The Rural Penalty

Policy Exchange

How NHS funding formulas are disadvantaging rural and coastal areas and putting health devolution at risk

Joe Robertson MP, Gareth Lyon, Dr Emma Watts, Dr Daniel James, Dr Helen Leach, Dr Sonum Bathia, and Ed Kennedy

Foreword by Layla Moran MP

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Foreword

By **Layla Moran MP**
Member of Parliament for Oxford West and Abingdon
Chair, House of Commons Health and Social Care Committee

Ask someone to imagine a typical English landscape and one might first reach for a rolling hill of a rural vista or a rugged seafaring scene. People living in rural and coastal areas should be able to get good-quality healthcare when they need it, just like anyone else. Yet far too often the communities who live in these beautiful areas feel as though they are afterthoughts in Whitehall policy making. Where we live may affect how that care is provided, but it should not determine whether we can get the help we need.

Being unwell or needing care in a rural or coastal area can bring added difficulties. How far away is the appointment? How will I get there when there is no bus? Can a family member or friend take time off work to take me? For those without a car or family nearby, the journey itself can be a burden and may prevent them from getting the care they need.

As an Oxfordshire MP, I know all too well that an attractive landscape, even in the well-heeled South, can mask pockets of deep poverty and health inequalities. What looks like a prosperous village can still be home to people struggling to reach the right care for them. This timely report, *The Rural Penalty*, asks us to look beyond the averages and understand the difficulties people face in getting healthcare because of where they happen to live.

The report brings to light the pressures facing rural and coastal communities, including less choice, older populations, seasonal demand and deprivation. It asks whether the direction of NHS policy and funding mechanisms reflect these needs and the costs of providing healthcare that people can access. Workforce is about people and place too. Beyond funding, there is the need to attract staff to these areas and help them settle. This is more complicated and nuanced than funding alone but getting it right will make a real difference to the people living there.

The report rightly points out that not every NHS service can be provided everywhere and achieving economies of scale in coastal and rural communities can be a challenge. However, it asks: when services are redesigned, a service centralised or a GP surgery merged, to what extent have the consequences for patients been adequately assessed? Has rurality been weighted fairly in that equation? When a service closes, has

the totality of the costs passed on to patients and their families through longer journeys, additional expense, increased isolation and dependence on other people, been considered? It's imperative that if some care does move further away from home that safeguards and checks are in place to ensure these changes also improve patient experience and reduce health inequalities for patients living in coastal and rural communities.

These questions are immediate and ones my committee are actively considering, most notably in our inquiry into delivering the estate for the Neighbourhood Health Service and our ongoing scrutiny of the work of the department. We are one year into the 10 Year Plan for the NHS and decision makers have an opportunity to listen to and co-create solutions with the hardest to help areas.

I would like to thank Joe Robertson, my colleague on the Health and Social Care Committee, for bringing this work together, and the contributors for sharing their research and experience. My thanks also to Policy Exchange for supporting its publication.

No one should face poorer access to healthcare or worse health outcomes simply because they live in a rural or coastal community. Everyone deserves a fair chance of a healthy life, wherever they call home.

Recognising the different circumstances of these communities is not special treatment. It is how we make fairness a reality in the care people receive and the lives they are able to lead.

When it comes to health, rurality should be recognised, not penalised.

Endorsements

"Having seen the difference continuity of care can make over many years, I know that general practice is about far more than treating an illness. It is about knowing someone as a person, understanding their family, their circumstances, their wishes, and what matters most to them.

Nowhere is that relationship more important than at the end of life. When a GP has cared for someone and their family over years, sometimes decades, they can bring a depth of understanding and trust at the moment when people are at their most vulnerable. They know what that person would want, they know their history, and they can help make sure their final days are shaped around the individual rather than simply the disease.

That is the extraordinary value of continuity in general practice: being there not just for a diagnosis or a prescription, but across the whole arc of someone's life, including, ultimately, helping them to die with dignity, comfort and the people they love around them."

Rt Hon Jeremy Hunt MP, Former Secretary of State for Health and Social Care

"A policy framework designed through an urban lens, exemplified by the assumption that a Neighbourhood Health area covers a population of 50,000 people, will not meet the needs of rural and farming communities.

The challenges facing rural areas are fundamentally different: greater distances, poorer connectivity, workforce shortages and higher costs of delivering services. If neighbourhood health is to succeed, it cannot simply be adapted for rural communities after the fact; rural communities must be built into the design from the outset.

The Prime Minister's new focus on locality is a huge opportunity. Ensuring neighbourhood health is designed through both a rural and urban lens will help reduce longstanding health inequalities and bring high-quality support closer to the farming people who need it most."

Sandy Kapila, Head of External Affairs, The Royal Agricultural Benevolent Institution (RABI)

Executive Summary

Health policy in the UK often gives the impression of being designed for a country in which all patients live in cities, within easy reach of multiple medical facilities and with a range of public transport options to get them there.

The picture across the 116 constituencies[1] of rural England is far removed from this.

This report shows that funding formulas, workforce policy and the assumptions in the NHS 10-year plan around "neighbourhood health" have all neglected this reality.

For every area like Manchester which could benefit from the thinking in the NHS 10-Year Health Plan's approach to localism, there are many rural and coastal areas; from Clacton to Cornwall via Cowes, where the results could be highly damaging for continuity of care, patient choice and availability of appointments and clinical services.

The gap between health policy assumptions and the reality in rural areas is a recognisable structural feature of the system: the rural penalty.

The rural penalty is a major challenge not just to the health of large parts of the country, it also threatens the viability of the ambitions in the 10-Year Health Plan for England[2].

One of the NHS 10-Year Health Plan's central ambitions is to shift the NHS from hospital to neighbourhood, treating people closer to home through expanded primary care, community diagnostics and services built around local populations rather than distant institutions. The Government's rural strategy[3] reiterates this ambition committing to care delivered "as locally as it can".

This ambition is welcome in theory. For this to succeed though rural and coastal areas need to be able to compete on a level playing field in recruitment and retention and need to be funded according to their local conditions.

If this does not happen then for all the 10-Year Health Plan's commitments to localism, the reality for many patients will be reduced local services, longer journey times and an increasing divide between better resourced areas in cities and under-provisioned rural and coastal areas.

Already rural surgeries are closing even as their populations grow[4], and rural hospitals are experiencing a brain drain not because of a lack of demand but because of a funding formula which fails to recognise the costs associated with serving a more dispersed and seasonally fluctuating population and one which has greater deprivation and health needs

1. https://www.data.gov.uk/dataset/f870c7a5-c2c3-4333-b2f1-d55ad68be2e5/rural-urban-classification-2021-of-westminster-parliamentary-constituencies-2024-in-ew
2. https://www.gov.uk/government/publications/10-year-health-plan-for-england-fit-for-the-future/fit-for-the-future-10-year-health-plan-for-england-executive-summary
3. https://www.gov.uk/government/news/government-commitment-to-deliver-for-rural-communities
4. https://bjgp.org/content/bjgp/early/2026/08/26/BJGP.2026.0126.full.pdf

than are currently recognised and because of NHS pay structures which incentivise staff working in more urban locations.

The NHS 10-Year Health Plan hinges on the NHS delivering more care locally is being funded by a formula which does not recognise the reality of large parts of the country where "local" is defined in dozens of square miles rather than one or two. Community provision cannot be the foundation of a rural and coastal NHS while the money and manpower necessary are being diverted elsewhere.

