RESEARCH BRIEFING

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Obstacles to using and providing rural social care

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Key messages

- There is considerable variability in the provision of services to people living 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.

Introduction

The comparative disadvantage that some rural people experience in regard to welfare services, education, employment, income, and life chances generally, have been well established and are succinctly summarised in a review by Shucksmith.[1] This briefing does not attempt to provide an overview of rurality or rural communities, nor explore the wider context within which debates about rural provision might take place. Information about these aspects can be found in a range of relevant sources which are identified at the end of this briefing. Instead, the briefing focuses on some of the most common obstacles to using and providing health and social care services in rural areas.

What is the issue?

Some obstacles to using and providing health and social care services in rural areas are easily recognised, such as the increased costs in time and transport taken to provide and access services, or the lack of alternative provision from the independent and voluntary sector. Others are

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less obvious and result from general features of rural life, such as the lack of anonymity, or from the interaction of other forms of disadvantage such as poverty and homelessness, which can impair people's capacity to find out about services and to use them.[2, 3, 4] Broader social problems, such as child abuse, domestic violence, and racism, may make it difficult for those who need help to access services[5, 6, 7, 8] as victims may be more isolated or fearful of stigmatisation.

The evidence base on rural social service provision is patchy[9] with uneven coverage of different user groups and services. This briefing draws upon a range of evidence including some from health provision where similar issues face service users and providers in regard to such things as access to services and joint working. Nonetheless, it should be recognised that most studies of existing rural service provision are innately conservative because they reflect what is provided, rather than what may be needed.[10] Moreover, the variability of rural settings can make it difficult to generalise findings from one area or region to another though evidence shows that the more remote the area, the more likely it is to suffer relative disadvantage.[11, 12]

Why is it important?

While there are continuing debates about how best to define what counts as a rural area, there is no doubt that however it is defined, the countryside is home to large numbers of people. The Office for National Statistics estimate that the proportion living in rural areas in England is about 20 per cent, and in Wales about 36 per cent.[13] People in rural areas are generally not well served by health and social services, and the problems that they face arise from a range of factors which either make it less likely that any service is available in the first place, or which make it difficult to access and use what is provided.

The tendency to idealise country life and to make inaccurate assumptions about what it is like, can be considerable barriers to the recognition of social problems and the development of effective responses to them. Thus, it may be wrongly assumed that poverty, drug use, racism, and domestic violence are essentially urban not rural problems.[14] Craig and Manthorpe, for example, note how the assumption that informal care networks, i.e. family and friends, are more prevalent in rural areas, can undermine the impetus to provide supportive services in the first place.[9] However, Wenger's research shows much more variable and complex patterns of dependence and inter-dependence.[15]

In recent years there has been a greater recognition by national government that rural people and their concerns have been marginalised. The reasons for this are complex and lie beyond the scope of this briefing, but perhaps the most significant factor has been that debates about rurality have been dominated by issues associated with agricultural policy rather than taking a broader view of rural life.[16] Nevertheless, considerable efforts are being made to ensure that better information is available on rural life (see CRC and DEFRA websites) and that government polices are 'rural proofed'.[17] Rural proofing is intended to ensure that all government initiatives are checked to ascertain their likely impact on rural people and communities. There have also been significant steps in developing checklists and processes to examine their suitability and impact in particular services such as health.[18]

What does the research show?

Variability in provision and costs of services

While there is considerable variability in the provision and availability of services between different rural areas, between different services, and between different social groups, the overall picture is of under-provision compared to urban areas.[2, 19, 20, 21, 22] For example, older people in rural areas are 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 seem to be lower than in urban areas.[23, 24, 25, 26] In addition, costs of rural services are usually higher because of the geography of rural areas and the smaller,

dispersed populations within them. Greater distances, longer journey times, the absence of adequate public transport, and the less intensive use of buildings and facilities, all contribute to cost pressures. For example, one local survey found that rural mental health services' staff spent between 25 and 33 per cent of their time travelling compared to seven to 10 per cent for urban staff.[27]

A comprehensive review of the evidence on the additional costs of service provision in rural areas, concluded that there was a clear cost premium in order to achieve a similar standard of service to that in urban areas.[28] It also found that even where there were uplifts in rural funding, these were often insufficient to cover the actual costs of service. For example, in one case where the uplift for rural domiciliary care was £51 per case, the modelled costs were estimated at around £460. Despite the sound evidence of the higher costs of rural provision, a number of reports have demonstrated that funding mechanisms for resource allocation to public services have disadvantaged rural populations.[29, 30, 31]

