Rapid review of the impact of rurality on the costs of delivering health care

The following summarises the objectives and emerging findings from a forthcoming report from the Nuffield Trust on behalf of the National Centre for Rural Health and Care.

Aims

The aims of this rapid review of the impact of rurality on the costs of providing health services were three-fold:

- To outline the policy considerations around accounting for unavoidable costs in providing healthcare in rural/sparse areas
- To review and summarise key evidence on the additional costs of delivering healthcare in rural areas
- To describe, quantify and critique current NHS allocation formulae in the four UK nations with respect to adjustments for rurality/sparsity

Current review of the national tariff payment system

On 9 October 2018, NHS England and NHS Improvement published their latest proposals for revamping the tariff system of payments to NHS trusts together with an overhaul of the market forces factor to better align the payment system with the goals of the new 10 year plan.

These proposals are currently out for consultation and provide the National Centre for Rural Health and Care and others with an opportunity to comment on issues related to the provision and cost of services in rural areas.

The rapid review by the Nuffield Trust aims to summarise these issues and provide a critique of the current methods for compensating for unavoidable costs associated with rurality

Draft notes on the review so far

Allocation policy background

The NHS, a universal health care system funded from general taxation and free at the point of use, has been the main route to meeting a founding principle for the service – providing equal opportunity of access for those at equal risk.

Since the early 1970s, supporting this goal has involved a recognition that populations and health care needs vary across the country and hence that different areas should receive different allocations from the total NHS budget.

But it has also been long recognised that in different areas of the country, health services find that the costs of providing care vary in ways that are unavoidable or uncontrollable due to differences in, for example, local markets for land, buildings and labour, and other factors associated with, for example, remoteness, population sparsity and rurality generally.

If no adjustment or compensation is made for such unavoidable costs then it is likely that some health services will not be able to afford their populations the same access to, and quality of, care compared to others.

On this basis, since the early 1980s adjustments to target budget allocations for health authorities (and now clinical commissioning groups) have been made to account for unavoidable variations in some costs, such as staff, land and buildings in different parts of the country (the market forces factor).

From the late 1990s, adjustments for the higher costs involved in providing emergency ambulance services in more rural areas due to longer travel times was introduced. And from 2016/17 there has been a potential compensation associated with eight hospitals at seven trusts seven rural NHS trusts with hospitals judged to face higher costs due to their unavoidable 'smallness due to remoteness' and hence unable to benefit from economies of scale.

How variations in health care needs and the costs of providing care are dealt with is not an easy matter; the weighted capitation system used by the NHS across the four territories of the UK has developed over the last 50 years or so as a result of numerous reviews and substantial econometric work into one of the most sophisticated systems for allocating public money anywhere in the world.

Nevertheless, trade-offs between desirable policy goals – equity of access vs the efficient use of scarce public money – are inevitable. Such trade-offs do not submit to technical fixes alone but also require judgements about what we are prepared to forgo (some degree of efficiency for example) to obtain some other benefit (more equal access to care for example).

Evidence on additional costs in rural areas

Our initial review of the research literature on unavoidable costs of providing health care in rural and remote areas suggests possible issues related to:

- Difficulties in staff recruitment, retention and overall staff costs.
- Higher travel costs and unproductive staff time.
- The scale of fixed costs associated with providing services within, for example, safe staffing level guidelines.
- Difficulties in realising economies of scale while adequately serving sparsely populated areas.
- More problematic is the quantification of these costs. On this, the research evidence is somewhat mixed, with some evidence suggesting these unavoidable costs are either minimal or non-existent and others suggesting varying degrees of unavoidable costs for certain types of costs. That said, NHS Improvement did approve an additional £20-25 million a year uplift in funding to one trust (Morecambe Bay) it deemed to have unavoidable costs in delivering care to a dispersed population.
- Documents published by NHS Improvement detailing proposals for revamping the tariff system indicate a view that fixed costs for emergency care services could be around 80% - evidence that smaller hospitals (and rural hospitals tend to be smaller) with lower levels of activity may face higher emergency unit costs.

Making allocations to rural areas

Our review of the current resource allocation process (which includes the approach to setting target CCG budgets and the tariff payment system for NHS trusts) suggests that:

- The allocations to local areas are heavily influenced by the decision made on what weight is given to the adjustment for inequalities / unmet need, which is not informed by evidence but remains a matter of judgment. This adjustment has the effect of directing money primarily towards urban areas.
- The scale of the adjustment for unavoidable smallness (£33m in total) is very small compared to both other adjustments and also NHS Improvement's own calculation on unavoidable costs used in adjusting funding for Morecambe Bay.
- The amount and method of compensation actually received by providers for unavoidable smallness is opaque and inconsistently applied to the seven trusts identified in this category. In addition, the 7

trusts received, in total, just 1.7% (£30m / £1,783m) of the total allocation through the sustainability transformation fund in 2017-18.

- The identification of providers with, and level of compensation for, unavoidable smallness is somewhat sensitive to cut offs used to identify trusts in this category and assumptions made in the analyses.
- The combined deficits for the seven trusts with 'unavoidably small' sites amounted to over a quarter of a billion pounds in 2017/18, which accounted for almost a quarter (23%) of the overall deficit for trusts and was higher than average, which possibly indicative of unavoidable rural costs.
- The delegation of powers to CCGs to compensate GP practices deemed 'atypical' (part of the definition of which includes proxies for remoteness) is not transparent.