# UK HEALTH SECURITY AGENCY [UKHSA] STRATEGIC PLAN 2023 TO 2026

## REVIEW AND COMMENTARY BY THE RURAL SERVICES NETWORK

**November 2023**

## INTRODUCTION

The Rural Services Network (RSN) and the National Centre for Rural Health & Care (NCRHC) welcomes the publication of the new UK Health Security Agency's first strategy which covers the period from 2023 to 2026.

Hardly surprisingly the word "rural" does not appear at all in the strategy. Nevertheless, there are some important phrases, and proposed actions from a rural policy perspective which do appear and are worthy of comment. **It is fundamentally important that the rural context is fully understood and embedded in all actions and policy interventions.**

**Almost 10 million people live in rural England – that is more than the whole of Greater London.**

In this review and commentary, we focus on those phrases and proposed actions and comment upon how important it will be moving forward to demonstrate that the UKHSA fully understands the wider context which applies across the rural areas of England.

At the same time that the UKHSAs strategy was published, the Annual Report of the Chief Medical Officer (CMO) for 2023 was also published. Its focus was "Health in an Ageing Society" and is an important document for the UKHSA to take into account when considering health inequalities. To quote page 7 of the UKHSA strategy "and we will always remember that health threats do not affect everyone equally. Deprived and vulnerable communities bear the brunt of adverse health outcomes and addressing health inequalities will be an integral part of everything we do. We will embed equity in the implementation of this strategy and in the specific projects we run, to ensure our efforts benefit everyone in Society but above all provide a focus of support for those with greatest need and at greatest risk".

Nationally it is often the case that "deprived and vulnerable communities" are regarded as being based in city and other urban areas. Nevertheless, rural vulnerability and deprivation exists as do the resultant health inequalities which impact the people and families concerned - but rural vulnerability and deprivation is 'pepper potted' across areas of relative wealth and prosperity. The hidden nature of rural vulnerability and deprivation and the other features of rural life (including

the demographics and deficiencies in social infrastructure/services to support communities) which can impact on health must not be overlooked by the UKHSA as it develops more detailed proposals and programmes going forward.

A core NHS principle is to provide services to all. Yet rural residents are disadvantaged due to poor access to transport, poor broadband and mobile phone connectivity, greater distance to receive timely care, a higher density of older people, the availability of affordable and appropriate housing stock and difficulties recruiting a healthcare workforce - all impacting on the health and care of rural residents.

**MAIN CONCLUSIONS OF THIS REVIEW AND COMMENTARY**

**(1) the UKHSA should acknowledge that the rural context means that rural areas are generally less resilient, and therefore more vulnerable to health security hazards.**
**(2) as a consequence of (1) above, very many rural residents are often disproportionately impacted**
**(3) the UKHSA, Government, other policy makers and opinion formers should be fully aware of, and rural proof their output, to reflect in their policies and programmes, the context of rural communities, rural deprivation, and rural vulnerability across England and (in this specific case) the impacts on health inequalities.**
**(4) for the UKHSA to be successful in its mission, it must sensitively and effectively address the specific needs of rural communities (and the social determinants of poor health in the rural context) and engage with central government to address the structural weaknesses concerned**
**(5) all relevant data to be collected (from all data sources) and analysed at the lowest possible geographical level and to support the recommendation of the CMO in his 2021 Annual Report to "Review the availability, access, and applicability of data on health and wellbeing outcomes and their determinants at lower geographical levels. This includes the analytical capacity across the system to collate, analyse, interpret, and disseminate the existing data".**
**(6) The Government should produce a cross governmental departmental and funded Rural Strategy to address the issues raised.**

**WHAT DO WE MEAN BY THE DEMOGRAPHICS AND DEFICIENCIES IN SOCIAL INFRASTRUCTURE/SERVICES?**

In no particular order, we refer in the main, to:

- **UNFAIR FUNDING REGIMES FOR ESSENTIAL PUBLIC SERVICES**
- **AN OLDER POPULATION WHICH IS AGEING FASTER THAN ELSEWHERE**
- **A SMALLER WORKING AGE POPULATION THAN ELSEWHERE**
- **WORKFORCE ISSUES**
- **LACK OF AFFORDABLE HOUSING**

- **LACK OF PUBLIC TRANSPORT OPTIONS**
- **POORER CONNECTIVITY (BROADBAND AND MOBILE PHONE)**
- **ACCESS TO HEALTH AND CARE**
- **HIGHER COSTS OF LIVING AND FUEL POVERTY**
- **INSUFFICIENT GRANULARITY OF DATA COLLECTION AND ANALYSIS**

**Each of these individually – but even more so collectively – impact on health inequalities.**

A 2022 report, "Rural as a region: the hidden challenge for Levelling Up" found that the Government's Levelling Up White Paper metrics - used to identify the regions most in need of levelling up - are too urban-focused, and do not account for disadvantage in rural economies within regions, often linked to limited local employment prospects, poor transport networks and weak connectivity. It called for the Government to rethink its choice of metrics and include more rural-relevant indicators such as workplace-based incomes, fuel poverty levels, access to further education and house prices relative to local earnings.

