Communities that live in Rural Deprivation
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Summary

Rural deprivation introduction

- This needs assessment considers the meaning of rurality and deprivation from geographical, public health and sociological perspectives in order to support the current trend towards greater collaboration between health and social services.
- Suffolk is a relatively wealthy county, with areas of deprivation in some town centres and rural areas.
- The rural population is older than that in urban areas. This difference will increase because of the natural movement of the younger population towards urban centres for education and job opportunities.
- The needs assessment cannot cover all issues of rurality, deprivation, and all aspects of health, health determinants and health services. So the focus has been on the areas in which greatest achievement might be made in improving the health of the population.

Rural deprivation key points

- Suffolk is a largely rural county with small towns but many more remote areas.
- Suffolk is relatively wealthy but has some areas of deprivation in town centres.
- There are pockets of deprivation in rural areas; these may be less apparent owing to the average scores on which deprivation indices are based.
- Many indicators show that health is better in rural areas. Major conditions such as coronary heart disease, cancer and stroke all have lower incidences.
- In contrast, death rates from suicide and undetermined injury are higher, which may also indicate a poorer level of mental health.
- Service provision is more expensive to provide owing to delivery charges, costs to staff attending in remote areas and time taken in travelling.
- Many older people may be “asset rich, cash poor”. The purchase of food and fuel may be a problem.
- Staff and patients (travelling to work or to attend a clinical appointment), may find the time taken and the cost incurred much higher than in urban areas, owing to distances to travel, poor public transport and the cost of running a car.
- Domiciliary services such as social care may be more difficult to obtain owing to the distance to travel.
- All these factors suggest that choice is reduced and costs may be higher both to the service provider and to the service user.
• Many services in rural areas such as postal services, doctors’ surgeries, public houses, libraries, village shops and dentists are gradually reducing in number.
• Services in rural areas will be increasingly difficult to provide owing to the ageing population, and younger people moving into urban areas for cheaper accommodation nearer to their place of work. This reduces the availability of the extended family to provide help when it is needed.
• Rural roads may be more dangerous that urban ones, and the rate of road traffic accidents and fatalities is much higher in the country.
• There is a strong network of voluntary services, but their use to supplement statutory services has been questioned.

Rural deprivation recommendations

1. Suffolk County Council should review the findings of the “Hidden Needs” report (Fenton 2011). Discussions should be held with the commissioners of that report and decisions taken on where targeted support will be made to prevent increasing isolation of rural communities.
2. Mental health services should provide more targeted and specific support to ameliorate rural isolation, amongst the indigenous population as well as migrant labour.
3. A survey should be carried out of people without cars who live in rural areas on how they access GP, dental, optician and hospital appointments. When appointments are offered to people living in rural areas, patient’s travel arrangements should be taken into account.
4. The studies available for this needs assessment have included a review of the voluntary sector and its input, some information on health services, and some information on health need, but these different analytical perspectives need to be brought together in order to reveal and allow analysis of the gaps. This is the joint responsibility of the CCGs and SCC Public Health.
5. SCC in conjunction with the district and borough councils should identify the most deprived rural wards and make firm plans on improving the life chances of the residents in those areas.
6. In taking decisions on budget allocation, SCC should consider the high value of the voluntary sector in reducing rural social isolation and support the sector to improve their performance.
What is rural deprivation and why is it important for Suffolk?

Introduction

The 2011 Census described 82.4% of the population of England as being urban and 17.6% of the population living in rural areas. Urban areas are defined as settlements of more than 10,000 people (DEFRA Rural Statistics 2015).

“Rural” is defined in a distribution developed by the Office for National Statistics (ONS) which assigned units at Output Area level to one of six types on the basis of their predominant settlement component (ONS 2013):

Urban
  • Major conurbation
  • Lesser conurbation
  • City and town

Rural
  • Town and fringe
  • Village
  • Dispersed (hamlets and isolated dwellings).

This classification has been applied to many indicators.

Nationally, the percentage of working age people in employment in 2013 was 71% in urban settlements and 76% in rural settlements. The rate is based on where people live and not where they work. People living in rural settlements may travel to work in larger urban settlements and vice versa for urban residents.