Access difficulties

Poor transport networks mean that service users and carers who do not have private transport are less able to access public services. However, while research shows that the rural poor are more likely to have a car than those in urban areas, they are also likely to spend a higher proportion of their income on transport.[32] Moreover, women, especially those in households with only one car, older people, people with disabilities, young people, and carers, are all much more likely to suffer transport poverty.[32, 33, 34, 35] Even where community or public transport is available, the times and frequency of service may militate against its use. Journeys may take too long, or services may be too infrequent, perhaps requiring users to spend too long at their destination, or they may not be available at convenient times, or in the evening and at weekends. People with disabilities may have difficulty boarding, and may be reluctant to wait for long in exposed places or fear being stranded if services are delayed or cancelled.[25]

Community transport schemes, though highly valued, may sometimes not be available for young people and this can disadvantage young carers.[34] Some health studies have reported 'distance decay, that is the phenomenon of service take-up diminishing, or being delayed, the further away that potential users live from the point of service, with consequent negative effects upon health outcomes for patients.[29, 36] This problem is likely to be exacerbated by increasing centralisation of services.[37]

Isolation and stigmatisation

It is sometimes assumed that rural life is a more isolated experience than urban living, but research such as Wenger's shows that this is not necessarily the case.[15] However, daily life in many small communities is often more socially exposed, in that the anonymity that urban dwellers have, by virtue of the size of their communities, is not possible in places where one's movements and relationships may be more easily observed and noted. While this informal surveillance may prompt helpful interventions from friends and neighbours, it can be problematic for those whose problems do not elicit a sympathetic response or who feel ashamed, or at risk, in some way. For example, a woman wishing to escape domestic violence may be deterred from seeking help at a family centre or Women's Aid Office if she fears that her visit might come to the attention of her abuser, or she may be reluctant to enter a refuge if it means a move many miles away from other people who might support her.[7]

Stigmatisation and isolation are widely reported in studies of people with mental health problems in rural areas. A survey in Scottish rural districts found that the lack of anonymity made some people reluctant to seek services and that a 'culture of silence' in some areas meant that people were unwilling to talk about emotional problems.[38] Indeed, in some instances, the more relaxed attitude to heavy drinking meant that alcohol misuse was sometimes used as a cover for mental health problems. Limited local understanding of mental health problems further isolated people, as did the lack of 'drop-in' facilities or other places to talk. Carers also report

feeling isolated and unsupported, especially where they lack private transport, though some found the social contact through interaction with service providers and other carers helpful.[39]

Ignorance and neglect of minorities

Rural populations may appear to be relatively homogenous in comparison to the evident ethnic diversity of some urban areas, but every rural county in England and Wales has some ethnic minorities within it.[4, 40, 41] A mistaken assumption of homogeneity can ignore or underplay other significant dimensions of difference, such as age, class, culture, and sexual orientation, by suggesting that they do not exist, or that they do not matter. This fallacy presumes that because minorities are not apparent, i.e. that their presence is unrecognised, then there cannot be problems of racism or other forms of prejudice. It may also be wrongly assumed that these minorities do not require services. Such assumptions have contributed to minority groups and individuals in rural areas receiving patchy health and social care services at best and, in the worst cases, very poor services.[5, 42]

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.[43] In addition, the growing numbers of migrant workers from the newer member states of the European Union has increased the diversity of some rural districts. While these workers are predominantly young, with 83 per cent of them being between 18 and 34 years of age, and without dependents, there is some evidence that they too are not making use of health services.[44, 45] It is also possible that their low wages and often precarious housing situations may make them more vulnerable to homelessness and problems of isolation. Certainly, their status as incomers makes them vulnerable to racism and in some areas there have been efforts to avoid or defuse such problems.[45]

Some groups may also experience isolation because of negative ideas held about them. This has been particularly true of travelling peoples like gypsies where research has shown how their semi-settled and nomadic lifestyles may be stigmatised by providers and the local community.[46, 47, 48] The Social Services Inspectorate has reported that the community care needs of travelling people are neglected, and both Cemlyn and Roberts state the need for a coherent and comprehensive multi-agency approach to service provision to travellers.[49, 46, 50]

User expectations and satisfaction with services

It is sometimes assumed that rural dwellers are more stoical about their circumstances and consequently may have lower expectations of public services, though there is little direct evidence of this. However, it is the case that the rural poor may not always recognise themselves as such[2, 25] and this may influence their perceptions of their needs and any subsequent responses to them.