**The research, authored by economists from Pragmatix Advisory, set out that despite being home to a fifth of the population and with a larger total population than London or the South-East, when evaluating all the headline metrics in the White Paper against the other nine geographies, England's 'hidden region' has a greater need to be levelled up than any other part of the country.**

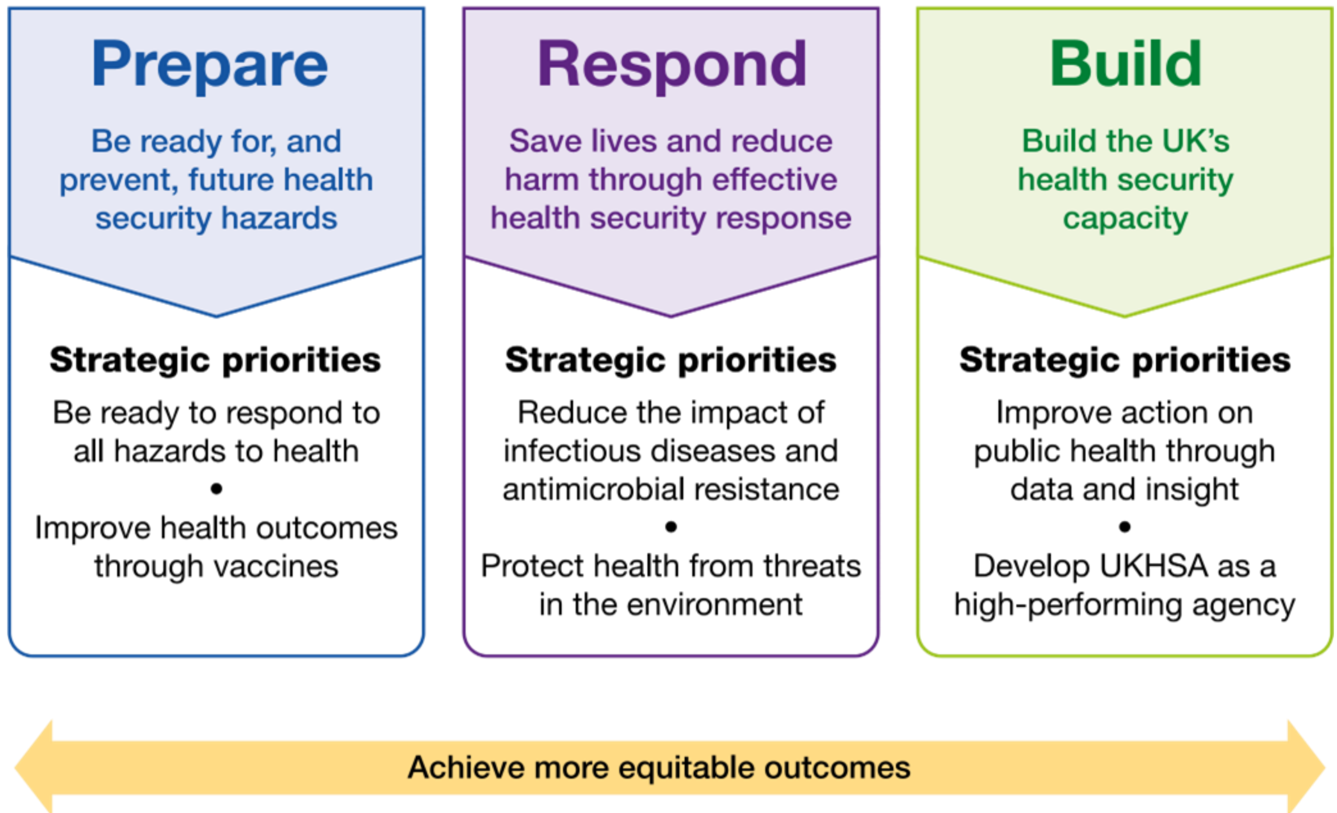
To quote from page 78 of the CMO's 2023 Annual Report "In social work and domiciliary care, recruitment is increasingly difficult, and the cost-of-living crisis has aggravated this. Social care workers and providers in rural areas particularly struggle due to poor public transport and fuel costs – staff cannot afford to drive to and from their clients and the rural nature means fewer clients can be seen due to journey times.

National research suggests other factors such as the perception of social care and pressure on staff to work more hours contribute to workforce shortages. However, in rural areas, lower numbers of people of working age, and more expensive housing costs is exacerbating this problem".

There is additionally the need to recognise the severe impacts of extreme weather conditions on rural areas – including the current lack of sustainability of the electricity network serving those areas.

**<u>THE STRATEGY'S STATED GOALS AND STRATEGIC PRIORITIES</u>**

The strategy sets out three goals each with two strategic priorities which together are intended to achieve more equitable outcomes. These are summarised below.:




**THE KEY PHRASES AND PROPOSED ACTIONS FROM A RURAL POLICY PERSPECTIVE**

There is a very great deal of crossover in the RSN's comments on the key phrases and proposed actions from a rural policy perspective which are set out in the UKHAS's Strategic Plan 2023 to 2026. We therefore just set out below the key phrases and proposed actions which we refer to and then comment on them collectively.

