NATIONAL CENTRE FOR RURAL HEALTH AND CARE

APPG Rural Health & Care

Inquiry Overview | February 2022

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National Centre for Rural Health and Care

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Introduction

For too long people in rural and coastal areas have experienced poorer access to health and social care services than their counterparts in cities and towns. For many the prospects of a healthy life are also worse, somewhat at odds with the perceived benefits of living the idyllic rural life. Almost one fifth of the population of England live in rural or coastal areas and they deserve better health and social care outcomes than is currently the case. This is not in any way a criticism of the staff or the hard-pressed system in which they work, far from it. They too deserve better.

It was against this background that the National Centre for Rural Health and Care and the All Party Parliamentary Group (APPG) on Rural Health and Social Care joined forces in 2019 to launch an Inquiry aimed at redressing these inequalities. The subsequent Report highlights the health and social care situation in rural areas and focuses on the challenges that must be addressed. It emphasises specific actions required to address rural disadvantage and ensure that people living in rural areas enjoy the same opportunities for health and care experienced by their urban counterparts, notwithstanding the obvious fact that all communities are characterised by socio-economic inequalities and the impact this has on health outcomes. This report is the result of the three year Inquiry and is based on a multiplicity of evidence from across the United Kingdom and indeed worldwide. It focuses on the specific challenges faced by rural populations compared to their urban peers. The result is a reasoned set of solutions for levelling-up the health prospects of those living in rural communities.

The Inquiry Report highlights the health and social care situation in rural areas and focuses on the challenges that must be addressed. The 2021 Chief Medical Officer's (CMO) Report on 'Health in Coastal Communities' also identifies these challenges only too well. The Inquiry Report mirrors the CMO's conclusions and amplifies the case for action.

Numerous witnesses gave evidence covering a wide range of sectors. They included academics

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who had undertaken relevant research work, policymakers and officials, practitioners in health and social care, and service users. The statutory, voluntary and private sectors were all included. Additionally, experts from across the globe contributed their expertise and experience, citing examples of good practice that potentially could be adopted elsewhere. Evidence was reviewed by the panel of participants at each meeting with particular attention being paid to the connectivity between different aspects of wider rural life and the impact on health, access to services, and the provision of social care.

Rural health disadvantages are not insignificant for the nation as a whole. 9.7 million people live in rural areas of England (more than those who live in Greater London), many in very isolated circumstances with few services or amenities for miles around. This number continues to grow. Residents are disproportionately older than average, often with a high number of co-morbidities, each presenting a different challenge to the health and care system.

Rural areas are also more likely to contain hidden areas of significant deprivation, masked by the way statistics are recorded. Moreover, coastal and rural economies are highly seasonal in nature. Tourism, the hospitality industry, agricultural production, and our fishing industry all influence the ebb and flow of rural and coastal populations.

Numerous witnesses gave evidence. This comprehensive report, drawn from 28 hours of evidence, 89 different witnesses, and 8 countries, has been a journey of discovery. The full report offers a comprehensive review of the deficiencies in rural health and care, together with the means for addressing them. It provides the basis for substantial improvements in the health, wellbeing and social care of rural citizens and the means by which we can offer rural residents the same access to health and care enjoyed by their urban cousins.

9.7M

million people live in rural areas of England

The Rural Population

It is perhaps self-evident that the first step in resolving rural health disparities is to build an understanding of the distinctive health and care needs of rural areas. There is no universal definition of 'rural', although there is significant agreement about the nature of rurality and its impact on health, wellbeing, and social care. Not surprisingly, there is a transition from rural to urban, with 'fringe' areas experiencing some elements of both. The term 'Rural' is not a single entity, but an overarching term often used to embrace three very different types of community, namely 'Coastal', 'Remote', and 'Rural'.

As mentioned already, coastal and rural economies are often highly seasonal in nature and the influx of large numbers of visitors and migrant workers at different times of the year leads to consequential peaks and troughs of demand upon the healthcare system.