In 2013, the unemployment rate overall in rural settlements was 4.6%. Nationally there was an increase in unemployment between 2007 and 2011, when it started to decrease and in 2013 the rate for all England was 7.4%. The unemployment rate has tended to be highest in urban settlement types and lower in rural village and hamlets and rural sparse settings.

“Working age” is now defined as 16 to 64 years for males and females.

Deprivation is often found in small pockets within a geographic area which is described by a single measure (for example the Index of Multiple Deprivation). This may be misleading. It is possible that in rural areas wealthier people may be either commuting for well-paid city employment, or may have retired or even moved to the rural areas to enjoy retirement. Other
people living in the vicinity may be in a quite different income bracket but even measurements at lower super output area level will not account for those differences (Shucksmith 2003). Caution is needed against assumptions as the employment indicators are based on where individuals live rather than where they work, so those who do commute to well-paid city jobs will have their income recorded against the rural economy.

Many people do not now travel for work, or only do so for part of the time. DEFRA (2015) found that the highest rate of home workers was found in rural hamlets and dispersed areas, at 33%, compared with 12% in urban areas. Overall rural areas had a higher rate of home working compared with urban areas. According to the Office for National Statistics, home workers were more likely to be working in higher skilled roles and earn on average a higher hourly wage (ONS 2013).

The rural population is older than in urban areas and this effect is likely to increase as younger people find accommodation unaffordable and move away, leaving an increasing proportion of ageing population. More than 50% of those living in rural areas are aged above 45 years, compared with 40% in urban areas, and overall there are proportionately fewer younger people in sparse areas.

Deprivation in rural areas

There is much evidence of the difficulties of rural living particularly in an ageing population. Studies have identified families and older people whose situation is “asset rich, cash poor”, owning large houses but on a limited income (SCC 2014) (Shucksmith, 2003).

Other factors influencing the cost and satisfaction of rural living included

- having to travel to access goods and services with additional petrol costs or fares
- having less choice and competition which can result in the higher cost of goods and services
- a higher proportion of income spent on essential services
- inadequate technological infrastructure, and
- having proportionally more older people (particularly pensioners living on the state pension) than in urban areas (Richards, 2011)

A comprehensive discussion is given in Shucksmith (2003). Different concepts are outlined as an approach to studying social exclusion:
poverty, an outcome, denoting an inability to share in the everyday lifestyles of the majority because of a lack of disposable income

- deprivation, lack of certain essentials such as food, housing, mobility or services
- disadvantage, essentially similar but considers all aspects of a person’s life and not only income or expenditure
- social exclusion, the breakdown of the systems in society that should guarantee the social integration of the individual or household.

Poverty is considered to be primarily *distributional*, but social exclusion focuses on *relational* issues. The term “rural deprivation” coined in the 1970s, was a counter to the threat of loss of funding in favour of urban authorities, leading to several attempts to measure and quantify rural deprivation.

Attempts to construct indices of deprivation which can be applied usefully to both rural and urban areas have been fraught with difficulty, and this has not yet been resolved.

**Rural deprivation and health**

The health of people in rural areas is on average better than that of urban areas (Defra 2014). Hypertension, all-cause premature mortality, total hospital stays and admissions due to coronary heart disease as outcome measures were strongly associated with older age and lower social class but there was no consistent pattern of better or poorer health in people living in rural areas compared with cities (Teckle et al 2012).

Infant mortality is lower in rural areas than in England as a whole. Life expectancy is highest in predominantly rural areas. Potential years of life lost from common causes of death such as cancers, coronary heart disease and stroke were lower in rural areas. This means that fewer people living in rural areas are dying prematurely of these diseases than those living in urban areas. This was not true of suicide and undetermined injuries which were higher in the rural than urban areas.

However the finding is corroborated by Teckle et al (2012) who found no consistent pattern of better or poorer health in people living in rural areas was found, compared to primary cities when examining the association between rurality and health in Scotland.