Key findings from our research were that:

- Coastal communities have **14.6% fewer postgraduate medical trainees, 15% fewer consultants and 7.4% fewer nurses** per patient than the national average — despite older, less well populations.
- Although existing funding formulas recognise rurality and deprivation to some extent, they do not adequately reflect the additional workload and complexity faced or for the additional costs faced by rural and coastal general practice. Lower patient numbers can mask more frequent and complex patient contact, while limited access to other services such as pharmacies, dentists and specialist services can place additional demands on GPs.
- High Cost Area Supplements pay staff more to work in expensive cities, and **nothing extra to work in remote or coastal Britain**.
- In North Norfolk, Category 1 Ambulance calls average **over 18 minutes**; in rural west Wales, only half of life-threatening calls are met within 8 minutes.
- Larger GP practice list sizes are independently associated with **lower patient satisfaction and weaker quality outcomes** — undercutting the assumption that scale improves care.

Neighbourhood health risks becoming centralisation by another name in large parts of the country. A framework built around populations of 50,000 to 250,000 plus treats headcount as a proxy for proximity when clearly in many areas it is not.

This centralisation relocates cost and clinical risk on to patients who must travel further and face more disruption as well as being able to access fewer options.

The NHS has spent years asking small rural and coastal services to justify their survival. **This report proposes an alternative approach in which every major change to funding or provision should consider the implications for the fifth of England which is currently missing out.**

This paper calls for Government to stop designing a national health service around assumptions grounded in large towns and cities, to ensure a level playing field for rural and coastal communities, and to end the rural penalty.

Recommendations

1. **Additional weighting for rurality** should be introduced within existing NHS budgets for primary care services funded outside the global sum. The rurality elements of the general practice funding formula, **Carr–Hill**, needs to be protected and strengthened.

2. The Government and NHS England should introduce an **Unavoidably Small Practice Adjustment** for practices where centralisation and economies of scale are unachievable as a consequence of geography, and closure risks leaving patients without reasonable access to care. Eligibility should consider population density and sparsity, and travel distance to alternative services, with support linked to quality standards. These measures need to be proactive, with support in place before a practice reaches the point of closure.

3. The Department of Health and Social Care should recognise the impact of **temporary residents** on health services in rural and coastal areas. It should develop funding mechanisms that reflect predictable seasonal fluctuations in demand, rather than relying solely on registered list size.

4. The Department of Health and Social Care should review **High-Cost Area Supplements and recruitment and retention payments** to ensure they adequately reflect local living costs and difficulties attracting and keeping staff. This review should consider whether rural and coastal employers have the funding and flexibility needed to compete for the workforce their communities need.

5. The next iteration of the NHS Long Term Workforce Plan needs to assess the wider barriers deterring highly trained professionals from working in rural and coastal areas, including **school performance, housing, transport and employment opportunities for partners**. The findings should be published, alongside a plan to address the barriers identified. In these areas, ICBs should be supported and funded to help local employers offer targeted packages, which could include relocation costs, travel costs and temporary housing.

6. **Continuity of care** should be an explicit and measured part of how NHS services are designed and commissioned. Any changes

to services should take account of whether patients can maintain contact with the clinician or team involved in their care. This is particularly important for vulnerable patients, older people and those living with multiple long-term conditions.

7. **Existing dispensing GP practices** already serve communities where a community pharmacy may not be viable or accessible. When services are commissioned through community pharmacies, these practices should also be commissioned to deliver them where they have the skills and capacity to do so. This should be built into national programmes, particularly vaccinations and public health services, with the funding, training and support needed.

8. The Department of Health and Social Care should commission **further research into rural and coastal health inequalities** to ensure future policy is informed by evidence that reflects the diversity of these communities.

9. The NHS should increase the proportion of **medical and healthcare training placements** in rural and coastal areas, particularly targeting where there are persistent staff shortages. Placements should also be longer, giving trainees time to build professional and personal connections locally and encouraging them to stay in these communities after their training.

10. A minister within the Department of Health and Social Care should be given **specific responsibility for coastal and rural healthcare**. Their role should include requiring an assessment of the impact on healthcare access in these communities before any new NHS policy, infrastructure change or reorganisation is implemented.

11. The **Choice Charter** announced in the Government's 10 Year Health Plan needs to be explicit that the legal right to choose is not a practical reality for many people living in rural areas. Where meaningful choice is limited, commissioners should set out how access will be improved.

12. **Neighbourhood health**, if designed incorrectly, could result in centralisation in disguise. Its implementation must take account of local geography and travel times, as well as population size.

13. The Department of Health and Social Care should review **how deprivation and healthcare need are measured** in rural and coastal areas, so that pockets of poverty are not hidden by wider averages. Assessments of need should also take account of ageing populations, poor transport and the distances people must travel for care.

14. NHS England should use the national **GP Patient Survey** results to look at patient experience by practice list size and rurality. It should evaluate practice mergers and neighbourhood provider reforms against patient satisfaction and **whole-system costs**, and publish the findings. This should include costs passed on to patients and their families, such as time off work, travel and the consequences of being unable to access care.

15. ICBs should identify how the **existing NHS estate**, including community hospitals and GP premises, can be used to provide more care close to home, including diagnostics, rehabilitation and specialist clinics. A **Local Access Test** should be carried out and its findings made publicly available before any of these facilities are closed. Where services can safely be delivered locally, hospital providers should work with local teams to bring staff and expertise into the community.

NHS Funding Formulas, NHS payscales and Rural Health

Funding allocations

Integrated Care Boards (ICBs) are responsible for the funding and commissioning of most local health services in England. They received £139 billion to cover core and primary medical services in 2025/26.[5]

The most significant factor in setting funding allocations for ICBs is the population of their area. The formula assumes an allocation on a per-capita basis and then adjusts this according to the perceived health needs of that population and cost of delivering health and care to them. This is inevitably an imperfect mechanism and can result in some areas benefitting or missing out disproportionately[6].

The other key factors impacting the weighting of funding are the age and sex of the population, a weighting for urban areas and a weighting for deprived areas as well as a cost-recognition factor which adds a weighting for the "market forces" factor of delivery costs in a given area. Adjustments are also made for other factors including childhood vaccination rates, PFI costs and a tapering measure "distance from target" which will be discussed later.

The intention behind this formula is to reduce health inequalities regarding access to services and patient outcomes as set out in Section 13G of the Health and Social Care Act 2012[7]:

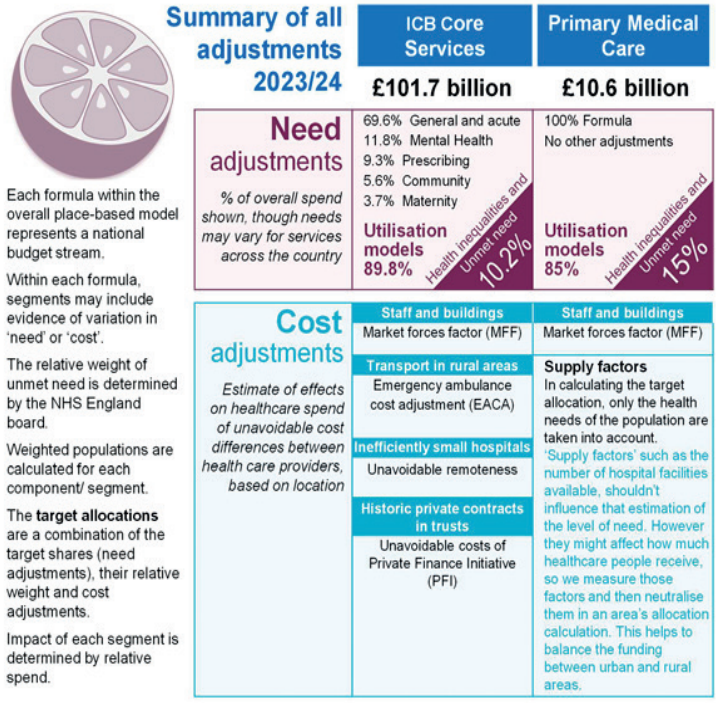
> *13G Duty as to reducing inequalities The Board must, in the exercise of its functions, have regard to the need to—*
>
> *(a) reduce inequalities between patients with respect to their ability to access health services, and*
>
> *(b) reduce inequalities between patients with respect to the outcomes achieved for them by the provision of health services.*