The Inquiry noted that access to health and social care is also a function of the wider world in which we live. The provision of services generally in rural, remote and coastal areas is poorer than in more heavily populated parts of the country. Public transport is often a major impediment to accessing health and social care, not just for patients but also for staff travelling to work. Due to poor public transport, cars have become essential for most people living in sparsely populated communities. Many more households own a car than in urban areas because they are an absolute necessity. Ironically, vehicle ownership is often seen as a measure of affluence, rather than essential, although vehicles owned in rural settings are by and large older and less energy efficient. Similarly, housing is also more expensive (excluding London), often less well maintained and not as energy efficient. Poorer educational provision and facilities for young people, fewer day centres for those of more advanced years, lack lustre digital connectivity, poor housing stock, and economic uncertainty in agricultural, other land based and tourism industries all influence the health and wellbeing of rural residents. It is not just access to healthcare that is compromised in rural areas, but the very determinants of health themselves.

The events of the last 18 months have led to a large number of people discovering the attraction of rural living and the lifestyle that it offers. The popular perception in the media is that countryside dwellers are wealthier, live longer and happier lives, which for some people is undoubtedly true. But the reality for a significant number of rural residents, often with complex co-morbidities, is that they live lonely lives without the same access to services and facilities that is available to their urban counterparts. For many newcomers, the very idea that there could be a challenge, albeit a well-hidden one, in the appropriateness, adequacy and quality of health and care provision in such idyllic settings seems almost counter intuitive.

Evidence presented to the Inquiry was clear. In essence, many rural residents are disadvantaged throughout their life-course compared to their urban counterparts. Access to maternity care is more problematical; the wider community services for children and young people are less accessible; primary and secondary care are not so readily available for people of working age, including preventative and screening services; and the provision of both health and social services for the growing proportion of older citizens is increasingly inadequate. We are not offering equal care for all in England, despite the commitment to do so. And as the last year and a half have made clear, undiagnosed and unaddressed health conditions usually end up resulting in higher costs, poorer health outcomes, reduced economic opportunities and, in a very real sense, a community that falls far short of achieving its potential.

The Policy Context

In 1948

When the NHS was launched, it was founded on three fundamental principles, namely.

- **It should meet the needs of everyone.**
- **It should be free at the point of delivery.**
- **It should be based on clinical need, not ability to pay.**

The more recent NHS Constitution is also founded on the principle of equal access to health care. The Constitution states that the NHS is available to all and that it has a 'social duty to promote equality through the services it provides and to pay particular attention to groups or sections of society where improvements in health and life expectancy are not keeping pace with the rest of the population'. It emphasises that people should not be disadvantaged because of where they reside and that nobody should be excluded, discriminated against or left behind. Despite these fundamental commitments, health and social care in rural areas has been raised as a concern in numerous reports over many years.

Policymakers all too frequently underestimate the challenges of living in a rural area and the costs of ensuring that services are available equally to all citizens, irrespective of their location. This is in part because the way we collect data distorts the situation in rural and coastal communities. Rural residents often appear to be more affluent than is the case and face higher costs of living but earn lower local wages/ salaries. The lack of service provision and access to care is often masked by data sets that are driven by urban circumstances and criteria and which do not reflect rural needs, perpetuating and even exacerbating the reduced health outcomes for so many people living in rural environments. Put simply, we just don't know as much as we should about the health and wellbeing of people living in rural, remote and coastal settings, but we do know enough to show that all is not as it should be. That disadvantage and inequalities exist is indisputable. Unlike cities and major towns, however, where specific postcodes are associated with poor health and poverty, inequalities and disadvantage are hidden in more dispersed communities.

The ability to access care is not just dependent on the location of health services. Public transport, digital connectivity and the availability of professionally qualified staff also determine the provision of accessible care. Public transport is a major limitation in rural areas; poor broadband and mobile phone speeds hinder alternatives to traditional health and social care; and workforce supply is a significant constraint. The Inquiry concluded that a strategy to address rural inequalities in health must embrace the full panoply of factors affecting access, not just a reprovision of health and social care services.

Quality Data

The Foundation for Funding, Planning and Action

The Inquiry acknowledged that it is often more difficult to provide health and social care services to dispersed populations or those living in more remote coastal communities. It is self-evident that the economies of scale achievable in more densely populated communities become more problematical in rural and coastal areas. Nevertheless, these rural areas make an essential contribution to the national economy, not least in terms of agricultural production, fishing and tourism – but also across most sectors – and their residents are entitled to the same services as their urban counterparts. The founding principles of the NHS make this clear!