1. Harmful health impacts from extreme weather are increasing. (page 7).
2. UKHSA will continue to make a significant impact on the health and prosperity of the nation. This includes (page 12):
    a. delivering better health outcomes for all individuals by preventing and reducing the impact of hazards to health
    b. supporting the improved health of the overall population, reducing health inequalities, minimising the burden and cost of health security hazards to the public, the NHS, and other public services
    c. enabling a resilient economy, with services and businesses better protected from the impacts of health security incidents.
3. We will advance our insight and expertise at a local, national, and international level, through maximising our data, surveillance, analytic capabilities, and our partnerships (page 13)

4. We will maintain a focus on equity and addressing health inequalities in all our work, recognising that health threats often disproportionately impact certain groups (page 13).
5. We use our clinical, operational, and analytical expertise and experience to deliver against the goal of being ready for, and prevent, future health security hazards. We work with the NHS and local authorities to deliver preventative services (page 14).
6. Our goal is to act quickly to protect people at risk, tailoring our work to reflect how some groups are disproportionately exposed to and impacted by health hazards. We provide evidence, evaluation, and insight to inform interventions and programme design – whether our own or that of other organisations – developing and sharing scientific insight, intelligence, and guidance (page 15).
7. We work across the national and local health and social care system (page 15)
8. We recognise that health threats impact people in different ways, and often disproportionately impact certain groups. We know that to be successful in our mission, we must sensitively and effectively address the specific needs of the people and communities at greatest risk. The importance of strong health protection systems that address health inequalities has never been clearer (page 16).
9. UKHSA detects, tracks, analyses, and interprets data, and develops forecasts on threats to health. Data underpins our ability to make policy and operational decisions which are grounded in evidence. We safely and appropriately collect and generate valuable data, which in turn drives our evidence and insight, identifying groups at specific risk from harm (page 21).
10. The goal of being ready to respond to all hazards to health means understanding the threats we could face, together with the risks to different populations and places, and using this to ensure we have the right surveillance to detect threats (page 26).
11. We will keep the growing and harmful health impacts of climate change at the forefront of our preparedness. Climate change increases the threat of infectious diseases … as well as environmental hazards (such as heat waves and flooding). We will better understand the impacts on health, particularly for the people and places at highest risk of poor outcomes, as well as supporting effective interventions to strengthen resilience and adapt to these changes (page 26).
12. Improved understanding of the impact of different health hazards on different groups and communities, to ensure that we are better prepared to address the needs those who are vulnerable or at high risk. This will enable UKHSA and partners to respond more effectively and achieve more equitable health outcomes (page 27).
13. Data is an essential component of effective public health action. Data underpins our ability to respond and make evidence-based decisions UKHSA will continue to develop and optimise our data and surveillance infrastructure and capabilities to keep ahead of the next health security threats and prevent them where possible. We will identify the burden of health security threats across all population groups to prevent and minimise the impact these threats have on health, society, public services, and the economy, locally and globally (page 37).

14. Lead a data transformation, as a key contributor to the health data and analysis landscape, by developing a new modern enterprise data and analytics platform for UKHSA and simplifying and rationalising our legacy data environment. This will enable us to make high-quality data accessible at scale and in a timely manner and improve our understanding of people and places at most risk from external health hazards (page 37).
15. Local partnerships: UKHSA provides leadership, coordination, expertise and support for preparedness and response at a regional and sub-regional level. UKHSA's regional teams respond to thousands of cases and incidents each year, as well as proactively working with partners to protect the public. (page 48). This includes:
    - NHS and Community Partners
    - Social Care Providers
    - Local Authorities
    - Integrated Care Systems
    - Local Resilience For a

## The RSN's Comments and Supporting Evidence in respect of the Key Phrases and Proposed Actions set out above.

Throughout, there is the recognition that health threats often disproportionately impact certain groups, for instance. "We will maintain a focus on equity and addressing health inequalities in all our work, recognising that health threats often disproportionately impact certain groups (page 13)."

In its response to the NHS Major Conditions Consultation (2023), the National Centre for Rural Health and Care [NCRHC] and the Rural Coalition set out details of the rural context (needs and characteristics, social and environmental circumstances). Those details are set out in this link, but some key aspects are quoted below.

"In rural areas **there is a very strong connection between other major social, environmental, and economic issues, such as quality and availability of housing** and the nature of employment, when it comes to the quantum of demand for health services. Respiratory illnesses are influenced by housing conditions and type of employment"; and

"Tackling the burden of 'major conditions' is not just an immediate issue that should be addressed in the proposed Strategy, it is also a longer-term public health matter as well. In general, and perhaps surprisingly, the public health indicators in childhood and adolescence are worse for those living in rural and coastal areas than for those residents in towns and cities. These indicators often translate over time into the ill health challenges reflected in the identified major conditions. It is essential, therefore, to invest now in the public health, prevention and health promotion measures that will mitigate against avoidable demand in the longer term."