There have been a number of surveys of user satisfaction with rural services which have generally found relatively high levels of satisfaction. For example, a survey that reviewed opinions about five services, including public and community transport and health services, found few differences between urban and rural respondents, with satisfaction rates of over 90 per cent.[51] However, care is needed in simply accepting such results because some studies ask users what they think about particular aspects of a service, such as its accessibility, while others enquire about overall satisfaction with a service, and this may elicit different perceptions. Service users may trade-off some factors against others depending upon the nature of the problem and the service concerned. For example, one study[19] shows that in order to access primary health care, people were prepared to travel for 30 minutes if this meant that they could have full-time service rather than have a part-time service located closer to them. Bowden and Moseley have also noted that the averaging of results across rural populations means that the views of the most disadvantaged rural dwellers may be collapsed with the perceptions of those who have higher incomes and, consequently, better access to personal transport, and the internet.[19]

Implications from the research

For organisations

A report for the Department for Environment, Food and Rural Affairs found some significant obstacles to developing the government's partnership agenda in rural areas.[52] Small voluntary organisations had difficulty understanding the plethora of different government initiatives, were sometimes excluded from consultation and participation, and disliked the cost of engaging with bureaucracies and their inconvenient meeting times. This report made valuable suggestions as to how capacity building might be achieved through such measures as skills development, subsidised accommodation, and civic recognition.

Other research shows that although it is widely assumed that joint working must be beneficial, there is not much evidence to support this idea, and measures such as co-location are not sufficient in themselves to improve outcomes.[53] One report noted that progress was sometimes hindered by poor partnerships or poor relationships with providers but found that ongoing efforts could overcome theses difficulties.[54] Furthermore, a narrow focus on structural integration of health and social care services is unlikely to succeed without integrated systems of goal setting, leadership and interdisciplinary delivery.[55] Additional complexities arise with differences in organisational cultures and management styles, and when health and social care providers' responsibilities span different geographical and political boundaries.[55] Interestingly, one small longitudinal study found that problems in multi-disciplinary practice diminished over time as respondents reported more positive experiences in the later interviews.[56]

The point noted earlier, that what is provided to service users and carers is not necessarily what is needed or even preferred, was exemplified in a comprehensive report into home care,[57] which noted dissatisfaction with the '15-minute slot model of service'; a model which is particularly ill-suited to rural provision with its comparatively high transport and time costs. The increasing interest in person-centred and outcomes-focused approaches[54, 58] which hold out the prospect of more appropriate and individually tailored services is welcome, as it is clear that some services like home care have become too narrowly targeted,[57] but there is no evidence yet of its purported benefits for rural dwellers. Finally, while there is some general evidence of difficulty in recruiting and retaining social care staff[57, 54, 59] there is little evidence on whether this is a particular issue in rural areas. However, in the light of the shift to direct payments and self-funded home care, it is likely that the problem of securing satisfactory providers may be more pressing in rural areas. One solution pioneered in some areas has been to organise home care service providers into geographically zoned areas which potentially reduces user choice but enhances access and reliability of service.[54]

For the policy community

The changing governance of rural areas, with the formation and growth of a range of different organisations with responsibilities for different aspects of rural life, has resulted in the decline of local government power and led to fragmentation of responsibilities, which may obstruct partnership working.[1] In fact, it has been suggested that many attempts to involve local communities in development are undertaken primarily to secure funding, rather than from some deeper commitment to participation.[66] The withdrawal of many local authorities from the direct provision of services by contracting out, together with a tendency for private sector providers to avoid the less profitable areas and services may result in rural people increasingly being left with unsatisfactory access to services.

Moreover, a recent review of measures designed to reduce social exclusion in rural areas found that, with the exception of Sure Start, these programmes lacked a rural awareness and concluded that rural proofing had had little effect.[67] Similarly, two reports from the Commission for Rural Communities showed

that the commitment to rural proofing was only partially fulfilled, and noted that a lack of data was still a problem in monitoring some standards, such as choice of health care providers, or the extent of intensive home care support for older people.[68, 69] The Commission also reported that rural schools were not providing the same levels of service as urban schools, but that there had been good progress in the development of Children's Centres.

The government's increasing reliance upon the voluntary sector to improve rural transport networks for better access to services, raises questions about the long-term support and sustenance of small voluntary groups.[53] Future research should focus upon the underlying reasons for the variations in voluntary sector activity in rural areas and should try to identify the constraints upon further expansion.[52] Craig and Manthorpe also suggest that further examination of intra-rural differences in service provision is required:

- to check whether informal care networks are stronger in rural areas
- to examine how carers and users actually cope and what their preferences might be
- to discover whether, and in what service areas, the private sector is actually stepping into the market in rural areas.[9]

They also note the need to avoid the unnecessary repetition of existing studies.