Allocations change year on year according to changes in population. But this has the potential to cause very significant changes to the budgets of ICBs, including significant real-terms reductions in some cases. In order to minimise the disruption of this, the Department of Health and Social Care has made a commitment to ensure that every ICB will see a real-terms per-capita growth in funding unless an ICB is receiving over 10% more than the formula justifies. This means that some ICBs will be under or over

5. https://www.england.nhs.uk/publication/allocation-of-resources-2025-26/
6. https://www.england.nhs.uk/wp-content/uploads/2023/01/allocations-2023-24-to-2024-25-technical-guide-to-formulae-v5.pdf
7. https://www.legislation.gov.uk/ukpga/2012/7/pdfs/ukpga_20120007_en.pdf

where they should otherwise be for their allocation. Distance from Target (DFT) is a mechanism intended to move the budget allocations of ICBs closer to where they should be over time[8].

Advisory Committee on Resource Allocation explanatory chart[9]



An adjustment is made for rurality in funding in relation to hospital, ambulance and emergency care in remote areas reflecting higher costs for example lower patient volume levels in less densely populated areas, lower likelihood of being able to transfer staff between sites meaning that more use of temporary staff is required, lower throughput levels with expensive equipment meaning a relatively higher cost per user and the higher costs of transport and travel between remote sites and locations[10].

There is, however, no additional weighting for rurality for primary care funding to ICBs as the Advisory Council on Resource Allocation (ACRA), the technical body tasked with determining the formula, is not yet convinced that there is sufficient evidence to demonstrate higher costs or workload for rural practices[11].

ACRA considered whether rurality should be included as a factor in the Primary Care model in determining workload but advised that it should be excluded from the model. This was because of the uncertainty over whether it was reflective of additional workload or systematic behaviour in rural practice not arising from workload.

Funding at a GP practice level (determined since 2004 according to a mechanism known as the Carr-Hill Formula) does have a weighting for rurality as an "unavoidable cost" alongside a "staff market forces factor" reflecting the higher costs of NHS pay in some areas. The formula also includes adjustments for other factors including patient age and sex, additional needs of patients and list turnover[12].

8. https://www.england.nhs.uk/wp-content/uploads/2023/01/allocations-2023-24-to-2024-25-technical-guide-to-formulae-v5.pdf
9. https://www.england.nhs.uk/wp-content/uploads/2023/01/allocations-2023-24-to-2024-25-technical-guide-to-formulae-v5.pdf
10. https://www.england.nhs.uk/wp-content/uploads/2023/01/allocations-2023-24-to-2024-25-technical-guide-to-formulae-v5.pdf
11. https://www.england.nhs.uk/wp-content/uploads/2023/01/allocations-2023-24-to-2024-25-technical-guide-to-formulae-v5.pdf
12. https://www.bma.org.uk/advice-and-support/gp-practices/funding-and-contracts/global-sum-allocation-formula

Carr-Hill applies principally to the global-sum element of practice funding (the foundational core payment made to surgeries to cover the cost of providing essential medical services.) An increasing amount of the income required to sustain general practice now sits outside of this global sum, including Quality and Outcomes Framework level funding (QOF), enhanced services, vaccination payments, Primary Care Network (PCN) -related funding and locally commissioned schemes. These funding streams do not contain a consistent adjustment for the additional costs of serving dispersed rural populations.

Government estimates suggest that because of the significance of these funding streams, currently only 50-60% of GP funding is covered by the Carr-Hill Formula, meaning that remaining practice funding would lack this rural component.

Consequently, an already insufficient rurality adjustment applies to only part of the income upon which practices depend. Its effect is diluted across overall practice funding, while significant elements of practice income do not recognise rural delivery costs at all.

Since ICB level funding allocations do not allow for rural weighting in primary care suggest that ICBs which have more rural practices are likely to be relatively shortly funded, ultimately leading to less funding than intended under the Carr-Hill Formula reaching GP practices.

This inconsistency is itself worthy of attention and suggests that DHSC has not sufficiently considered the specificity of rural funding.

The Carr-Hill Formula is under review[13] and Ministers have accepted that it is not fit for purpose[14]. MPs for rural areas have explicitly called for a greater weighting for rurality to be incorporated.

Since adjustments for rurality are already insufficiently weighted to reflect the additional workload, infrastructure requirements and unavoidable costs faced by practices serving sparse and dispersed populations the existing rurality adjustment **must be protected in any future reform of Carr-Hill and** strengthened to reflect the modern realities of rural and coastal general practice. Rurality should also be properly reflected within ICB primary medical-care allocations and the wider funding streams upon which practices increasingly depend.

Additional funding requirements for farmer health needs

There are also particular and under-researched health costs associated with the health of farmers.

Farming communities experience what is known as the 'farming health and wellbeing gap'. The Royal Agricultural Benevolent Institution (RABI's) Big Farming Survey[15] of over 15,000 farming people found evidence that the health and wellbeing of the farming population was lower than the rest of the UK population. Currently there is no specific weighting for this in health funding formulas.

The survey found evidence that farmers are more likely to experience

13. https://www.gov.uk/government/news/patients-in-poorer-areas-to-get-better-access-to-gps
14. https://hansard.parliament.uk/Commons/2026-02-11/debates/25B6B416-8A89-4367-BCF5-4F40519C6CF9/RuralGpsFunding
15. https://rabi.org.uk/about/big-farming-survey/

pain, injury, and mobility problems:

- Over half (52%) of the farming community experience pain and discomfort.
- Pain and discomfort in the 35-44 farming age group is 16 percentage points greater than the national average.
- One in four have mobility problems.

In addition, the report found, depression and anxiety are more common in farming communities:

- Almost half (47%) were experiencing anxiety and for almost a fifth (18%) this was classified as either moderate or severe.
- Around a fifth (19%) of farming people know of someone who attempted suicide in the last five years.

Research by the National Centre for Remote and Rural Medicine (NCRRM) also looked at health outcomes for farming people compared to the general population[16].

The key finding was that farmers are more likely to die from preventable causes:

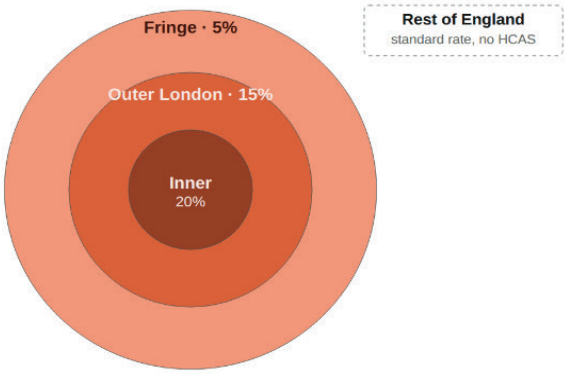
- Late presentation of physical health issues resulting in death.
- Late presentation of mental health issues leading to suicide.
- Fatal accidents on farms – 21 times higher than all industry average.

