

Welsh Office. (1998b) *Better Health Better Wales: Strategic Framework*. Cardiff: Welsh Office.

## Appendix I

### Suggested rural health and well-being research programme for Wales

The Rural Health Intelligence Programme has identified many gaps in our knowledge about the health and well-being of rural communities in Wales. The following is a summary of issues that should be addressed in a rural health and well-being research programme for Wales.

#### A. Rural specific health issues:

- zoonoses (diseases passed from animals to man);
- mortality and morbidity associated with land based industries;
- a comparative analysis of mortality, morbidity, access to health care and health inequalities across the urban/rural continuum;
- research to determine if distance decay occurs in Wales, and if so, what the key factors are and what effective interventions may be to minimise avoidable mortality and morbidity.

#### B. Defining rurality

The need to define rurality was identified as a priority in both measurement and rurality workshops, as the lack of consistent definition of rurality for health purposes limited the generalisability of findings from rural health research studies. The following research should be taken to inform the development of a definition of rurality that reflects contemporary health and well-being issues in rural Wales:

- a scoping study of the current state of research into rurality to assess the range and nature of definitions;
- mapping rurality using the different criteria at national, local and community levels with service providers;
- mapping current policy and practice in rural Wales in relation to access and its measurement;
- scoping the existing evidence base on social capital;
- scoping current research on geographical issues relating to rurality, socio economics, housing and demography at national, local and community level.

Action should be taken to consult with local agencies at each step in decision making on defining rurality: option appraisal, selection and evaluation of rural criteria.

### **C. Clarifying the link between poverty, deprivation and health inequalities in rural areas**

There is a need to undertake research into the relationship between poverty, deprivation, social capital and health inequalities in rural areas. Particular concerns have been expressed about the use of the Welsh Index of Multiple Deprivation in rural Wales. As this is a key policy driver in identifying health need and deprivation there is an urgent requirement that its applicability should be assessed in a systematic manner through a planned programme of research that includes consultation with local stakeholders.

The key issues for investigation include:

- the sensitivity of current indices to rural deprivation for the cost of living, fuel and transport;
- the appropriateness of the weighting of the access to services especially access for remote and peripheral communities and for the rural vulnerable i.e. older people, the chronically sick, the disabled and their carers;
- the possibility of extending the housing domain to take account of basic amenities such as gas, mains water and sewerage as well as new services such as mobile phone reception and broadband;
- taking account of the higher than average proportion of older people that live in rural Wales and their greater likelihood of making use of health and social care services;
- action should be taken to establish small area data on income (including self employed income) to ensure that the Welsh Index of Multiple Deprivation income domain captures real data rather than using proxies such as benefit uptake;
- evaluation of the effectiveness of area based programmes in addressing rural deprivation;
- the identification of indicators of health need at household or sub ward level - this should include benefit claimants but should not exclude the rural poor.

### **D Social inclusion**

It is recommended that research be undertaken into social inclusion programmes in rural Wales using relevant, accessible and appropriate indicators, methodologies, outcomes and time scales to evaluate the process and outcomes. Additional research should be undertaken to identify what is effective in maximising participation by patients, clients and the public in planning and implementing policy.

The current body of research on capacity building, social capital and empowerment should be more widely disseminated to practitioners.