The road to better healthcare for rural communities starts with a more accurate and reliable understanding of their circumstances and experience. Sound data are essential for effective rural planning. Current data are inadequate, not least because the way information is collected and used at present distorts the situation in rural and coastal communities. The mechanisms used to collect data, although reliable in more densely populated areas, are often inappropriate for more sparsely populated localities. The consequence is that the basis for planning is flawed, as are the formulae for funding. The Inquiry concluded that a new approach to measuring health and care is needed, one that is relevant specifically to rural circumstances or, at the very least, where the data are viewed through a rural lens.

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Summary of Recommendations

The Inquiry resulted in twelve recommendations, grouped under four major headings:

i. Build understanding of the distinctive health and care needs of rural areas

Different rural communities exhibit different characteristics, and this often requires adapting health and social care approaches to any given place. On the other hand, rural places also exhibit many shared characteristics. Common 'place-based' issues in rural communities include distance, the small scale of service provision and, for coastal and island locations in particular, the impact of seasonality.

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.

Collecting information on health and social care in rural places comes with a range of key challenges. Current indicators (including the Index of Multiple Deprivation) frequently mask pockets of deprivation and poor health outcomes in rural communities, which are more visible when concentrated in densely populated urban environments. Sparsely populated areas, by definition, include relatively small sample sizes and the subsequent aggregation of data can exacerbate the apparent invisibility of certain health issues. At the very least, a specific rural focus should be applied when analysing the data already collected.

Understanding health and social care in rural settings needs to be embedded at the start of professional training. Specific rural content should be included in the curriculum for every first degree in medicine, nursing and social care. Moreover, rural work experience should be mandatory in general practice training, every geriatrician course, every nursing course and, indeed, every health care course.

ii. Deliver services that are suited to the specific needs of rural places

Witnesses to the Inquiry were adamant that all policies should be 'rural proofed' for their impact on health and care – and that they clearly were not at present. This should apply not just to health planning, but policies concerned with transport and technology as well. Indeed, a specific rural 'health and care technology strategy and platform' should be developed urgently to support approaches to delivering care in rural areas. Inadequacies in current infrastructure undermine the ability to develop new, more effective and efficient ways of providing care.

Island and coastal populations are particularly disadvantaged. The Inquiry found that national delivery models and funding formulae are further compromised in an island and coastal context. Witnesses described how the national funding formulae, including in terms of emergency services, does not cover operational costs.

The Inquiry concluded that, in order to improve outcomes in key areas of rural healthcare need, specific core pathways should be developed for cancers, heart disease, stroke and mental health.

iii. Develop a structural and regulatory framework that fosters adaption and innovation

The overall structure of health and social care provision in England is complex. It comprises Government departments, national Non-Departmental Public Bodies (NDPBs) and executive agencies, local clinical commissioning groups, primary care, the NHS, local authority and independent provision, as well as Sustainability and Transformation Partnerships (STPs) and Integrated Care Systems (ICSs) working to improve and integrate services. The role of unpaid carers must also be considered. The new ICS model offers the potential for a simpler, better co-ordinated system,

which should foster and empower local, place-based flexibility. Services for the future should be designed around rural communities and their unique needs and circumstances rather than employing a 'one size fits all' model, largely designed around urban environments.

Under current arrangements, residents in rural areas have less choice, and experience higher costs in relation to the care system and accessing it. Rural GP practices should be allowed more scope for innovation, including practice-based public health initiatives. The lack of pharmacies in rural areas is acting as a driver for the Dispensing Doctor approach, although the increasing scarcity of pharmacies is in itself a cause for concern. The absence of any meaningful recognition of the additional costs of emergency services in rural areas should also be addressed in future contractual arrangements, together with the true costs of delivering health and social care to dispersed populations – this is far more than 'travel related costs'.

Possibly the most limiting factor of all concerns the workforce. Other organisational and structural initiatives become irrelevant without the necessary system capacity and capability. Time and again witnesses referred to this as a huge limitation in providing the same level of care to rural residents as that offered to people living in more densely populated areas. Moreover, workforce limitations will be further exposed as the number and proportion of older people increases noticeably over the coming years. The Inquiry heard that Health Education England is addressing the issue as a priority and this report confirms that a robust rural component in workforce planning is needed urgently.