**The 2022 NCRHC/APPG Rural Health and Care Inquiry report recommended:**

**Recommendation 4**: Core health and care pathways for cancer, heart disease, stroke, mental health, and all emergency care must be urgently reviewed to better meet the rural need

**Recommendation 5**: "Rural health proof" housing and planning, transport, and environment policy

**Recommendation 6**: Develop a rural technology health and care strategy and platform

**Recommendation 10:** Fund research into the nature, connectedness, and integrated treatment of complex co-morbidities across primary, secondary health and social care

**Recommendation 11:** Integrate health and social care budget setting in rural areas as a test pilot of the Health and Care Bills ambition and measure combined health and care outcomes against that budget

**Recommendation 12**: Empower the community and voluntary sector to own prevention and wellbeing.

We commend the University of Central Lancashire's report on "Remote and Rural Health and Medicine" first published in February 2020 but updated in January 2022. It highlights many of the issues we refer to.

The workforce in rural areas has been and will remain primary care orientated. We know that recruitment and retention problems has led in France and other countries to what the French have called medical deserts and even if we are not there yet, there is a strong chance that we will also be soon.

It is crucial that the rural workforce needs to be "Fit for Purpose" and that means a change in how we train the rural workforce and the need to blur some of the boundaries between primary and secondary care to do so. We need to also explore different models of secondary care with more community engagement and the training of a generalist consultant cohort.

The Kings Fund Report states:
For decades successive governments have consistently failed to deliver on promises to make England's health and care system focused less on hospitals and more on primary and community care"
"The report outlined several recommendations to correct the "longstanding policy failure," including targeting future spending growth at primary care and community services, prioritising investment in primary and community care buildings and equipment and reforming the ailing social care system. It also emphasised that more staff must be incentivised to work in primary care and community services, through pay and career progression, and potentially by introducing mandatory primary and community training placements for clinicians /leaders."

## DETAILS OF THE RURAL CONTEXT OF THE ISSUES WE REFER TO AS THE DEMOGRAPHICS AND DEFICIENCIES IN SOCIAL INFRASTRUCTURE/SERVICES

We set out in the **Appendix** to this document some of the key facts and impacts thereof which we refer to.

We, of course, recognise that there are health benefits from living in or access to the countryside where people and families can afford to do so. However, "you can't eat the view".

**We fully acknowledge that most of these need action by the Government but consider that the UKHSA does have a role in considering the direct and indirect health equality issues as summarised in the main conclusions of this review and commentary on Page 2 and the Appendix of this document.**

**APPENDIX 1**:

**DETAILS OF THE RURAL CONTEXT OF THE ISSUES WE REFER TO AS THE DEMOGRAPHICS AND DEFICIENCIES IN SOCIAL INFRASTRUCTURE/SERVICES**

## (1) Government Funding for Essential Public Services

It is impossible to focus on equity and addressing health inequalities without addressing the fact that across essential public services impacting on health, rural areas are treated unfairly in the government's formulae for the distribution of national funding to meet needs and engage in prevention measures.

The UKHSA should., as part of its work, investigate and report to Government on the distribution of funding which impacts on health (including social and structural issues). **The RSN offers its help in reviewing such fair funding.**

**Analysis by the Rural Services Network shows that for 2024/25, when compared with their predominantly urban equivalents:**

- Predominantly rural local authorities receive some 14% more grant funding per head to pay for social care services (£162.43 compared to £142.57).
- Predominantly rural local authorities receive some 57.5% less grant funding per head to pay for their public health responsibilities; (£73.09 compared to £46.42).
- Overall Government Funded Spending Power per head is £536.51 for urban authorities and £394.80 for rural – a gap of 36% (£141.71),
- Rural residents will pay on average 20% (£112.33) per head more than their urban counterparts in Council Tax due to their Councils receiving less Government grant.
- Urban authorities are budgeting to spend almost double that of rural on so called discretionary services – which include things like bus service support, support to the voluntary and community sectors and economic development generally. In 2022/23 planned expenditure on public transport per resident was around five times more in urban areas than rural.

**The above is despite the fact that it costs more to deliver services across rural areas and the cost of living is higher. Rural workers earn £1,600 a year less than the national average**

Other analysis has shown that almost 12% of all residents who live in a rural area are providing informal care to someone else on a regular basis. Indeed, 24% of older people who live in a rural area are providing such informal care. Both figures are higher than the national average.

In 2015, ACRA analysed the potentially higher costs faced by hospitals which are 'unavoidably too small to achieve full economies of scale.' The analysis identified 12 hospitals (all serving rural areas) which fitted the unavoidable smallness criteria.

Analysis in 2018 revealed that just six rural hospital trusts carry a quarter of England's health service's funding deficit.

There are other service delivery challenges which impact on providers of health and social care in the rural context. In tourist areas there is a large seasonal increase in the population which creates demand in the health sector. The increase in the workforce coming into rural areas seasonally from elsewhere tends to introduce a degree of disorder and uncertainty healthcare-wise - they may be unregistered, there may be no access to their previous records, it may be difficult to engage with them via usual (primary care) channels for either their chronic illness or for preventative or even acute healthcare.

**(2) A particular group in both the rural and coastal context are the more elderly populations.**

The CMO in his 2023 Annual Report (page 2) says "For policymakers, the biggest concern I have is that government and professional bodies have not recognised the degree to which the population living in older age is concentrating geographically in the United Kingdom in general, and England specifically. The great majority of people move out of cities and large towns before older age, concentrating geographically in coastal, semi-rural or peripheral areas, often with relatively sparse services and transport links.