Workforce and payscales

There is also a great degree of variation in pay according to the national payscales for NHS staff. This variation is likely to contribute to staff being more attracted to the higher pay areas and to making it harder to recruit or retain staff in those areas which do not benefit from the higher rate.

High Cost Area Supplements in NHS pay by geography[17]

16. https://link.springer.com/article/10.1186/s12245-026-01243-9
17. https://www.nhsemployers.org/publications/tchandbook



Inner London — 20%, up to £8,746

Camden	Lambeth
City of London	Lewisham
Hackney	Southwark
Hammersmith & Fulham	Tower Hamlets
Islington	Wandsworth
Kensington & Chelsea	Westminster

Outer London — 15%, up to £6,137

Barking & Dagenham	Enfield	Kingston upon Thames
Barnet	Greenwich	Merton
Bexley	Haringey	Newham
Brent	Harrow	Redbridge
Bromley	Havering	Richmond upon Thames
Croydon	Hillingdon	Sutton
Ealing	Hounslow	Waltham Forest

Fringe — 5%, up to £2,270

Hertfordshire	Essex	Kent
Dacorum	Basildon	Dartford, Gravesham & Swanley
Hertsmere	Brentwood, Billericay & Wickford	
Royston, Buntingford & Bishop's Stortford	Epping Forest	
South East Hertfordshire	Harlow	
St Albans & Harpenden	Thurrock	
Watford & Three Rivers		
Welwyn Hatfield		

Berkshire	Surrey
Bracknell Forest	East Elmbridge & Mid Surrey
Slough	East Surrey
Windsor, Ascot & Maidenhead	Guildford & Waverley
Wokingham	North Surrey
	Surrey Heath & Woking

Every other NHS trust in England pays the standard national rate, with no HCAS. Zones follow 2005 PCT boundaries (NHS Terms and Conditions Handbook, Annex 8).

A report by Sir Chris Whitty in 2021[18] suggests that areas outside of

18. https://assets.publishing.service.gov.uk/media/60f98750e90e0703bbd94a41/cmo-annual_report-2021-health-in-coastal-communities-accessible.pdf

any of these HCAS zones can indeed face pronounced recruitment and retention issues. The report finds that:

> *"…despite coastal communities having an older and more deprived population, they have 14.6% fewer postgraduate medical trainees, 15% fewer consultants and 7.4% fewer nurses per patient."*

And it notes that:

> *"Challenges to the recruitment and retention of health and social care staff is a common concern expressed by coastal Directors of Public Health and NHS leaders."*

The report also includes a number of case studies highlighting the challenges many rural or coastal areas face in recruitment and retention.

Parliamentary exchanges suggest that the same issues apply in rural areas, with it being claimed that in Devon, one in ten nursing roles and one in eight mental health roles were unfilled[19].

The Nuffield Trust has previously raised concerns that there are considerable variations in staffing levels throughout the country and that the current HCAS bands do not adequately reflect changes in living costs over the past two decades[20].

With increases in fuel costs over recent years and the relative lack of public transport options in rural and coastal areas compared to more urban areas (as well as lower levels of public transport subsidy[21]) it is likely that relative costs of living will have increased more in these areas than in urban areas.

The principle of the need for further incentives to aid recruitment and retention in rural health settings has previously been accepted to an extent through the Targeted Enhanced Recruitment Scheme[22] with up to £20,000 in incentives being offered to GP speciality trainees committing to working in rural settings. Although the scheme was withdrawn due to funding pressures, the significant increase in applications during its operation suggests a high degree of price sensitivity[23].

The scheme in Wales remains funded for new starters until 2027 and includes conditions to remain within the targeted area for 12 months after qualification. This decision to withdraw funding was made before any formal evaluation of retention, meaning that a scheme with demonstrable positive recruitment impact was scrapped without establishing whether it met the longer-term workforce needs, particularly in rural areas. There is a strong case for reinstating and fully evaluating TERS schemes, including incorporating conditions on employment similar to the scheme in Wales, to establish whether it improves rural GP retention and subsequent health outcomes for rural communities.

The need for incentives of this sort is likely to increase significantly if the NHS 10 Year Plan's intended shift to primary and local provision in communities is to be achieved which depends on there being enough GPs, particularly in rural areas, to deliver it. These should be reflected in the expected NHS Long Term Workforce Plan.

19. https://hansard.parliament.uk/commons/2022-11-01/debates/A30FCB47-780A-432D-BC63-C3B65B1261F7/WorkforceShortagesRuralAreas
20. https://www.nuffieldtrust.org.uk/research/placed-at-a-premium
21. https://www.gov.uk/government/statistical-data-sets/transport-expenditure-tsgb13
22. https://medical.hee.nhs.uk/medical-training-recruitment/medical-specialty-training/general-practice-gp/how-to-apply-for-gp-specialty-training/targeted-enhanced-recruitment-scheme
23. https://www.pulsetoday.co.uk/news/workforce/nhse-cuts-gp-golden-handshake-scheme-due-to-budget-pressures/

The move to more local health provision is inevitably going to create a greater need for more local recruitment and flexibility. As such there is an increasingly strong case for the NHS disapplying national pay bands altogether and allowing providers to respond to local market conditions as well as the individual experience and merit of the employee and their fit with the organisation's needs and priorities.

This will need to be reflected in the formula for funding allocations over time.

Age, Migration and Rurality: The Changing Geography of Health Need

Current policy and funding in general practice is built around an urban model, underpinned by understandings developed in urban settings and a research base that has historically lacked rural and coastal-specific insights. Added to this are societal misconceptions around what a 'life in the country' looks like: idyllic and affluent, with homogenous stereotypes of older couples or farming families. These assumptions mask issues like rural deprivation, hide diversity within rural populations and lead services designed around this narrow image to struggle or fail to meet the health needs of their local communities.

Several factors, including internal migration, population change, geography and service accessibility, all shape the patterns of healthcare utilisation in rural areas, but are less consistently reflected within current funding models.

A growing challenge for rural and coastal general practice is the fluctuating nature of the local population. In-migration has grown substantially, peaking around the Covid-19 pandemic, with an overall increase of around 8% in the rural population between 2014-2024[24]. It is estimated that between 2022 and 2032, the number of households in majority rural authorities is expected to grow faster than in other authority types[25].

Health systems are generally designed around resident populations, but rural areas continue to be dynamic, with in-migration redistributing age, wealth, illness and healthcare need across geography over the life course. Despite this, general practices in rural areas are closing, leaving growing populations unable to access healthcare; these closures are often linked to difficulties recruiting and a financial envelope unable to cover the costs of delivering healthcare[26]. Thus, the first challenge to the totemic status of urban-models and understanding in funding debates: population growth and demand are rising precisely in the areas policy treats as static or low-need.