Finally, one general theme that emerges from some of the British literature on rural social services[14, 70, 64, 71] and is also present in the more extensive international literature[10, 72, 62, 73] is that local social context matters greatly and that, consequently, attempts to innovate or develop services without consideration of the nature and capacity of communities appear to be doomed to failure. The consistent message is that 'one size does not fit all' and that politicians and managers need to allow variability and flexibility to permit appropriate adaptation to local circumstances.[74]

For practitioners

The increased difficulty in gaining information about services in rural areas because of the lack of other sources and sites of help and advice, means that practitioners must develop better ways of publicising their services. Local council offices, post offices and doctors' surgeries are useful sites, but more active schemes for dissemination are required. Outreach work and publicity through bodies such as churches and voluntary organisations, through schools and places of employment, and through inclusion in local council mail shots, can help to promote awareness of the range of social and transport services available to local residents. An awareness of the limits of public transport, or of the limited access that some people may have to private transport, means that care should be taken in arranging appointments or opportunities for users to access other services.

Practitioners in rural areas may be expected to provide a broader range of service than their urban colleagues, yet they may not be well supported by their training, in supervision, or in updating their knowledge. Consequently, they may have to take a much more proactive approach to developing and sustaining their practice. In addition, the social dynamics of small communities raise a number of issues for both users and practitioners. While these have not been the subject of much research in the UK, practice experience, together with studies from other countries,[60] indicates that there are additional difficulties in managing confidentiality, and that uncertainty about this may be a deterrent to seeking help. Practitioners who live and work in the same area face additional challenges in managing personal and professional boundaries. Despite these and other difficulties, in terms of professional development and lack of career opportunities, research from Australia and the USA suggest that many rural practitioners value the engagement that working in small communities brings.[61, 62]

For users and carers

As noted earlier, changes in the organisation of services, such as centralisation in health care, has

switched some organisational costs like transportation from the providers of services to users. Agencies should therefore work together on measures such as transport audits and user preference surveys, to improve the delivery of services and access to them. For example, respite services should be appropriately scheduled and of sufficient duration to permit rural carers effective respite, by allowing them time to have travel for their own needs and to access other services.[20] Users appear to have little interest in who organises or provides their services. What seems to matter most is that they are available and effective,[53] that users have opportunities to influence the development of services and have some control over what sorts of services they are offered.[57, 54, 58]

In the future, developments in using videos, television, computers and the internet may well enhance access to some services for some people. Similarly, other technical developments such as timed medication dispensers can help isolated individuals keep to their correct drug regime, and perhaps reduce the need for monitoring visits in some cases, while pressure sensors may be used to switch on lights for frail elderly people who get up during the night, and may even be used to alert monitoring services.[57] Self-directed and telephone-assisted parenting training programmes have had some success in this regard.[63] However, it remains the case that the poorest and most marginalised groups are the least likely to have access to these technologies.[19]

For people with mental health problems, service user groups and networks play an important part in both connecting them to other people and organisations, and in creating a constituency for their representatives when they are involved in formal consultation with service providers. The Highland Users Group in Scotland and the Powys Mental Health Alliance in Wales are two valuable examples of how the views of users over large geographical areas can be mobilised, though it should be noted that, even within user organisations, there can be tensions between local voices and more regional concerns.[64, 65]

Useful links

Commission for Rural Communities
www.ruralcommunities.gov.uk

Department of Environment, Food and Rural Affairs
www.defra.gov.uk/rural

Institute for Rural Health
Gregynog, Newtown, Powys. **www.irh.org.uk**
(see also **www.ruralhealthgoodpractice.org.uk**)

Related SCIE publications

Research briefing 02: Access to primary care services for people with learning disabilities (2004)

Research briefing 03: Aiding communication with people with dementia (2004)

Research briefing 04: Transition of young people with physical disabilities or chronic illnesses from children's to adult's services (2004)

Research briefing 11: The health and well-being of young carers (2005)

Research briefing 12: Involving older people and their carers in after-hospital care decisions (2005)

Research briefing 15: Helping older people to take prescribed medication in their own home (2005)

Research briefing 19: The impact of environmental housing conditions on the health and well-being of children (2005)

Research briefing 20: Choice, control and individual budgets: emerging themes (2007)

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