Older people form a significantly larger proportion of the population in rural than in urban areas.

| | Age Over 65 | Age Over 85 |
|---|---|---|
| Predominantly Rural areas | 24.5% | 3.3% |
| Predominantly Urban areas | 16..1% | 2.1% |

Official population projections show that the share of the population in predominantly rural areas which is aged 65 or over is expected to rise to just under 31% by the year 2041 (20.8% for predominantly urban). For over 85 -year -olds the projected figures by 2041 are 5.4% for rural and 3.4% for urban.

The number of over 65s between 2021 and 2041 in Predominantly Rural local authorities is projected to increase by 45.8% (40.6% for Predominantly Urban). The number of over 85s between 2021 and 2041 in Predominantly Rural local authorities is projected to increase by 92.6% (70.7% for Predominantly Urban).

For those over 85 years old who need support their care needs are recognised to be more complex (and expensive) to meet.

The health and care challenges facing those living in rural and coastal areas are well documented. People living in peripheral areas experience issues relating to accessing primary and secondary healthcare, domiciliary care, medicines, shopping, and transport. The response times of health care professionals are often longer because of the distances involved, which is particularly important for emergency presentations such as stroke and heart attacks. Access to leisure services, cultural events and suitable physical activity can also be limited, which provides additional challenge in accessing activities that prevent and delay onset of poor health. These issues can be compounded by the effect of loneliness which may come from living in a sparsely populated area. Technological infrastructure and limited access to broadband can also impact on health and care provision in remote areas. As discussed in the 2021 Chief Medical Officer's Annual Report 'Health in Coastal Communities', (and these comments apply also to rural areas in general) "if we do not tackle the health problems of these communities vigorously and systematically there will be a long tail of preventable ill health in peripheral areas which will get worse as current populations age."

As acknowledged by the NHS Long Term Workforce Plan, the increase in health and care need from an ageing population will not be uniform across the UK and will grow more rapidly in peripheral areas. Geographies with the oldest populations, especially in rural and coastal areas, have been found to often be most under-served.

To quote from the recommendations in the CMO's 2023 Annual Report "Older age is becoming increasingly geographically concentrated in England, and services to prevent disease, treat disease and provide infrastructure need to plan on that basis. **This should be seen as a national problem and resources should be directed towards areas of greatest need, which include peripheral, rural and coastal regions of the country.** The NHS, social care, central and local government must start planning more systematically based on where the population will age in the future, rather than where demand was 10 years ago. This includes building or adapting housing and transport to be appropriate for an older population".

The CMO in his 2021 Annual Report said (and again these comments apply also to rural areas in general)

"Given the health and wellbeing challenges of coastal communities have more in common with one another than inland neighbours, there should be a national strategy to improve the health and wellbeing of coastal communities. This must be cross-government as many of the key drivers and levers such as housing, environment, education, employment, economic drivers, and transport are wider than health."

The current mismatch between health and social care worker deployment and disease prevalence in coastal areas needs to be addressed."

## (3) Workforce Issues

The other issues referred to in this document such as funding, affordable housing, transport, cost-of living etc. all impact on workforce recruitment and retention.

Medical, nursing and health professionals also raise concerns about access to quality post-16 education in some rural areas.

Research has identified several workforce (or recruitment and retention) issues that particularly impact rural areas, including difficulties with

- Recruiting a range of staff, including doctors and consultants, to posts in rural settings, including at smaller hospitals.
- Maintaining consultant hospital teams with all the required skills, given the trend towards sub-specialisms; and
- Ensuring that health professionals have sufficient access to training, networking, and compulsory development opportunities.

Shortages within the social care workforce may explain (at least, in part) the higher rate of delayed patient transfer from hospitals found in rural areas. Many of these will be people requiring a care package when returning home

A workforce issue which affects social care providers in rural areas is that in tourist areas a significant number of seasonal jobs become available in the tourist season and many care staff leave the sector for those better paid and less stressful jobs for the summer months.

**The following has been taken from the National Cantre for Rural Health and Care's assessment of the NHS Long Term Workforce Plan**

"Rural and coastal communities experience significant additional workforce challenges by virtue of their particular circumstances. With growing rural populations and associated ageing and morbidity, rural communities are often distant to services; their hospitals regularly struggle to recruit to characteristically small teams and experience greater costs by virtue of their size. This can lead to less equitable health and care provision.

Rural primary care, whilst also experiencing significant workforce challenges, plays a unique part in supporting the local health and care system, with development of extended skills, an emphasis on generalism, and multidisciplinary integrated working. This enhanced role can and should be harnessed to support health and care provision in rural communities.

Generalist skills, extended practice and competency-based teams will need to be at the heart of approaches across both primary and secondary care. The geographical narcissism that has viewed rural clinical practice as inferior to its urban counterparts must be addressed through training, with development of Rural Clinical Schools which recruit from local communities, links to (or creation of rural) academic campuses, 'in-reach' attachments, universal opportunities for rural experience, and potential for additional rural qualifications.

Special rural GP training programmes will promote the opportunities as a rewarding career. Widened access into medical professions that consider rural needs will ensure sustainable success. Appropriate training facilities and training, support and recompense for tutors are essential. Shared-learning, flexible working practices and peer support including use of comprehensive clinical networks will all be important in retaining health and care professionals in rural areas.