These reports also recognise the “masking of deprivation” and ill-health and the diverse
experience of rural communities, just as much as in urban communities. This raises the question of a different approach to measuring deprivation and need that is not dependent even on lower super output area geographies (Shucksmith, 2003). OCSI (2015)\(^1\) analysed the volume and pattern of the ‘rural share’ of deprivation, helping understand whether targeted area-based programmes or broader thematic interventions might be more appropriate. These would be more closely targeted on individuals rather than a wide population poverty prevention strategy.

This is an important public health issue for Suffolk, which, as shown in the next section, is a largely rural area. Rural deprivation may be experienced in households but not reflected in statistical analyses, demonstrated in national work by Shucksmith, (2003) and also specifically related to Suffolk by Fenton et al (2011) who noted that “hidden” deprived households in a mixed economy area are likely to be particularly vulnerable when resources are allocated to areas with the highest average levels of need.

This is important to public health analysis as “hidden” deprived households are likely to be vulnerable and may become further marginalised. Defra (2015) noted that the percentage of people living with relative and absolute low income\(^2\) is lower in rural areas than in urban areas, but nevertheless many thousands of individuals living in rural areas are in households below average income. There is a close relationship between lower income and poor health, thus rural deprivation is a public health priority.

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\(^1\) OCSI’s programme of work on rural exclusion is helping local, regional and national partners make the case for increased regeneration funding to rural areas, and enabling mainstream services in rural areas to more effectively target services.

\(^2\) with an income below a percentage (60% in this case) of median income (the income earned by the household in the middle of the distribution in a given year) and absolute low income (below a threshold of median income, in this case 60% of median income) in a specific year adjusted for inflation, before or after housing costs.
What is the local picture?

Urban Rural Classification by age

The 2011 Census described 82.4% of the population of England as being urban and 17.6% of the population living in rural areas.

Table 1 shows the distribution of urban and rural population for Suffolk, the percentage rural population being significantly greater than that of England, based on mid-2012 population data. The proportion of the population in the older age groups is greater in the rural than the urban areas.

Table 1: Suffolk population, urban and rural, by age group 2011

<table>
<thead>
<tr>
<th>Age groups</th>
<th>Urban 458,900 (62.7% of Suffolk) with age structure</th>
<th>Rural 273,500 (37.3% of Suffolk) with age structure</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-15</td>
<td>84,300 (18.4%)</td>
<td>49,100 (18.0%)</td>
</tr>
<tr>
<td>16-29</td>
<td>76,600 (16.7%)</td>
<td>40,200 (14.7%)</td>
</tr>
<tr>
<td>30-44</td>
<td>86,500 (18.9%)</td>
<td>47,400 (17.3%)</td>
</tr>
<tr>
<td>45-64</td>
<td>119,300 (26.0%)</td>
<td>75,900 (27.8%)</td>
</tr>
<tr>
<td>65 &amp; over</td>
<td>92,200 (20.1%)</td>
<td>60,800 (22.2%)</td>
</tr>
</tbody>
</table>

Source: Suffolk Diversity Profile 2012

This needs assessment is concerned with the population living in the rural areas of Suffolk. This excludes the towns of Lowestoft, Beccles, Bury St Edmunds, Woodbridge, Felixstowe, Ipswich, Greater Sudbury, Stowmarket, Haverhill, Newmarket and Mildenhall.

Figure 1 shows the rural urban distribution for Suffolk according to the ONS classification can be seen in Figure 1. Figure 2 shows the population density across the County. The main urban areas in Suffolk include the county town of Ipswich and the large towns of Bury St. Edmunds and Lowestoft. Elsewhere in Suffolk, population is located in smaller market towns and villages and in more isolated settlements in the countryside and along the coastline.
This needs assessment was prepared in July 2015 by the Public Health Action Support Team on behalf of Suffolk County Council.
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Deprivation

Figure 3 shows that, relative to England as a whole, Suffolk has only pockets of deprivation. A total of 10.6% (45/436) LSOAs in Suffolk fell into most deprived quartiles of LSOAs in England. These LSOAs were located mainly in the large towns: Ipswich, Lowestoft, Bury St. Edmunds, Haverhill, Sudbury, Newmarket, Felixstowe, Beccles, and in some parts of the rural area, mainly in eastern Suffolk.