The Inquiry concluded that the relevance of existing professional skills, together with current training arrangements, should be reviewed, including an exploration of shorter competency-based routes to registration. This should be undertaken in conjunction with the Royal Colleges and Health Education England (or its successor) with a view to creating a wider variety of health and care professionals who will be better equipped to manage the needs of rural populations. This would include arming future health professionals with a broader range of generalist skills, both through initial training and continuing professional development (CPD). For example, witnesses from a primary care background endorsed the importance of enhanced knowledge and competence in general practice, covering priority areas such as mental health, emergency medicine, general medicine, public health, and dermatology. The Inquiry concluded that this could make a huge contribution in bringing care closer to where people live and work.

iv. Develop integrated services that provide holistic, person-centred care

Research should be funded into the nature, interrelationships and integrated treatment of complex co-morbidities and their management across primary, secondary and social care in rural situations. To facilitate the planning and delivery of integrated care, budgets should also be integrated and the ICS model is a valuable step in this direction. As part of ongoing evaluation, health outcomes should be measured against the combined budget, as envisaged in the Health and Social Care Bill. The CQC should have a formal role in assessing equality of service across the specific geographies within the whole ICS area.

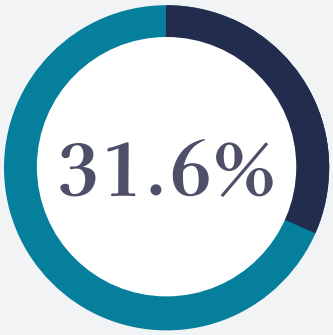
The Inquiry also acknowledged that the contribution of community and voluntary organisations is frequently underestimated, not least with respect to prevention and wellbeing. The Third Sector should be a partner in the integrated planning system and resourced accordingly, where it is cost effective to do so and in the community's interests.

A Call for Action

‘Levelling-up’ is not just about the north-south divide or socio-economic inequalities; the urban-rural divide must be tackled as well.

Numerous reports in recent years have emphasised the growing unmet health and care needs of the rural population. The average age is already higher than in urban communities and this will increase significantly over the coming decades. This is especially true for the 85+ age group whose care needs, when they arise, are usually more complex, and expensive, to meet. In 2041 it is projected that over 65 year-olds will account for 31.6% of the Predominantly Rural population (21.1% for Predominantly Urban). Over 85s are projected to account for 6.2% of the Predominantly Rural population (3.7% for Predominantly Urban).

We really cannot afford to delay any longer. Evidence provided to the Inquiry identified a range of effective interventions and they cover the full panoply of economic, social and environmental sectors. It is clear that an overarching, place-based rural strategy is required; a piecemeal approach will lack coherence and impact. The now widely accepted World Health Organisation concept of ‘Health in All Policies’ was never needed more than in the rural context. Not only will the solutions be multisectoral, but so too will the benefits. Poor health may be a cost to society, but better health is a social and economic resource. In this sense, health and wealth are indivisible.



In 2041 it is projected that over 65 year-olds will account for 31.6% of the Predominantly Rural population

There was universal agreement that rural circumstances require very different arrangements for health and social care. Marginal adjustments to an urban model are wholly inadequate and result in rural residents receiving a lower level of care than elsewhere. Aside from the methodological and organisational approach to care for dispersed communities, the underpinning model must also reflect the true cost of rural provision. Witnesses overwhelmingly concluded that current funding arrangements should be addressed urgently in the interested of fairness and equity.

People in rural areas have to travel further for treatment, often experiencing greater difficulty accessing specialist provision and emergency services. The somewhat disparate availability of services and facilities in rural localities, compounded by poor public transport, is seen as a key determinant of rural health inequality. Poorer health outcomes are the result. Furthermore, local service delivery is hampered by inadequate digital connectivity, which also hinders the introduction of alternative, rurally relevant methods of assessment and care. Staffing levels, inflexible professional boundaries, and a lack of locally based training and professional development all compound the problem.

Numerous witnesses identified distance from services as a defining characteristic of rural places. A delivery model that concentrates services in urban areas fails to meet the needs of rural people – this is exacerbated by poor public transport. This is compounded by a failure to design and deliver services that meet the specific requirements of rural and coastal communities, whether in primary care, hospital provision, or community and social services.

The inquiry heard from numerous witnesses about shortcomings in the funding of health and care in rural

areas. These ranged from emergency services, hospital trusts to social care provision (in both home care or in care/nursing homes). Evidence received by the Inquiry confirmed that funding formulae do not properly reflect the impact of rurality on service delivery costs. For example, little more than a handful of rural hospital trusts account for almost a quarter of the total accumulated NHS deficit. Moreover, although it is certainly the case that the funding of social care is an issue nationally, rural local authorities spend a disproportionately higher share of their budget on these services and the local Council Tax payers have to fund more of those costs than their urban counterparts.