Ageing Population

There has been a rise in older populations within rural and coastal areas. Current data suggests that over a quarter of rural populations, and a fifth of coastal populations, are aged 65 or over, and the proportion of older

24. GOV.UK. Population Statistics for Rural England [Internet]. 2026 [cited 2026 Mar 29]. Available from: https://www.gov.uk/government/statistics/population-statistics-for-rural-england

25. https://assets.publishing.service.gov.uk/media/696637175534c732221e0e09/1_Population_14_01_26.pdf

26. RCGP. Number of GP practices in England falls by over a thousand in under a decade as patient numbers rocket [Internet]. 2025 [cited 2026 Jul 7]. Available from: https://www.rcgp.org.uk/News/Number-of-GP-practices

residents rises further with increasing rurality, partly due to in-migration trends coupled with youth out-migration[27]. Age is one of the strongest independent predictors of healthcare utilisation. Many older people live with multimorbidity, polypharmacy, frailty and functional decline requiring increased input from general practice and other health and social care services. These age-related factors transform healthcare need independently of socioeconomic deprivation and yet current funding models do not sufficiently account for the increased costs of delivering healthcare to this group of patients. Equally, contractual changes that focus on digital routes and appointment urgency may fail to meet the needs of a group at risk of digital exclusion or most affected by a lack of transportation in geographically dispersed areas[28]. This leads to a mismatch between contractual obligations, what practices can realistically deliver, and what patients want.

The increasingly older demographic in rural and coastal areas also has implications for social care. Whilst there is varied provision across rural areas, it remains considerably less than in urban area[29]. Costs are higher, linked to higher transport costs, increased travel time for domiciliary visits or fewer third and voluntary sector support organisations. Rural areas also face challenges recruiting and retaining a social care workforce, creating increased demand for agency staff, again increasing costs, or reducing provider capacity[30]. With these demographic trends demand for both community-based and residential social care is likely to increase, which will put increasing pressure on an already stretched workforce, further emphasizing the need for funding and service models that recognise the higher costs and logistical challenges of delivering care in rural settings

Seasonal Population Change

Healthcare demand is generated by the people present in a place, not simply by those officially resident there. This distinction becomes particularly important in rural and coastal communities where tourism, second-home ownership and seasonal employment generate fluctuations in local population size over much shorter timespans. These fluctuations are not adequately captured by funding mechanisms based predominantly on registered list size.

Many practices face substantial, yet predictable, increases in temporary patient numbers during holiday periods and still need to manage the needs of their registered population. Whilst remote access and appointments with home practices can alleviate some of this pressure, many still access care locally; one Cornish practice estimated that 1000 appointments were used by temporary residents every year[31]. There is reimbursement for temporary patients, but this relies on practices having robust administrative workflows in place to capture these additional registrations and fails to adequately remunerate practices where medical care may be more complex. Despite entirely predictable ebbs and flows of population across rural and coastal areas, core funding allocation remains based overwhelmingly on registered list size and fails to reflect the workload and impact of seasonal

27. 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 report. Available from: www.nuffieldtrust.org.uk/research/rural-health-care

28. Pugh R, Scharf T, Williams C and Roberts D (2007). Obstacles to using and providing rural social care. Social Care Institute for Excellence. Available from: https://lx.iriss.org.uk/sites/default/files/resources/Obstacles%20to%20using.pdf

29. Pugh R, Scharf T, Williams C and Roberts D (2007). Obstacles to using and providing rural social care. Social Care Institute for Excellence. Available from: https://lx.iriss.org.uk/sites/default/files/resources/Obstacles%20to%20using.pdf

30. Ugarte V (2023). Social Care in Rural Areas. Available from: https://impact.bham.ac.uk/wp-content/uploads/2024/04/IMPACT-Network-Rural-Areas-Discussion-material-FINAL-revised.pdf

31. BBC News. Doc Martin village plea to tourists to help Cornwall's NHS [Internet]. 2025 [cited 2026 Jul 7]. Available from: https://www.bbc.co.uk/news/articles/czey2e49615o

population change.

Around 35,000 Seasonal Worker visas were granted in 2024 but there is limited data available on healthcare utilization[32]. Healthcare demand generated by migrant agricultural workers may only be partially captured through registered patient lists, despite seasonal concentration of need.

Case Study – Lake District Tourist Health Pilot

The Problem

During peak holiday seasons, areas like the Lake District experience a massive influx of holidaymakers, often quadrupling the local population. Because UK guidelines dictate that unregistered tourists are entitled to free primary care, local surgeries often face intense, unfunded workloads. In fact, severe strains from dealing with thousands of unregistered tourist appointments previously led to local practices (such as the Central Lakes Medical Group) handing back their contracts as they were unable to manage the volume of additional unfunded work.

The Solution: The Tourist Health Hotline Pilot

To combat this, the Grange & Lakes Primary Care Network (PCN) and Cumbria Health on Call launched a targeted pilot campaign that was later scaled into a permanent service:

- The Hotline: A dedicated phone line operating from 9:00 AM to 5:30 PM every day.
- Target Audience: Any holidaymaker or visitor in the region who is not registered with a local GP.
- How It Works: Instead of tourists overwhelming local surgery reception lines, they call the hotline. Triage teams direct them to the most appropriate healthcare channel, whether that means managing non-emergency issues, handling minor ailments, or ordering emergency prescription medication while away from home.
- The Goal: To ease the daily burden on physical general practices and properly signpost tourists to alternative services.
- Preserving Care for Residents: As Dr Julie Colclough (Director of the Grange & Lakes Primary Care Network) notes, the biggest structural impact has been allowing rural practices to "continue to care for the residents living and working in the area" while still ensuring visitors' needs are safely managed elsewhere.

Hidden Populations

Defining the 'rural population' as a single homogenous group risks overlooking the considerable diversity within rural communities. Protected characteristics, disability, ethnicity, migration status and homelessness frequently intersect with rurality to compound barriers to healthcare

32. GOV.UK. Seasonal workers survey results 2024 [Internet]. 2024 [cited 2026 Jul 28]. Available from: https://www.gov.uk/government/publications/seasonal-workers-pilot-review/seasonal-workers-survey-results-2024

access and may remain poorly represented within routine datasets and funding allocation.

Around a quarter of the Gypsy, Roma and Traveller communities are based within rural areas in England[33]. Members of these communities have higher prevalence of long-term illness and ill-health, reduced life expectancy and face complex access barriers at individual and system level. Rural homelessness is also rising, in part driven by general and rural-specific increases in the cost of living, yet remains largely hidden in part due to stereotypes around rural affluence[34]. Current data estimates that rural areas receive 65% less homelessness funding per capita than urban areas despite growing understanding of unmet need[35]. These population challenges demonstrate how rural and coastal practices may be required to deliver more intensive, flexible and coordinated care without the resource to match.

Initiatives in Scotland[36] and Wales[37], examining the experiences of those living with disabilities, found that intersecting characteristics, for example disability combined with rurality, produced greater barriers to access, notably around poorly adapted buildings and infrastructure. Established rural barriers such as transport, distance and limited provider availability compound further for those with protected characteristics, including learning disabilities or language and communication needs

Policy in this area needs to be evidence-based, and at present the evidence base is thin, risking continued underservice of society's most vulnerable rural residents.

Rural Deprivation

Socioeconomic deprivation remains a well-evidenced predictor of morbidity and mortality and places substantial additional demands on general practice. Conventional measures for deprivation, for example the Indices of Multiple Deprivation [IMD], include factors such as use of financial benefits, unemployment, educational attainment, and health issues that shorten or lower quality of life, amongst others.

Even with a review of the funding formula, any subsequent over-reliance on deprivation measures as a driver of healthcare demand risks obscuring other structural factors. Conventional deprivation measures describe characteristics of places rather than dynamic populations. They may therefore underestimate healthcare demand in comparatively affluent but older communities, fail to capture barriers created by geographic accessibility and overlook predictable seasonal variation in service demand. Consequently, deprivation alone cannot fully explain observed patterns of healthcare utilisation.