Figure 3: Indices of multiple deprivation 2010 by lower layer super output area

Routine population datasets do not allow differentiation between rural and urban areas. We know that the rural population is proportionately older than the overall population of Suffolk, and older people are at risk of both economic and social deprivation (particularly in rural areas), especially if they live alone. Over 40% of people aged 75 and over live alone, and in most parts of Suffolk, at least one person in ten of retirement age is living in poverty and the rural population is fragmented throughout the County. The proportion of very elderly people
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in the population is expected to rise, presenting a challenge to both public and third-sector service providers (Fenton 2011).

Suffolk Action with Communities in Rural England (Suffolk ACRE) and Suffolk County Council commissioned Oxford Consultants for Social Inclusion (OCSI) to further develop the evidence base on rural deprivation across the County (Fenton et al 2011). This showed that 42% of the whole population of Suffolk live in rural areas, and that nearly the same proportion of some deprived groups live in rural areas. This was based on the 2001 census; since then more towns have grown beyond the 10,000 size so they have been ‘moved’ from the rural into the urban category.

The Suffolk countryside contains almost an even share of people with long-term illness, adults with no qualifications and low-income pensioners. OCSI’s research enabled deprivation to be examined at the smaller Output Area (OA) scale rather than the much larger Local Super Output Areas (LSOA). It identified 11 rural Suffolk OAs within the 10% most deprived OAs in the whole region. The number of people living in deprivation in the OAs constituted only 16% so the large majority of people living in situations of rural deprivation live in parts of the countryside where most of their neighbours were not in similar circumstances. Such close apparent economic inequality can have a particularly adverse effect on the health of those in deprived circumstances and indeed can decrease the overall level of health status in the area (Wilkinson and Pickett 2009).

In addition to reviewing need, community service provision was documented in the Suffolk Rural Services Review (Gibson 2012) undertaken by Suffolk ACRE. Every town and parish council in the County was invited to take part, with the exception of eight towns, which were excluded from the Rural Survey, as the population exceeded 10,000. The purpose of the survey was to establish the level of service provision available in rural parishes and towns in Suffolk.

Geographically, Suffolk contains a number of small towns which are situated significant distances away from the three main hubs of Ipswich, Bury St Edmunds and Lowestoft. Although services provide out-reach to smaller towns, issues such as limited transport links, slower broadband speeds alongside funding cuts to organisations that serve these towns, act as a barrier to equity of service provision.
A multi-agency conference was held in Leiston in June 2015 to focus on issues faced by residents and the services supporting them. The conference was well attended with a number of important issues discussed. The conference not only provided an opportunity for links to be made between agencies to facilitate an improved level of joint working, but allowed focused discussion about important issues for the town. Actions that resulted from the event include: seeking funding for a youth worker and summer activities for young people, additional support from the substance misuse treatment service and the development of a directory of services. Additionally there was support for a Leiston Needs Assessment to be developed.

A further conference is organised to take place in November 2015 to track the progress of the recommendations and to give those who attended the event in June, an opportunity to update on developments.

**What is the evidence base for interventions? What is best practice?**

**Access**

Much of the literature analyses the difficulties of, rather than the solutions to provision of and access to health and social care in rural areas.

- There is considerable variability in service provision to people in rural areas but overall they are less likely to receive services comparable with their urban counterparts.
- Rural services cost more to deliver than those in urban areas and a higher burden in the time and cost of access falls upon rural service users.
- The needs of some rural dwellers, especially those from minority ethnic groups, are often neglected.
- Efforts to ensure equity in terms of the standards and levels of service provision through policy initiatives such as ‘rural standards’ and ‘rural proofing’, have had mixed success so far (Pugh et al 2007).

Others (Longley et al 2014) have reviewed service design to account for rurality:

- Ensuring that those elements of the patient pathway which can be delivered locally are so delivered
- Organising clinics and other services to recognise the difficulties of transport;
- Giving the patient a choice when deciding on the location of their specialised care
- Providing patients and their families with up-to-date and detailed information on
issues such as public transport, suitable overnight accommodation for visitors

- Much greater use of telehealth.

