The impact of rurality on the costs of delivering healthcare

In January 2019 the Nuffield Trust published a report looking at the evidence behind the costs of providing rural healthcare together with a critical appraisal of the current funding formulae in England. This report, prepared for the National Centre for Rural Health and Care is an accessible read for anyone who is interested to find out more about how healthcare allocations for primary and acute care are adjusted for different populations, in particular, those related to rural areas, and how this has changed over time.

It was in the 1970s that it was first recognised that health needs vary across the UK and allocation formulae were first introduced. Additional factors have been taken into consideration at later dates, such as land costs in the 1980s and ambulance service costs in rural areas in the 1990s.The report highlights a number of inadequacies and challenges with the current funding formulae, not least how the definition of rurality varies, often based on judgement rather than evidence. Population size, density and travel time to other facilities are just a few of the factors which may be considered and this differs further when comparing the home nations and internationally. Rurality can also be compared to sparseness, and being 'unavoidably small', each with their different criteria. Further complexities are added when considering the supply induced demand in urban areas, more aged population in rural locations who typically present later and the need for GP practices to provide a wider range of services as they are not available elsewhere.

The funding allocation formulae differ between CCG allocations, acute care, community services and primary care, but they all take rurality into account in some way. The report concluded that there was evidence of the challenges resulting from a rural setting which may lead to increase costs, including recruitment and retention, in itself resulting in higher agency use; higher fixed costs due to needing certain facilities and staffing levels regardless of use; increased staff travel costs and time; higher staff costs due to more independent working and therefore higher grade staff; less opportunity and less competitive outsourcing; limited opportunities for economies of scale. However, research evidence is very variable as to what the associated costs are. In 2018 the Accounting and Corporate Regulatory Authority reported that evidence of costs which were quantifiable and nationally consistent, such that they could be factored into allocations, was not available. International examples, where rurality is more extreme, such as in New Zealand and Canada, provided more evidence but has less applicability locally.

Allocations also include a 'pace of change' algorithm, to ensure year to year changes as historical funding becomes less significant, to not result in too significant a change which would upset the local health economy. For example, the authors quote current specialist service funding still to have 54% based on historical funding levels. Measures of health inequalities and the 'market forces factor' (which takes into account costs associated with geographical locations such as land costs) still have the largest effect on allocations, which favour urban areas. The factors which attract more funding to rural areas, such as unavoidable smallness and ambulance costs, have far lower weighting.

The reality is that the allocations do not necessarily reflect the actual funding the healthcare service gets, and are subject to 'local variations'. This could be a reflection of the inadequacy of the existing formulae or perhaps more likely the challenging financial climate of today's NHS. Although core CCG allocation are thought to favour urban areas, recent data suggests that London and rural areas do tend of receive a disproportionately high level of funding in comparison to the health needs of the populations they serve. This is clearly and area which requires more research.

This report is well written and serves as a good summary of the issues and challenges regarding the costs of providing rural healthcare and the various funding formulae. It would equally be of interest for those who are involved in economical research evaluations, and those interested in looking at their local costs and trying to unpick the factors involved. Readers will come away more informed, but with the clear message that there is a far from complete understanding of the exact nature and cause of the additional costs associated with rural healthcare, and a lack of transparency with funding allocation formulae.

Full report:

Palmer B, Appleby J and Spencer J. (2019). Rural health care: A rapid review of the impact of rurality on the costs of delivering health care. Nuffield Trust. [Accessed at https://www.nuffieldtrust.org.uk/files/2019-01/rural-health-care-report-web3.pdf on 29/04/2019]

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