

The NHS Next Stage (Darzi) Review: Implications for Rural Areas

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Key principles for the NHS

- A fair service
- A personalised service
- An effective service
- A safe service

A fair NHS

- Assumption of inverse care in GP provision:
- “Areas where life expectancy is lowest match the areas with fewer GPs . . . Mid Devon PCT has over twice as many GPs per head of weighted population as Oldham PCT”
- In general, rural areas are perceived to be ‘over-resourced’, urban areas ‘under-resourced’

Problems:

- (1) Life expectancy does not measure crude or absolute rates of ill-health and thus need for curative care

PCT name	Age-standardized Death Rates (per 100,000 people):		Absolute Morbidity Rates (QOF count per 100,000 population)	
	Cancer	Circulatory Diseases	Cancer	Coronary Heart Disease
Oldham PCT	139.7	134.4	604	3,773
Mid Devon PCT	112.4	75.1	795	3,601

- (2) Rural areas have higher than average crude or absolute health care needs but their 'weighted populations' tend to be lower than their actual populations because the formula gives greater weight to deprivation than age
- 1000 real people = a weighted population of 890 people in Mid Devon (and a per capita allocation of £1,225)
- 1000 real people = a weighted population of 1,136 in Oldham (and a per capita allocation of £1,512)

Provision of GPs using alternative denominators of need

DEFRA's Rural-Urban Classification	Registered Patients	HCHS Weighted Population	Rates per Full Time Equivalent GP				Ave Distance to patient
			Patients Registered with CHD (QOF)	Patients with Self-reported CVD	Patients on Mental Health Register (QOF)	Patients Registered with Cancer (QOF)	
Major Urban PCTs	1,856	1,861	63	142	12.4	11.9	1.57
Large Urban PCTs	1,842	1,732	71	166	11.3	13.8	1.97
Other Urban PCTs	1,886	1,751	68	160	11.1	12.7	2.21
Significant Rural PCTs	1,833	1,621	69	171	9.7	14.4	2.88
Rural-50 PCTs	1,724	1,512	69	166	8.9	14.7	3.37
Rural-80 PCTs	1,658	1,400	67	157	8.9	14.6	4.21

- Using direct indicators of ill-health, rural GPs carry a significantly higher burden than urban GPs (with the exception of mental health & diabetes)
- Geographical proximity to GPs is significantly lower in rural areas
- Policy implications arising from the Darzi review could exacerbate the inverse care experienced by aging rural (not younger deprived!) populations

A personalised NHS

- Emphasis on 'choice' and decentralisation epitomised by the idea of the polyclinic
- Marketisation agenda inappropriate for rural areas (not attractive to independent operators; rural patients value access more than 'shopping around')
- Increased emphasis on capitation for NHS payments likely to disadvantage rural GPs

- Decentralisation of services (e.g. rehabilitation, nurse specialists etc) more feasible – but already happening!
- Enhanced role for community hospitals
- Need to consider volume thresholds required to maintain diagnostic skills in community hospitals
- Community hospitals have higher unit costs. Will the resource allocation formula compensate for this?

An effective NHS

- Centralisation agenda
- DGHs in rural areas have maintained a wider range of specialisms than DGHs in conurbations (i.e. potential for change is greater?)
- For some services (e.g. trauma, stroke), a population threshold of 1-2 million is implied for improved quality outcomes – what does this mean for rural areas?

- More travelling for patients and their families
- Barriers associated with distance (distance decay) could be made worse with implications for patient outcomes
- Difficulties in providing adequate follow-up for patients discharged from tertiary centres
- Financial instability for DGHs that decentralise services to polyclinics or community hospitals and centralise services to tertiary centres

- One size does not fit all
- How can rural patients benefit from centralised specialised care without compromising on access, follow-up etc?
- Evaluate cost-benefits of centralisation against alternative models (e.g. closer working across specialities, outreach programmes, specialist training programmes, interchange of staff)

A safer NHS

- Darzi focus on MRSA but centralisation may be more significant for rural areas
- Adequate planning of patient transport?
- Evidence-based quality thresholds do not always result in practical (safe) solutions
- E.g. O&G > 4,000 births per year required for consultant-based units to be of sufficient quality/financial sustainability – unrealistic and dangerous