Mental health is an issue which is perceived to be more difficult to manage in the rural setting. (Pugh et al 2007). Stigmatisation and isolation are widely reported. Whereas in some situations rural life may be perceived to be a more solitary existence than urban life, daily life in small communities may be more socially exposed, leading to greater difficulties in dealing with personal issues such as mental health problems, or domestic violence. The lack of anonymity may lead to a culture of silence, making people unwilling to talk about or admit to personal problems.

A similar situation of stigmatisation and isolation in women wishing to escape domestic violence was also identified.

Pugh (2007) recognised that:

- people in rural areas are generally not well served by health and social services,
- the idealisation of country living may deny the presence of poverty, drug misuse, domestic violence and racism.

He noted that between different social groups, the overall picture is of under-provision compared to urban areas. Older people in rural areas were likely to be receiving lower levels of supportive services such as domiciliary care and meals on wheels than those living in urban areas, and the general take-up rates for welfare benefits seemed to be lower than in urban areas.

**Rural service provision**

A number of studies have identified parity of health status between the rural and urban communities. Hypertension, all-cause premature mortality, total hospital stays and admissions due to coronary heart disease as outcome measures were strongly associated with older age and lower social class but there was no consistent pattern of better or poorer health in people living in rural areas compared with cities (Teckle et al 2012). There is agreement that where there is a rural deficit, it lies in service provision and access rather than in health status.

Others have reviewed service design for better rural delivery:
• Ensuring that those elements of the patient pathway which can be delivered locally are so delivered
• Organising clinics and other services to recognise the difficulties of transport
• Giving the patient a choice when deciding on the location of their specialised care
• Providing patients and their families with up-to-date and detailed information on issues such as public transport, suitable overnight accommodation for visitors
• Much greater use of telehealth (Longley et al 2014).

Dissatisfaction was recorded on the social care “15-minute slot model of service” which was particularly ill-suited to rural provision with its comparatively high transport and time costs (Glendinning et al 2006). The increasing interest in person-centred and outcomes-focused approaches offered more individually tailored and appropriate models of service, but it was too early to show purported benefits for rural dwellers.

• An idea pioneered in some areas has been to organise home care service providers into geographically zoned areas thus reducing user choice but enhancing access and reliability of service.

In a study seeking ways of improving access to hospital care, Gruen et al (2003) found that simple 'shifted outpatients' styles of specialist outreach to local facilities were shown to improve access, but there was no evidence of their impact on health outcomes. Outreach as part of more complex multifaceted interventions involving primary care collaborations, education and other services was associated with improved health outcomes, more efficient and guideline-consistent care, and less use of inpatient services.

Costs and funding

Equitable health resource allocation is considered as health and social services departments are required to work in partnership and to attain national quality standards. A case for a rural premium can be made on the basis of precedent as England is the only country in the UK that does not make a major adjustment for rurality in its NHS formula (Asthana et al 2003). A study by Yang et al (2014) reviewed whole system costs of falls in people over the age of 65 years found that on average, the cost of hospital, community and social care services for each person admitted for a fall were almost four times as much in the 12 months after admission, than the cost of the admission itself. The most dramatic increase was in
community health care costs (160 per cent), compared to a 37 per cent increase in social care costs and a 35 per cent increase in acute hospital care costs.

- This finding is a recommendation for a planned care pathway to better-integrated responses to frail elderly patient’s needs.

**Transport and access**

Transport was a major problem. Poor transport networks meant that service users and carers living in rural areas who did not have a private car would have less opportunity access to services. Those with a private car would spend a much higher proportion of their income on transport. Even where public transport was available, the timings and frequency of service could militate against it use.

This problem has been characterised as “distance decay”, the phenomenon of service take-up diminishing, or being delayed, the further away that potential users live from the point of service.

This was corroborated in the Suffolk research by Suffolk ACRE (2012). People were asked whether they could reach their GP or their dentist by public transport, and comments received showed that in many cases it would be difficult if not impossible.

**Ethnic minorities**

A study of rural child care in Suffolk found that ethnic minorities were less likely to use child care services, partly because of the costs, but also because of their perception that these were aimed at a white clientele (ACRE 2002).