Dental access needs particular attention with consideration given to the potential for redistribution of longitudinal integrated training programmes and further development of a multi-professional dental workforce with associated rural training opportunities.

**Use of technology has proved a significant enabler in improving access to health and care in rural as well as other areas and can be further harnessed so long as attention is given to issues of connectivity and the digital divide experienced by some groups.** Whilst national approaches are clearly important, we believe that more local level devolution and planning will be necessary to enable a more nuanced response to rural workforce challenges. **We would propose that as part of national 'Next Steps' arrangements a Place-Based workstream be established to support implementation in specific geographical and other contexts such as (but not exclusively) rural communities.** We would be pleased to advise and provide expertise from our organisation, members and via our wider national and international networks to aid this and ensure that the excellent opportunities outlined in the National Workforce Plan are fully realised for rural and coastal communities."

**The NCRHC/APPG Rural Health and Care Inquiry recommended:**

**Recommendation 3:** Include specific rural content in every first degree in medicine, nursing, Allied Health Professionals, and social care. Mandate rural work experience in every general practice course, every geriatrician course, every nursing course, and all core health care training

**Recommendation 7:** Enable and empower local placed based flexibility in the ICS structure

**Recommendation 8**: With the Royal Colleges and Health Education England/NHSE/I, review the match between the existing health and care professional structures and the skill needs of today to meet health and care demands with a view to creating a wider variety/diversity of health and care professionals with shorter training courses

**Recommendation 9**: Hard-wire generalist skills training across the medical professions, in both core and updated CPD training

A key issue in recruitment terms is the need for spouses, partners and/or family members to access work (or education/training) to meet their needs. It isn't just about the person needed to fill the vacancy.

## (4) Lack of Affordable Housing

People and families need access to a home they can afford if they are to be able to live and work in rural areas. House prices are higher in rural areas compared to urban and, with lower-than-average wages earned in the rural economy, and higher cost of living overall, it makes accessing housing unaffordable. Rural areas also suffer from a lack of affordable rental accommodation, as more properties are changed into more lucrative short- term holiday lets. Access to genuinely affordable homes must be addressed if rural economic growth and sustainable rural communities are to be achieved.

Rural communities should be diverse and inclusive places where people of all ages and backgrounds can live together. A supply of affordable housing helps to ensure that is the case. Without it, rural communities become places where only the more affluent can afford to live.

Equally important is that those who grow up or have connections in rural communities have the option to live there. This includes young people forming new households, typically with limited financial resources. A supply of affordable housing keeps families and local support networks intact which, in turn, helps to address health issues caused or exacerbated by isolation and loneliness.

We stress that the unaffordability of housing in rural areas impacts on the recruitment and retention of health care professionals, teachers, police officers etc – and does not just impact on lower paid and/or seasonal workers.

Businesses in rural areas need access to a workforce, including for jobs which typically attract or can only sustain modest pay rates. This includes many of those who are classed as “essential workers”. A supply of affordable housing benefits the rural economy, with employers able to recruit and retain staff across a range of jobs.

As the CMO says in his 2023 Annual Report “Where property prices are highest, the pool of working age adults from which to recruit is more limited than other areas of the country. Availability of staff restricts providers’ ability to take on work and the overarching market challenges mean this area cannot grow capacity to meet demand.”

Excluding London, the average house purchase price I the first quarter of 2023 was £124,000 higher in rural areas than it is in urban areas.

The housing affordability index measures the cost of bottom quartile housing as a multiple of bottom quartile annual earnings. In 2022 that multiple or ratio was:

- 8.8 in predominantly rural areas, having risen from 8.0 in 2015; and
- 7.6 in predominantly urban areas (excluding London), having risen from 6.8 in 2015.

## (5) Lack of Public Transport Options

As stated in the CMO's 2023 Annual Report "Transport and mobility are necessary for an independent life, and for many forms of enjoyment. Supporting and maintaining active transport (walking and cycling) for as long as possible is good for physical and mental health. As people grow older, they may lose the ability to drive safely and having a public transport system which meets the needs of older people is important for independence, especially in more rural areas."

Due to the lack of public transport options rural residents are much more reliant on the car. Fuel and other running costs are an ongoing issue. When travel as both a car driver and passenger are taken together, 90 per cent of the distance travelled by people living in Rural Villages, Hamlets and Isolated Dwellings was made by car compared with 72 per cent in Urban Conurbations and 81 per cent in England as a whole. For families where family members need to go in different directions or at different times those households need several cars.

Rural residents travel further than their urban counterparts. Those living in small rural settlements (villages and hamlets) on average travelled 6,450 miles in 2021. That is 45% more than the average resident from an urban town or city. Whilst travel was curtailed in 2021 by the Covid pandemic, the rural-urban comparison shown here matches a long-established trend.