The additional costs to the NHS are described in the full Inquiry Report. Witnesses also described the additional non-NHS costs of poor infrastructure, which impinge upon access to and the delivery of health and social care services. Many of these costs fall on the service providers, but significant additional costs are also imposed upon patients, their carers and consumers, especially travel costs and through Council Tax.

The NHS Constitution is founded on the principle of equal access to healthcare. The Constitution emphasises that people should not be disadvantaged because of where they reside and that nobody should be excluded, discriminated against, or left behind.

Alongside funding, workforce capacity is perhaps the greatest impediment to the delivery of equitable health and social care in rural areas. Traditional, urban-centric

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professional models and skill sets are not as appropriate in rural settings as they are in more concentrated populations supported by a high technology secondary care system. New thinking, for example, is required in the recruitment, retention and training of rural GPs. And as for nursing, although retention is better than urban areas, recruitment is more difficult. In the community, social care is perceived as the poor relation to other health and care occupations, with high demand, low wages, access to transport and high turnover all being major factors. Traditional professional boundaries do not always best serve rural residents and it is quite clear that the entire workforce system requires a major overhaul. Once again, the message is that 'rural' should not merely be a 'tweaked' version of urban health and care but should be built from the ground upwards.

Without clear changes in policy direction and decision-making, the situation will move from urgent to critical. As the last 18 months has made clear, undiagnosed and unaddressed health conditions usually end up resulting in higher costs, poorer health outcomes, reduced economic opportunities and, in every sense, diminished and disadvantaged communities. And it was clear from the expert witnesses that these issues impact many communities up and down the country.

Change isn't necessarily easy, but change is nevertheless required. The solutions are there, they just must be recognised and owned, as indeed the Inquiry has recognised. They then need to be properly funded. We owe it to our rural communities to ensure that health and social care provision meets their needs now and in the future. If we are truly serious about 'levelling up', we must ensure that rural residents have the same access to timely, quality services as those living in more densely populated areas.

The health care needs of rural communities have been side-lined for far too long. There is clear evidence that change is required in how we provide tailored, person-centred, community-based approaches to health and care services in rural communities. Government can no longer turn a blind eye to the needs of almost a fifth of the population.

Moreover, any future approach must take account of the relationship between health and other policy areas such as housing, transport and digital technologies. Any solution requires different layers of Government and local communities to work together across traditional sectors to ensure a joined-up, place-based approach. The current 'one size fits all' model is not just ineffective, it is also inefficient. The principle must be equal access to care, not identical provision. It should be consumer/needs led, not provider driven, based on the unique specific circumstances of rural communities.

The Inquiry into Rural Health and Care provides solutions. It is not rocket science but does require commitment. The knowledge and the wherewithal exist to improve the health prospects for rural residents. A network of organisations stands ready to help, including the National Centre for Rural Health and Care and the Rural Services Network for local government alongside other rural service providers and the Rural Health and Care Alliance.

However, the unresolved question remains: Does the political will exist to capitalise on the opportunities presented in this Report?

Appendixes: Inquiry Recommendations and Selected Rural Facts

Appendix 1

Inquiry Recommendations

1. Build understanding of the distinctive health and care needs of rural areas

- **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).
- **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.

2. Deliver services that are suited to the specific needs of rural places

Given the events of the last two years, it is clearer than ever that services need to meet the needs of their local population as well as developing interwoven health and care pathways.

- **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.

3. Develop a structural and regulatory framework that fosters adaption and innovation

We need to develop a structural and regulatory framework that fosters rural adaptation and innovation. This needs to include re-working skills to create more specialist generalists and other fluid and adaptable workforce positions.

- **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.

4. Develop integrated services that provide holistic, person-centred care

The system needs to develop better integrated services that provide holistic, person-centred care best suited to patient needs.

- **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.

Notes

a. More detail can be found in the full report.

b. All sessions were recorded and the notes can be found on the NCRHC website: https://www.ncrhc.org

Appendix 2

Selected Rural Facts

Source:

Department of Environment, Food and Rural Affairs. Statistical Digest of Rural England December 2021 Edition.

