Policy Statement

Rural health inequalities relating to cancer

Background
Around 20 per cent of the population in England, 30 per cent in Scotland and just below 40 per cent in Wales live in rural areas. Evidence suggests that those living in rural areas are attending health services when their cancer is at a more advanced stage and that this is having an effect upon the treatment options available to them and consequently survival rates.

Although the population of the UK, as a whole is ageing, the population bands under the age of 40 have decreased in size at a greater rate in rural compared to urban areas. As age is a significant factor in cancer incidence, rural areas may experience higher rates of the disease.

Stage at diagnosis
Cancer Research UK, in collaboration with the Scottish Department of Health, found that rural patients were reluctant to go or return to their GP and less confident about demanding quick treatment compared to their urban counterparts. This is likely to be one of the reasons why individuals living in rural areas are more likely to have their cancer diagnosed at a later stage; one study found that 52 per cent of urban bowel cancer patients were in the early stages of the disease when diagnosed compared to 39 per cent of rural patients. Increased distance from a cancer centre has also been associated with poorer survival rates and patients living in remote areas are less likely to be diagnosed before death.

Access to services
Research has tended to focus upon unmet need for health services and deprivation in urban areas. At the same time, those living in rural areas often have worse access (in terms of transport and proximity) to health services which can lead to poorer cancer outcomes. Public transport facilities are often lacking in rural areas with; study found that around 50 per cent of rural households were more than a 13 minute walk to a bus stop and 29 per cent of rural settlements had no bus stop.

Health services in rural areas are often very different from those in urban areas. Many areas do not have a local GP making it necessary to drive or use public transport to access primary health care. For those living in rural areas attendance at secondary services is more likely to require a substantial journey compared to urban residents. Other points of contact for health services, such as chemists, may
also be more difficult to access in rural areas. Within the rural environment the ‘Patient Choice’ agenda is only viable if the patient, and their family, have the capacity (financially, physically and emotionally) to travel to services. Access difficulties may be further compounded if individuals are older, or have co-morbidities which prevent ease of travel.

There is also evidence that those living in rural areas are less satisfied with the primary health care services that they have access to; due in part to a shortage of GPs and perceived shortness of time available with their GP. The same study also found that individuals had to travel long distances for surgery and a lack of public transport made this difficult for those without a car. Further to this, Jack et al. found inequality in the treatment given to lung cancer patients and postulated that this could be a consequence of variations in access to oncology services.

Next steps
Scotland and Wales both have higher percentages of their population living in rural areas and, because of this, services have been developed in ways which seek to meet this group’s needs. There may also be methods of service provision, in other countries, which are effective at meeting the health needs of rural communities. Such examples of good practice should be explored, and implemented, in England if found to be effective at improving access to cancer services among rural populations.

Giving patients a choice in the provision of their healthcare is currently high on the political agenda. The needs of those in rural areas must be considered within the development and implementation of choice programmes to ensure that inequalities in access to cancer services between (rural and urban) population groups are not increased.

Further information
There is also evidence of significant pockets of deprivation within rural areas that have been given less attention than that found in urban areas. Deprivation often manifests itself differently in the two areas (urban deprivation tends to be found among a whole community compared to rural deprivation which is more likely to be at the scale of family or individual often in close proximity to economic wealth) with the result that some measures of deprivation do not accurately measure the scale of the problem in rural areas. Social exclusion is also a problem within rural areas with widespread closure of local amenities, due to a lack of economies of scale, meaning that there are fewer opportunities to develop social networks.

The following quote is from the chairman of the Commission for Rural Communities (whose tagline is ‘Tackling rural disadvantage’) and spells out an ongoing commitment to ‘rural proofing’ policy that is also being taken forward by DEFRA.

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1 Scotland currently operates 19 mobile units which deliver breast screening to remote areas. The units provide the same service as the static centres and their allotted routes ensure that screening round lengths are met.
“Building a rural dimension into policy and practice remains as important as ever. I have seen at first hand the impact on individuals and communities of the acute shortage of affordable rural housing and how vulnerable people in rural areas miss out on vital support simply because of where they live. Rural issues must be addressed if all people, communities and businesses are to share the benefits of public policy and delivery”
(Taken from: Challenging government to meet rural needs)

References


4 Campbell et al. (2001) Rural and urban differences in stage at diagnosis of colorectal and lung cancers British Journal of Cancer 2001 84(7); 910-914

5 Campbell et al. (2000) Rural factors and survival from cancer: analysis of Scottish cancer registrations British Journal of Cancer 2000 82(11); 1863-1866