Travel times required to reach a workplace or services are typically longer for rural than for urban residents. This time difference is most marked for those who rely upon public transport, as the statistics below for the year 2019 show

**Average minimum travel time by public transport or walking to reach nearest service or centre**

| To reach the nearest: | From rural areas | From urban areas |
|---|---|---|
| Employment centre (with 5,000+ jobs) | 55 minutes | 26 minutes |
| GP surgery | 23 minutes | 11 minutes |
| Further education institution | 37 minutes | 18 minutes |

**For travel by public transport or walking in 2019:**

- the average minimum travel time to a hospital was a little over one hour in rural areas, compared with a little over half an hour in urban areas (this, of course, only applies where there are busses from the rural area).
- fewer than half the users living in rural areas have access to places with 5,000 or more jobs within 45 minutes, compared with 91 per cent of users in urban areas.
- 51 per cent of users living in rural areas do not have access to their nearest hospital within an hour's travel, compared with 8 per cent of users in urban areas.

- the services with the lowest average number of service locations available to those in rural areas within a 60-minute journey time were hospitals (with around one) and places with 5,000 or more jobs available (with around two to three)

Over the decade from 2011/12 to 2021/22 bus vehicle mileage in predominantly rural areas declined somewhat for commercially run services (-10%) but more than halved for local authority subsidised services (-54%).

As mentioned previously, another feature is that local authorities in predominantly rural areas have less funding available to them for spending on bus services (than equivalent urban local authorities). On a like-for-like basis, urban authorities are allocating 4.7 times as much from their budget as rural authorities to subsidise bus services.

Research suggests that about one in four bus routes have ceased in county and rural areas over the eleven years from 2010/11 to 2021/22. This estimate aligns with findings from another recent study, which adds that prior to the pandemic bus route cuts had mostly impacted subsidised services, but the arrival of the pandemic (in 2020/21) had its largest impact on commercially run services.

## (6) Poorer Connectivity (Broadband and Mobile Phone)

Some of the technological back-up for primary care, e.g., diagnostics and telecare, is limited in rural areas either because this has been consolidated in urban centres or because of limited connectivity.

Digital connectivity in rural areas, both broadband and 4G/5G, still lag well behind urban areas in capacity, if they exist at all. They are likely always to be behind the 'cutting edge'. Only 35% of rural households have Gigabit capability. It will be very important either to invest substantially in this or ensure that future actions do not make assumptions about availability that cannot be realised in practice.

There remain an estimated 350,000 premises in England which cannot yet access a fixed decent broadband connection (meeting the Universal Service Obligation (USO) standard), of whom 40,000 don't have an alternative option to try a wireless connection. The USO is the level the regulator (Ofcom) considers necessary for everyday use, though is likely to prove inadequate for many businesses, home workers and students. Earlier Ofcom reports found that rural premises, including rural SMEs, were many times more likely to fall into this category than urban premises.

There also remain notable challenges with mobile connectivity at rural premises. At 51% of those in England it is not possible to get a 4G connection on all four mobile networks (BT-EE, Virgin Media/O2, Three and Vodaphone) when indoors. 4% of rural households do not get mobile coverage indoors. The comparable figure for being unable to get a 4G connection outside of rural premises is 10%.

The Government's October 2023 consultation in respect of Very Hard to Reach Premises sets out the case for intervention in what is a clear example of market failure in respect of essential infrastructure. The consultation says:

*"good digital connectivity plays an important role in levelling up our rural communities, it increases productivity and helps to expand opportunities for flexible working, online education, and leisure activities. Therefore, providing better digital infrastructure is an important mechanism to help remedy economic and social exclusion."*

*"there has been an increased trend for both public and private services to migrate to digital models. In many areas of the public sector, from GP practises and hospital consultations to HM Courts and Tribunal services, digital technology is being used more to help deliver more efficient and cost-effective public services"* It goes on to say that *"in other sectors, such as high street banking and retail shopping this trend has been longstanding, with transactions and customer support moved from shops and bank branches to online platforms."*

**The consultation acknowledges that the above presents a particular challenge in rural communities, where there are fewer alternative physical locations to access such services, and greater distance required to reach them. It further acknowledges that these issues are further compounded when local public transport options are infrequent or unavailable.**

The consultation states *"**therefore, as the typical delivery of these services moves further towards wholly digital models, there is a substantial risk that the communities which are very hard to reach may be left behind. These communities are in part characterised by typically poorer quality broadband connections, or even no connection at all, and are likely to require additional consideration to avoid social and economic exclusion."***

The consultation further acknowledges that *"those whose broadband connection impedes their ability to take full advantage of the above trends face further exclusion from a society where increased connectivity has supported a more dynamic economy and labour market. **Young people from lower income households are particularly vulnerable to the long- term impact this could present, older generations who also faced mobility challenges and are more dependent on community level service provision are also affected."***

## (7) Access to Health and Care

The health and wellbeing of the nation's population is as relevant to and important for rural communities as it is to those who live elsewhere. This universality is embedded within the vision that led to the creation of our National Health Service.

A recent EFRA report on mental health concluded that 'rural communities needs are not fully reflected in mental health policy and services and NHS planning.'

Rural councils are struggling to deliver social services due to rising costs and increased demand.

Health services that serve rural populations need to be safe and of high quality. They also need to be geographically accessible. This can lead to a dilemma, often not well resolved, where services become more specialised and centralised, but are then more distant from rural communities. This has been exacerbated by significant cuts made to rural bus routes.