There are also concerns that measures, such as the IMD, prioritise urban disadvantage or fail to capture rural deprivation in a meaningful way. The latest 2025 update of the IMD added a rural supplement which includes acknowledgement of unreliable digital connectivity, reduced spatial bias (a major criticism had been that deprivation in rural and coastal areas was more 'spread out' geographically and thus harder to capture), and

33. Friends, Families and Travellers (2022). Briefing: Health inequalities experienced by Gypsy, Roma and Traveller communities. Available from: https://www.gypsy-traveller.org/resource/briefing-health-inequalities-experienced-by-gypsy-roma-and-traveller-communities/

34. Tunaker C, Carr H, Burke L and Reyes-Pascal G (2023). Homelessness in the Countryside: A Hidden Crisis. Available from: https://research.kent.ac.uk/rural-homelessness/home/final-report/

35. Homeless Link. Rural idyll or hidden deprivation [Internet]. 2026 [cited 2026 Jul 7]. Available from: https://homeless.org.uk/news/rural-idyll-or-hidden-deprivation/

36. Scottish Government (2026). Inequalities and challenges experienced by disabled people in Scotland: evidence review. Available from: https://www.gov.scot/publications/evidence-review-inequalities-challenges-experienced-disabled-people-scotland/

37. Welsh Government (2015). Review of Evidence of Inequalities in Access to Healthcare Services for Disabled People in Wales. Available from: https://www.gov.wales/sites/default/files/statistics-and-research/2018-12/151015-review-evidence-inequalities-access-healthcare-sevices-disabled-people-en.pdf

consideration of transport accessibility challenges[38]. However, there remain limitations including under-recognition of rural-specific issues, such as the higher cost of living in a rural area, and that the overall methodology[39] to calculate the deprivation scores remains skewed to an urban context[40]. Rural and coastal practices are therefore doubly disadvantaged with deprivation being underestimated and additional costs relating to patient needs not being sufficiently factored in.

Conclusion

Population movement, demographic ageing, accessibility and seasonal fluctuation continually reshape demand for services, yet current funding mechanisms continue to rely predominantly on static inputs such as resident list size and deprivation-based measures. These factors also frequently intersect: an ageing population in a coastal town, for example, may also experience seasonal tourist influx alongside under-recognised local deprivation. Where this occurs, the resulting mismatch between funding and workload is likely to be greater than any single factor in isolation. A funding model built overwhelmingly around registered list size and a narrow deprivation metric cannot adequately reflect the realities of rural and coastal general practice. This leads to a systemic underestimation of workload and complexity in areas where general practice access is already under strain.

38. McLennan D, Noble S, Penney B, et al. The English Indices of Deprivation 2025, Deprivation in Rural Areas: A Supplementary Report. London: Ministry of Housing, Communities & Local Government; 2025 [cited 2026 Jul 11]. Available from: https://assets.publishing.service.gov.uk/media/6900a6e984b816d72cb9aa58/IoD_2025_Rural_Report.pdf
39. Ovenden-Hope T, Brown V, Achtaridou E. The Pretty Poverty Report [Internet]. Plymouth: Marjon University; 2025 [cited 2026 Jul 7]. Available from: https://www.marjon.ac.uk/educational-isolation/The-Pretty-Poverty-Report.pdf
40. Rural Services Network (RSN). Rural Lens Review: Indices of deprivation 2025 [Internet]. 2025 [cited 2026 Jul 7]. Available from: https://mail.rsnonline.org.uk/rural-lens-review-indices-of-deprivation-2025

Patient Choice: Depending on Where You Live

Patient choice: being able to decide where one receives care, has become one of the defining principles of the modern National Health Service in England. The NHS Constitution for England states that patients "have the right to make choices about the services commissioned by NHS bodies and to information and support to make these choices."[41] Over successive decades, this principle has been strengthened through legislation and national policy, reflecting a broader shift towards a more personalised and responsive healthcare system.

Patient choice is intended to improve quality, efficiency and accountability by empowering patients to select the healthcare provider that best meets their needs. Patients are intended to have a meaningful choice over their GP practice, hospital provider, consultant-led treatment, community services and mental health services, with competition between providers expected to drive up standards of care, reduce waiting times and enable greater responsiveness to patient preferences. This approach remains central to the Government's 10-Year Health Plan, which sets out an ambition to deliver "a patient-controlled NHS, that provides real choice, real control and real convenience for patients". It commits to the introduction of a new Choice Charter, designed to strengthen patients' ability to exercise greater control over where and how they receive care.[42]

When the NHS talks about patient choice, it is often talking about a theoretical choice: the right to choose between different providers. But how much attention is given to whether patients can actually exercise that choice? Transport, geography and providers' capacity to take on patients properly considered are all factors which practically impact on patients' effective ability to exercise choice. This is particularly the case for coastal and rural patients. While they may have the right to choose under the NHS Constitution, but the practical realities of geography mean their ability to exercise that right varies considerably.

The Limits of Geography

NHS infrastructure has, for good reasons, been created in dense patient populations because large numbers of patients allow economies of scale to be reached and services to be used. In cities and large urban areas, patients will have nearby hospitals, tertiary and specialist services, and multiple GP surgeries. In these locations, providers operate with competition. Where there are fewer patients, mainly in coastal and rural locations,

41. Department of Health and Social Care (2023) The NHS Constitution for England. Available at: https://www.gov.uk/government/publications/the-nhs-constitution-for-england (Accessed: 21 July 2026).

42. Department of Health and Social Care (2025) Fit for the Future: 10 Year Health Plan for England. London: Department of Health and Social Care.

the opposite is true. The range of services decreases, there are greater recruitment problems for NHS professionals, and far higher personal costs for individuals to exercise patient choice.

It will be no surprise that the Department for Transport found that rural patients faced longer journeys to a GP surgery or hospital across all modes of transport.[43] DEFRA's research looked at how easily people could reach a hospital, GP or pharmacy and found that almost half of those living in remote rural areas fell into the 'very low connectivity' band.[44] They are effectively among the most cut off from NHS services and will therefore have far less choice when accessing care.

The Government's push towards 'neighbourhood health', with around 50,000 people used as a guide for a single-neighbourhood provider, must ensure that geography doesn't become the single greatest barrier to patients accessing services and exercising their right to choose.[45] Clearly, a 'neighbourhood' of 50,000 people in central Manchester is not comparable to the same number of patients living across a large, dispersed area in West Somerset. This means that patients with the same notional rights to choice under the NHS Constitution will have unequal ability to exercise them.

The Geography of Patient Choice

In Manchester, patients are empowered by their NHS constitutional right to choose. Greater Manchester benefits from 411 GP practices, compared with 24 in the county of Herefordshire.[46] In Manchester Central alone, 93% of registered patients were found to have a better-rated GP surgery within two miles of their existing practice.[47] The city also ranked among those with the most hospitals per head of population.[48] Coupled with good transport links, this means many patients are a short walk or bus ride from their local provider, or a better-rated alternative. Competition for patients may also help push up quality.[49]

In North Norfolk, the coastal town of Wells-next-the-Sea has experienced long ambulance response times. Local monitoring for April and May 2019 recorded an average response of over 18 minutes for the most life-threatening calls against a national target mean of 7 minutes, and over 35 minutes for serious but less immediately life-threatening calls against a target mean of 18 minutes.[50] North Norfolk also has a high prevalence of stroke, making timely access to hospital particularly important.[51] Patients needing acute hospital care generally have to travel outside the district, principally to Norwich, with some served by hospitals in King's Lynn or Great Yarmouth.[52] For a patient in North Norfolk, choosing another hospital means first considering how they will get there. A shorter waiting list elsewhere may be of little benefit if the journey is too difficult or repeated visits are unaffordable.