Another East of England study (Gilpin et al, 2006) showed the growing numbers of migrant workers from the newer member states of the European Union, 83% of them being between 18 and 34 years of age, and without dependants, for whom there was also some evidence that they were not making use of health services.

It was also possible that their low wages and often precarious housing situations made them more vulnerable to homelessness, problems of isolation and unhealthy behaviours.
Volunteering

There has been a turning to voluntarism and self-help in recent years. A voluntary medical transport scheme reviewed in the Midlands (Sherwood, Lewis 2000) found it played an important role in the welfare of rural residents, particularly elderly women and was effective but raised questions about the viability of the scheme and also about increasing calls on the voluntary sector as a means of delivering health care to rural people.

In 2011 Suffolk had 3,100 registered charities, many focused on the rural areas. One we heard about was the coffee caravan, equipped with coffee, tea and homemade cakes, with information about organisations and the services available to members of the public. Volunteering both for those providing services, and those for whom the service exists is an important intervention in health promotion by reducing isolation and giving a sense of self-worth.

What is the pattern of services in Suffolk at present?

Suffolk Rural Services Review 2012 gives a detailed picture of what services and community resources exist in rural communities across Suffolk. Four hundred and thirteen Parish and Town Councils (up to 10,000 population) were contacted and provided 345 responses, an 84% response rate. A number of the questions relating to health facilities giving widespread information on these.

The Executive Summary indicates (among many other indicators) that 30% of parishes offer IT and computing skills classes, 67% have no youth organisations and 63% have no banking facilities. In 69% of parishes there is no post office and 94% have no railway station. A broadband quality rating of average, poor or still unavailable was submitted by 83%, and 68% had no general store, 18% had no scheduled bus service, 78% did have a pub but 80% had no doctor’s surgery.

These results were compared with a previous study four years earlier and found that almost all services were less available that they had been. The sense of the study was that rural areas are increasingly isolated, in essential services supporting health, in communications, and transport, but also in structures supporting social life leading to the potential for increased isolation and loneliness.

Services directly relevant to healthcare are given in the tables below:
Table 2: Suffolk ACRE Survey, GP Surgery by Parish, 2012

<table>
<thead>
<tr>
<th>Doctor’s surgery in parish</th>
<th>% response</th>
<th>No. parishes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Responding parishes which do not have a doctors’ surgery within them</td>
<td>80%</td>
<td>276</td>
</tr>
<tr>
<td>Responding parishes which do not have a permanent doctors’ surgery within them</td>
<td>14%</td>
<td>50</td>
</tr>
<tr>
<td>Responding parishes which do not have a visiting doctors’ surgery within them</td>
<td>2%</td>
<td>6</td>
</tr>
<tr>
<td>Respondents who chose not to answer</td>
<td>4%</td>
<td>13</td>
</tr>
</tbody>
</table>

Source: Suffolk ACRE Ltd

Table 3: Suffolk ACRE Survey, Dentist available by Parish, 2012

<table>
<thead>
<tr>
<th>Dental surgery in responding parish</th>
<th>% response</th>
<th>No. parishes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Responding parishes which do not have a dental surgery within them</td>
<td>90%</td>
<td>313</td>
</tr>
<tr>
<td>Responding parishes which have a private dental surgery within them</td>
<td>3%</td>
<td>12</td>
</tr>
<tr>
<td>Responding parishes which have an NHS dental surgery within them</td>
<td>1%</td>
<td>3</td>
</tr>
<tr>
<td>Responding parishes which have both an NHS and private dental surgery within them</td>
<td>3%</td>
<td>11</td>
</tr>
<tr>
<td>Respondents who chose not to respond to this question</td>
<td>2%</td>
<td>7</td>
</tr>
</tbody>
</table>

Source: Suffolk ACRE Ltd

For 117 (34%) patients the distance to travel to the dentist was more than five miles.
Table 4: Suffolk ACRE Survey, Other health service visiting or permanent by Parish, 2012

