RURAL HEALTH CONFERENCE

Challenging times – One Year On. Working together to deliver effective rural health services.

9.35am – Introduction to the day.

Good morning ladies and gentlemen, and welcome. I would like to congratulate the Rural Health Network for organising today's event.

This conference is an integral part of supporting the Rural Health Network's wider aims.

The purpose of our meeting is to enable health professionals to share learning and to exchange thought provoking information with the aim to improve public health and deliver more effective rural health services.

To uphold these objectives, this event will focus on the latest developments in health services (including rural telehealth and tele-care), as well as providing an opportunity to attend several cutting edge workshops highlighting 'best practice' projects or initiatives.

In 2011 I founded the Rural Fair Share campaign to encourage the Government to address the ongoing disparity in funding between rural and urban areas.

The campaign brings together Members of both Houses of Parliament, along with organisations, community groups, and individuals concerned about the welfare of our rural communities.

The campaign supports impartial, objective, needs based policy which is equitable to all.

As part of our aim to continue improving rural health services it is essential to begin by focusing on the key issue which must be addressed; namely the need to prevent health inequalities continuing within the NHS.

Because of the current model of resource allocation within the NHS, the areas that are grappling with the highest burdens of chronic illness and disability do not receive the highest NHS allocations.

We must challenge this.

It is an issue which requires urgent attention from not only health and public health professionals, but also those responsible for the current resource allocation model.

The majority, *if not all, of* the research that has been sanctioned by the Advisory Commission on Resource Allocation (ACRA) – which derives NHS funding formulae - has used the 'utilisation-based' approach.

In this approach - estimates of health care needs are obtained from regression models describing how the historic use of services relates to socio-economic characteristics.

The approach has been widely criticised on the basis that a population's *use of services* provides an inadequate measure of its *need for services*.

The flaw is simple; where services are better funded (relative to need) they will tend to be more accessible and thus more heavily utilised (relative to need). This will be reflected in utilisation data and result in models – and allocations – which overestimate the actual level of need.

Therefore, services remain well-funded and their use remains high. Conversely, utilisation-based models risk underestimating the needs of populations which make poor use of services precisely because service provision is already poor.

Furthermore, in the current model, the highest levels of NHS funding go to areas which are classified as the most 'socially deprived.'

And here is the key; deprivation and disadvantage are often thought of as an urban phenomenon. Rural deprivation is often masked within areas of apparent rural affluence.

Recognition needs to be given to these pockets of deprivation within rural areas, and to the inequalities of access to health services.

While deprived areas do have the highest mortality and morbidity rates in standardised terms, because they generally possess a younger population, there are lower crude burdens of disease and thus lower needs for curative NHS care.

Yet for most conditions (mental health excluded), age is a more significant determinant of morbidity and mortality than deprivation. Therefore, the health communities grappling with the highest burdens of chronic illness and disability – in crude terms - serve the most ageing areas.

In a recent survey commissioned by MacMillan Cancer Support, nearly half of the GP's, oncologists and specialist cancer nurses surveyed said that, 'age discrimination is resulting in older cancer patients not getting the best treatment.'

This supports the notion that staff working in demographically older areas have far fewer resources at their disposal.

These examples of ageism are not isolated examples. They are representative of the trend in which young, deprived areas are receiving comparatively too much funding.

This is illustrated by the amount the NHS spends on cancer treatment in Tower Hamlets compared to Dorset.

Tower Hamlets is a deprived, but youthful population. Whilst Dorset is more affluent, but with the country's highest proportion of the population aged 75 plus.

In 2010 Tower Hamlet's NHS foundation spent £13,087 per cancer patient, whilst its Dorset counterpart spent just £4,075 – only ⅓ as much. This is clearly unfair and happened as a result of the current model of resource allocation.

So, why does this matter to rural communities?

With approximately 50% of those living in rural areas aged over 45 years, the rural population is on average older than in urban areas. *(Statistical Digest of Rural England February 2012).*

This means that the current resource allocation formula, dominated by the utilisation-based approach and focusing on deprivation over age, is directly affecting our rural areas.

The important principle here should be health care equality and an aim to promote equal opportunity of access to health care for people at equal risk.

Rural services in England should be improved whenever possible.

Ageism should not be prevalent within NHS resource allocation.

Our aim must be to ensure that areas that are struggling with the highest levels of chronic illness and disability receive the highest NHS allocations.

So, without further ado, I'd like to give the floor to Professor James Ferguson, who will discuss what England can learn from Scotland's experience in effectively deploying telehealth to rural communities.