The Isle of Wight could be one of the country's clearest illustrations of geographical constraint. It represents the issues that arise when policymakers and commissioners use 'as the crow flies' tools to assess access to services. These cannot account for transport, costs and, in the

43. Department for Transport (2021), Journey Time Statistics, England: 2019, Tables JTS0102 and JTS0103. Published 4 November 2021. Available at: https://www.gov.uk/government/statistics/journey-time-statistics-england-2019/journey-time-statistics-england-2019

44. Department for Environment, Food and Rural Affairs (2026), Statistical Digest of Rural England: Connectivity and Accessibility. 22 July 2026, p. 76; supplementary data tables. Available at: https://www.gov.uk/government/statistics/connectivity-and-accessibility-statistics-for-rural-england

45. Department of Health and Social Care and NHS England (2026), Neighbourhood Health Framework. Published 17 March 2026. Available at: https://www.gov.uk/government/publications/neighbourhood-health-framework/neighbourhood-health-framework

46. NHS Greater Manchester (no date), Primary Care: 411 GP practices. https://gmintegratedcare.org.uk/primary-care/; Wye Valley NHS Trust (no date), General Practice Opportunities: 24 practices in Herefordshire. Available at: https://www.wyevalley.nhs.uk/work-with-us/general-practice-opportunities.aspx

47. HealthSay (no date) Best and Worst NHS GPs in Manchester Central. Available at: https://www.healthsay.co.uk/articles/807-best-and-worst-nhs-gps-in-manchester-central (Accessed: 21 July 2026).

48. NowPatient (no date), The UK Cities for the Best Healthcare. Commercial comparison of 50 UK cities. Available at: https://nowpatient.com/health-news/uks-best-healthcare-cities

49. Gravelle, H., Liu, D., Propper, C. and Santos, R. (2019), 'Spatial competition and quality: Evidence from the English family doctor market', Journal of Health Economics, 68, 102249. Available at: https://doi.org/10.1016/j.jhealeco.2019.102249

50. Holliday, V. (2021), North Norfolk Coastal Ambulance Response Times Working Party. North Norfolk District Council, 5 July, pp. 1–2. Response-time data for April and May 2019. Available at: https://modgov.north-norfolk.gov.uk/documents/s6682/OS%20Ambulance%20Response%20Times%20Update%20Report.pdf

51. Norfolk and Waveney Acute Hospital Collaborative (2025), Our Case for Establishing a Group Model, pp. 9 and 19. Available at: https://www.nnuh.nhs.uk/wp-content/uploads/2025/03/250226-NWAHC-Case-for-Establishing-a-Group-Model-FINAL-VERSION.pdf

52. North Norfolk District Council (2024), Response to Healthwatch Norfolk's consultation on Benjamin Court, July, pp. 2–3. Identifies the acute hospitals serving the district and transport barriers. Available at: https://healthwatchnorfolk.co.uk/wp-content/uploads/2024/07/NNDC-response.pdf

case of the Island, a stretch of sea.

Earlier this year, the closure of three care homes left some residents needing mainland placements because suitable local alternatives were unavailable. In one case raised in Parliament, a man was moved against his family's wishes, separating him from his wife of 63 years.[53]

Choice for patients living on the Isle of Wight is limited when it comes to acute hospitals—just the one—with patients needing to travel to the mainland for many specialist services.[54] An ambulance transfer to Southampton General Hospital can take at least two hours for a journey of around 12 miles as the crow flies, with the return journey taking the ambulance and its crew out of service for roughly five hours in total.[55]

Geography is not the only barrier for coastal and rural patients when it comes to exercising choice. A patient in Clacton-on-Sea does not have a sea crossing separating them from other providers, but coastal areas have fewer consultants per patient than the national average.[56]

Where patients have less choice, it is perhaps no surprise that they may also face longer waits. Across rural England, distance, scattered populations and fewer services limit where patients can turn for an appointment. The CQC's 2023/24 State of Care report found that the areas with the highest proportion of patients waiting more than two weeks for a GP appointment were disproportionately rural. Half of the ten worst-performing areas were in the South West of England, while the best-performing areas were overwhelmingly urban.[57]

Policy blind spots

NHS Dentistry

It has become widely accepted that NHS dentistry is increasingly difficult to access, and this is particularly true in rural England. Areas with poor provision have become known as 'dental deserts'. A 2026 study found that 97% of people living in the most deprived dental deserts were in rural areas.[58] Policy Exchange's 2025 report, *Pulling Teeth*, argued that private treatment has become a necessity for many patients unable to access NHS care.[59] For rural patients in this position, dentistry becomes another expensive cost of rural living. The Government's own 2024 dental recovery plan acknowledged the difficulties facing rural and coastal communities and proposed mobile dental vans to reach isolated areas.[60] It is imperative that these communities receive support, but NHS dentistry must also be viable for smaller populations, even if this means a higher cost per patient.

Pharmacy Services

Successive governments have increased the use of pharmacists to help reduce pressure on the health system, particularly GP surgeries. The policy itself is sound. Pharmacy First has delivered 14 million consultations since its launch in February 2024, and the newly announced expansion could allow up to three million additional consultations a year to take place in community pharmacies once fully rolled out.[61]

53. Quigley, R. (2026), Isle of Wight Dementia Patients: Discharge to Mainland Care Homes. House of Commons debate, Hansard, 16 June. Available at: https://hansard.parliament.uk/commons/2026-06-16/debates/BC41B11D-C826-4057-9A77-7E872E51C8D2/IsleOfWightDementiaPatientsDischargeToMainlandCareHomes

54. Isle of Wight NHS Trust (no date), About Us; Patient Transport. Acute services are based at St Mary's Hospital; specialist transfers include Southampton and Portsmouth. https://www.iow.nhs.uk/about-us Available at: https://www.iow.nhs.uk/services-and-departments/patient-transport

55. Solent Freedom Tunnel (no date), Hospital and Healthcare. Campaign estimates of ferry-dependent ambulance transfers; not NHS performance statistics. Available at: https://solentfreedomtunnel.co.uk/hospital-and-healthcare/

56. Chief Medical Officer (2021), Annual Report 2021: Health in Coastal Communities. Department of Health and Social Care. Available at: https://www.gov.uk/government/publications/chief-medical-officers-annual-report-2021-health-in-coastal-communities

57. Care Quality Commission (2024) State of Care 2023/24: Access to Primary and Community Care. Available at: https://www.cqc.org.uk/publications/major-report/state-care/2023-2024/access/primary (Accessed: 21 July 2026).

58. Devlin, H. (2026), 'High-need dental deserts in England: a national spatial analysis of NHS access and deprivation', British Dental Journal, 241, pp. 191–194. Published 14 August. High-need deserts are areas in deprivation deciles 1–3 with no NHS-listed practice within 5 km of the area's centre; 97% refers to their residents. Available at: https://www.nature.com/articles/s41415-026-9877-2

59. Lyon, G. (2025), Pulling Teeth: Filling the Gaps in Dental Provision. Policy Exchange, pp. 13, 21 and 24. Available at: https://policyexchange.org.uk/wp-content/uploads/Pulling.Teeth_.pdf

60. NHS England (2024) Millions more dental appointments to be offered under NHS Dental Recovery Plan. Available at: https://www.england.nhs.uk/2024/02/millions-more-dental-appointments-to-be-offered-under-nhs-dental-recovery-plan/ (Accessed: 21 July 2026).