Population

- 'Rural' is defined as an area that falls outside of settlements with more than 10,000 resident population.
- The Rural/Urban Local Authority Classification categorises districts and unitary authorities on a six-point scale. These are often aggregated into three categories: Predominantly Rural; Urban with significant Rural; Predominantly Urban.
- The Local Authority Classification also considers some urban areas as Hub Towns (population between 10,000 and 30,000), where they provide services and business for a wider rural hinterland and are designated 'Rural' for this purpose.
- 9.7 million people (17.1%) of the population in England, lived in rural areas in 2020 compared to 46.9 million (82.9 %) in urban areas.
- Around 502,200 people (0.9%) of the population live in rural settlements (2020) in a sparse setting, as defined by the Office of National Statistics.
- The rural population has a higher proportion of those aged 65 and over (25.4%) compared with the urban population where (17.1%) are 65 and over.
- Sparse settings have the highest proportion of those aged 65 and over, where 30.7% of the population are aged 65 and over.
- In 2020, the 'white ethnic' group accounted for 96.8% of the rural population compared with 81.7% in urban areas.

Employment

- In 2020, the average unemployment rate in rural areas was 3.5 per cent compared to 5% in urban settlements. However, this does not reflect under-employment (the fact that many rural workers undertake more than one part-time job just to make ends meet).
- In 2019, 1,072,000 (22%) of all workers living in rural areas were based at home. This compares to 2,978,000 (13%) home workers in urban areas.
- In 2019/20 'Agriculture, forestry & fishing' accounted for 15.0% of local registered businesses in rural areas overall (31.9% in a sparse settings). Other prominent sectors in rural areas are 'Professional, scientific & technical services' (14.5 per cent of businesses), 'Wholesale & retail trade; repair of motor vehicles' (12.7 per cent) and 'Construction' (12.4 per cent).

Transport and Travel

- In 2018/19 people living in the most rural areas travelled almost twice as far per year than those in the most urban areas.
- In 2018/19 in the most rural areas 87 per cent of travel was made using a car (as a driver or passenger) compared with 67 per cent in the most urban areas.
- The average total distances travelled are much higher for people living in Rural Town and Fringe areas (32 per cent higher) and in Rural Villages, Hamlets and Isolated Dwellings (50 per cent higher).
- The miles travelled by walking has increased more in Rural areas than in Urban areas over the period 2009/10 to 2018/19. Average distance travelled by those from Rural Villages, Hamlets and Isolated Dwellings has increased by 17% and by those living in Rural Town and Fringe by 16%.

- The average minimum travel times to reach the nearest key services were longer for people living in rural areas for all services compared with people living in urban areas.
- More services were available on average for people living in urban areas for all service types and all journey times compared with those for people living in rural areas, when walking and using public transport.

Accessibility to Services

- 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.
- 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 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).
- 43 per cent of users living in rural areas had access to a General Practice within half an hour's walk compared with 95 per cent of users living in urban areas.
- For people living in rural hamlets and isolated dwellings in a sparse setting, average minimum journey times by car in 2019 to places with 5,000 or more jobs was 50 minutes and it also took on average 50 minutes to travel to the nearest hospital.
- People living in rural areas had on average two General Practices available within a 15 minute journey compared with eight General Practices in urban areas.

Broadband

- Overall, average broadband speeds in rural areas tend to be slower than those in urban areas. In 2020 the average speed in Predominantly Rural areas was 54 Mbit/s compared with 81 Mbit/s in Predominantly Urban areas. This is because there is less superfast broadband in rural areas and rural premises are typically further away from cabinets, with long copper line connections, leading to slower performance.
- Speeds vary because it is harder for network operators to recoup the fixed costs necessary for upgrading exchanges and cabinets in rural areas, where there are lower population densities, and therefore fewer end subscribers.

Housing and Fuel Poverty

- In 2019, in Predominantly Rural areas the average lower quartile house price was 8.6 times the average lower quartile earnings, compared with 7.4 times in Predominantly Urban areas (excluding London). Housing in Predominantly Rural areas is, on average, less affordable than in Predominantly Urban areas (excluding London).
- Homes in rural areas are typically less energy efficient and are often more reliant on potentially more expensive heating fuels.
- Overall, the average fuel poverty gap for households that were fuel poor in 2019 was £216. However, the average fuel poverty gap for fuel poor households in Rural Villages, Hamlets and Isolated Dwellings was £585.


365