<table>
<thead>
<tr>
<th>Type of Health service</th>
<th>% with service visiting or permanent in the parish</th>
<th>No. Respondents with service visiting or permanent in the parish</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pharmacy</td>
<td>14%</td>
<td>49</td>
</tr>
<tr>
<td>Prescription collection point</td>
<td>19%</td>
<td>64</td>
</tr>
<tr>
<td>Chiropody</td>
<td>11%</td>
<td>39</td>
</tr>
<tr>
<td>Chiropractor</td>
<td>5%</td>
<td>17</td>
</tr>
<tr>
<td>Alternative therapies</td>
<td>7%</td>
<td>25</td>
</tr>
<tr>
<td>Other</td>
<td>6%</td>
<td>19</td>
</tr>
</tbody>
</table>

Source Suffolk ACRE Ltd

Suffolk has two district general hospitals, at Ipswich and at Bury St Edmunds. There are also smaller community hospitals with a limited range of services, and also small community outpatient services. The population to the north of the County also access James Paget Hospital in Norfolk.

Transport and access are very important. Studies have shown that the further a patient is from services, the less likely he or she is to attend for treatment, even where the condition is serious. The ambulance service has targets for reaching patients, but these are averaged across the County, so some patients may have to wait longer than the average time, and targets may still be reached.

It is also known that road traffic accidents are much higher on country than urban roads. In 2012, the Department for Transport reported that most fatalities (almost 60 per cent) occur on rural roads, with 38 per cent occurring on rural A roads and a further 21 per cent on other rural roads. This is considerably higher than the 42 per cent of traffic which is found on these roads (DfT 2013).
At 10 miles the journey by car should take about 20 minutes. However more detailed work would be needed to analyse travel times by public transport. The 2001 census found that 55,000 households in Suffolk had no car, and that over a quarter of all households were in rural parts of Suffolk.

**What additional information is needed?**

- Coverage of the County by secondary and tertiary care services, and information on private and public transport to those services for accessibility, for opportunity for older people to visit family members, and for follow up visits.
- Availability of screening to remote communities.
- A very important aspect of rural life is transport, accessibility, and road traffic accidents in remote areas and this should be considered in any future work.
- A review of the fast changing developments in telemedicine in the rural situation should be incorporated into any next stages.
• An audit of how people visit the GP, dentist, optician, or pharmacy if there is no car.
• What healthcare is in place for Eastern Europeans working long hours and living in rural areas close to their employment? Are employers placed under any duty of care for their employees?

What can be concluded?
• Suffolk is a largely rural County with small towns but many remote areas.
• Suffolk is relatively wealthy but has some areas of deprivation in town centres.
• There are pockets of deprivation in rural areas; these may be less apparent owing to the average scores on deprivation indices are based.
• Many indicators show that health is better in rural areas. Major conditions such as coronary heart disease, cancer and stroke all have lower incidences.
• In contrast, death rates from suicide and undetermined injury are higher, which may also indicate a poorer level of mental health.
• Service provision is more expensive to provide owing to delivery charges, costs to staff attending in remote areas, and time taken in travelling.
• Many older people may be “asset rich, cash poor”. The purchase of food and fuel may be a problem.
• Staff and patients (travelling to work or to attend a clinical appointment), may find the time taken and the cost incurred much higher than in urban areas, owing to distances to travel, poor public transport, and the cost of running a private car.
• Domiciliary services such as social care may be more difficult to obtain owing to the distance to travel.
• All these factors suggest that choice is reduced, and cost may be higher both to the service provider and to the service user.
• Many services in rural areas such as postal services, doctor’s surgeries, public houses, libraries, village shops and dentists are gradually reducing in number.
• Services in rural areas will be increasingly difficult to provide owing to the ageing population, and younger people moving into urban areas for cheaper accommodation nearer to their place of work. This reduces the availability of the extended family to provide help when it is needed.
• Rural roads may be more dangerous that urban ones, and the rate of road traffic accidents and fatalities is much higher in the country.
• There is a strong network of voluntary services, but their use to supplement statutory services has been questioned.
This needs assessment was prepared in July 2015 by the Public Health Action Support Team on behalf of Suffolk County Council.

References


DEFRA. (2014) Living in Rural Areas. Rural Health Data from ONS and the National Centre for Health Outcomes Development. Available at: Last accessed 14/06/15. https://www.gov.uk/government/publications/rural-health


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