On the other hand, there is a drive to expand the range of (non-acute) services which are provided away from main hospitals sites at community hospitals or health centres. Digital adoption and telehealth also have rural potential, assuming there is fast and reliable network connectivity.

The importance of mental wellbeing is increasingly recognised across all age groups. If common mental health problems are included, they are widely experienced and have costs for society at large (including lost working days). Whilst levels of mental ill-health are not especially high in rural areas, there are concerns such as access to relevant support services and for isolated farming communities.

For many rural people receiving regular care support is vital. It allows many to continue living at home. This includes support from statutory services, voluntary organisations and (informally) from family or friends. Rural areas typically have fewer or less accessible day care centres and the like.

Rural residents can wait 3 times longer for an ambulance.

## (8) Higher Costs of Living and Fuel Poverty

A Rural Cost of Living report commissioned in July 2022 by the Rural Services Network showed that across all areas surveyed the cost of living was demonstrably higher across rural areas than elsewhere:

**WAGES:** Rural 6% lower than urban £23,117 v £24,540

**HIGHER NUMBER** of SMEs and self-employed

**HOUSE PURCHASE PRICES**: 39% Higher (Excl London). In villages and hamlets 55% higher

**RENT:** Rural spends 47% of earnings on rent – Urban 43% for low- income urban households. 61% reduction in availability in rural communities post pandemic

**FOOD PRICES:** Rural spend £65.50 on food – 2% higher than urban (Gap even greater where physical access to food shops or digital access to online shopping is an issue)

**COUNCIL TAX**: (then) 21% Higher ((£104 per head) in rural than urban

**TRANSPORT:** Rural household spend £113.90 per week. Urban £76.20. 12.3% of disposable income compared to 9.9%. Cost of car ownership including need for more than 1 car per household

**HEATING:** To take rural households out of Fuel Poverty £501 v urban £223. Energy costs of rural dwellings 10% higher than urban

**TRIPLE WHAMMY**. Transport, Heating and Lower Wages

A follow up survey of rural households by the Rural Services Network (RSN) reported in May 2023. It showed that more than 75% of respondents say that their financial situation has got worse over the last year. Responses to the online household survey were received from 6,780 rural residents in a clear demonstration of the severity of the situation.

**Headline findings of the survey showed:**
After paying for essentials, two thirds of respondents are in households with little income left over for other things. **However, a fifth of respondents live either in households with no income left over, or in households where the essentials alone exceed their income**. These essentials included rent or mortgage, food and drink, essential car or travel costs and childcare.

**The survey highlighted concerning findings where rural households cited ways they are trying to save on home heating costs, such as wearing more clothing, sitting underneath blankets or duvets, running heating for shorter periods, and living in fewer rooms. Some describe how the constant cold is affecting their physical health or mental wellbeing.**

**Households living in rural areas have the highest fuel poverty rate of 15.9% compared to urban areas having the overall median rate of 13.4%. For rural areas, the fuel poverty gap in 2022 was £956 compared to the lowest fuel poverty gap in London of £223. (annual fuel poverty statistics published on 28 February 2023 for the year 2022)**

## (9) Insufficient Granularity of Data Collection and Analysis

As stated in the CMO's 2021 Annual Report "The paucity of granular data and actionable research into the health needs of coastal communities is striking. Improving this will assist the formulation of policies to improve the health of coastal communities. Local authorities, ONS and NHSE/I need to make access to more granular data available. Research funders, including NIHR and UKRI, need to provide incentives for research aimed specifically at improving coastal community health." This is true for rural areas as well as coastal.

Whilst the NHS may collect data at a Lower-Level Super Output Area (LLSOA) level many others who collect provide important data do not. It is also essential that data is analysed at LLSOA level) and public reported.

It is very important from a rural perspective that intra-regional disparities are given as much weight as inter-regional ones, as they can be just as great if not greater. This fact is often overlooked because of the "averaging" impact of comparing large scale populations with each other and combining rural and urban in population

analysis, rather than looking at urban and rural separately. Just as the planning and delivery of health and social care is based on a model designed for people living in concentrated populations, so too are the formulae for measuring disadvantage in rural areas.

In his 2021 Annual Report the CMO recommended "Review the availability, access, and applicability of data on health and wellbeing outcomes and their determinants at lower geographical levels. This includes the analytical capacity across the system to collate, analyse, interpret, and disseminate the existing data. This needs consideration of data sharing arrangements." Again, this is true for rural areas as well as coastal; and

"Further multi-disciplinary research is required to understand the multiple drivers of poor health outcomes in coastal communities and test effective interventions and solutions. This requires specific incentives to leading health academic groups by research funders ". Once again, this applies equally to rural areas.

**The NCRHC/APPG Rural Health and Care Inquiry recommended:**

**Recommendation 1:** ***Rurality and its infrastructure must be redefined to allow a better understanding of how it impinges on health outcomes.*** The factors driving health inequalities in sparsely populated areas must be measured with a greater degree of specificity and granularity, so that health and social care services can be properly funded, planned, and delivered more effectively.

**Recommendation 2:** Identify and measure drivers of health inequalities at a greater level of granularity (1000 head of population should be a denominator)