61. NHS England (2026), Patients to Get Quicker Treatment for Migraines, Acne and 3 Other Everyday Conditions at Pharmacies. 10 September. Reports 14 million consultations since February 2024 and an estimated 2–3 million annual consultations for the five new conditions once fully rolled out. Available at: https://www.england.nhs.uk/2026/09/patients-to-get-quicker-treatment-for-migraines-acne-and-3-other-everyday-conditions-at-pharmacies/

Yet these additional services may mainly benefit healthcare provision in towns and cities, where community pharmacies have larger populations to serve and greater opportunities to achieve economies of scale. There are now 1,500 fewer high street pharmacies in England than in 2017[62], with Community Pharmacy England warning that closures are affecting access particularly in rural areas. Its Director of Research and Insights, Dr James Davies, warned that closures can "create pockets where patients will find it harder to access medicines, collect prescriptions and get advice from their local pharmacy".[63] Expanding pharmacy services could relieve considerable pressure on general practice, but rural surgeries and their patients cannot benefit in the same way if there is no local pharmacy left to provide them.

Of course, in very rural locations with the sparsest populations, a community pharmacy may not be viable. This has long been recognised, and there is a workable solution in the form of dispensing doctors: GP surgeries that can dispense medicines to eligible patients where access to a pharmacy is difficult.[64] However, recent government policy has overlooked these rural outposts.

Following the terrible meningitis outbreak in Kent, which claimed two lives, the Government commissioned a one-off MenB vaccination service for eligible young people through community pharmacies.[65] Yet dispensing practices were not included as providers. NHS England acknowledged that it had not specifically considered dispensing doctors when designing the service, although it said it would consider supplementary provision in areas with poor pharmacy coverage.[66]

Dispensing Doctors Association Chief Executive Matthew Isom said: "In remote, rural and coastal communities … the most logical place to go would be their local dispensing practice." He warned that students would instead have to travel further for vaccination, often without decent public transport.[67]

Young people live in rural areas too, and they should not be given additional barriers exacerbating health inequalities. Where the Government considers a service important enough to commission through community pharmacies, it should also commission that service through dispensing practices where local pharmacy access is limited. This should be a standard part of policy design, with the funding and support needed to deliver it, particularly for public health programmes and vaccinations so that rural patients have a practical way to benefit from the services being offered elsewhere.

Conclusion

The credibility of the Government's Choice Charter must be in serious doubt whilst health inequalities arising from geography remain unaddressed in policy. The Countryside Alliance points out that one in four postcodes in Britain is rural.[68] Commissioners should be required to show how new services will reach rural and coastal communities. Expecting patients in these areas simply to go without, pay more or accept being overlooked

62. https://www.chemistanddruggist.co.uk/news/funding/over-280000-people-have-lost-their-local-pharmacy-this-year-IAWDHCCNZBEMHEU6AF7SFVCDOU/

63. Community Pharmacy England (2026), Pharmacy Closure Concerns. 25 September. Reports National Pharmacy Association analysis of pharmacy closures and comments from Dr James Davies. Available at: https://cpe.org.uk/our-news/pharmacy-closure-concerns/

64. Dispensing Doctors' Association (no date), About Dispensing Practice. Available at: https://www.dispensingdoctor.org/dispensing-practice/

65. NHS England (2026), Young People Urged to Book Lifesaving Meningitis Jab at High Street Pharmacies. 13 July. Available at: https://www.england.nhs.uk/2026/07/young-people-urged-book-lifesaving-meningitis-jab-high-street-pharmacies/

66. Colquhoun, A. (2026), NHSE Did Not Consider Dispensing GPs in Meningitis Vaccination Programme. Dispensing Doctors' Association, 21 July. Available at: https://www.dispensingdoctor.org/news/nhse-did-not-consider-dispensing-gps-in-meningitis-vaccination-programme/

67. Colquhoun, A. (2026), NHSE Did Not Consider Dispensing GPs in Meningitis Vaccination Programme. Dispensing Doctors' Association, 21 July. Available at: https://www.dispensingdoctor.org/news/nhse-did-not-consider-dispensing-gps-in-meningitis-vaccination-programme/

68. Countryside Alliance (2026), Countryside Alliance Launches Campaign Urging Government to Reset Its Relationship with the Countryside After 27 Damaging Policies Targeting Rural Britain. 4 September. The postcode figure covers Britain, not England alone. Available at: https://www.ruralreset.org/media/countryside-alliance-launches-campaign-urging-government-to-reset-its-relationship-with-the

would be a decision lacking in compassion and entirely disregarding patient choice.

Places must compete for people

The narrative over many years has been that there is a shortage of NHS staff, including nurses, doctors -especially GPs - and other health professionals. Staffing shortages in remote rural and coastal areas are therefore presented as a natural consequence and that inevitably geography will mean some patients miss out.

There are of course workforce pressures and shortages. However, where those professionals work is shaped by institutional structures, a series of policies and a lack of political intervention. Teaching hospitals, medical schools and specialist hospitals are largely based in urban areas which can put rural and coastal areas at an immediate disadvantage in that they have to first persuade staff to move to a more unfamiliar professional and personal setting to take up an offer of employment.

It should come as no surprise that professionals remain in the areas where they spent years training and where the opportunities are created.

Highly trained professionals will choose jobs based on a range of factors beyond salary including quality of life, opportunity and place. By the time a GP qualifies, they will generally be in their late twenties or older and may already have a partner, children and established ties to a community. Moving to a rural or coastal area is therefore a decision for the whole family, shaped by schools, housing, a partner's employment prospects and proximity to family and support networks.

They will also consider the nature of a rural career. Take a GP working in a rural area. There may be no local pharmacy offering pharmacist-led services, too few patients to justify a walk-in centre and fewer sexual health clinics. This work therefore, will likely fall back to the GP.

There is also the question of what happens when a patient deteriorates, whether in a GP surgery or during a home visit. GPs, community nurses and other healthcare professionals may have to wait for an ambulance that has further to travel and takes longer to arrive. They must manage the risk while waiting, which also takes time away from other patients. This adds to both the workload and the responsibility of the job.

For some doctors, the chance to practise the full breadth of medicine will be attractive, but for others, the isolation and risk will be off-putting.

How the system reinforces opportunities in areas that are already best served

London and other large cities have world-class hospitals. These cities naturally benefit from the workforce who study and later train there. During these years, relationships, friendships and professional connections are formed.

Once qualified, professionals can find opportunities and employment without having to move home. Research, teaching and many specialisms are often available within the same area. Moreover, their partners have a wider choice of jobs, which will also influence where they choose to work and live. Trying to persuade one person to take up a role also means persuading and providing for a whole family.

Last year, NHS England's own review found that rural and coastal areas have the highest concentrations of older patients. These patients are more likely to have chronic conditions and multiple health problems, and they consult more often. The review also found that coastal and rural areas struggle to recruit and retain staff despite clear population need.[69] In the call for evidence, respondents highlighted that the distribution of training posts did not meet the needs of healthcare providers. Stakeholders also reported that placements in cities and specialist tertiary centres were more attractive than those in remote and rural areas. [70]

This is important to recognise, as the distribution of training posts shapes both the education of NHS staff and where they will go on to live and work. Areas that benefit from public investment in training have years to build ties with those professionals and persuade them to stay. Rural and coastal employers must then work harder to attract them, or recruit those who have been unable to secure a post in their preferred location.

A training rotation of a few months in a rural or coastal area will not be sufficient to resolve this issue. If trainees arrive in services already overstretched by staff shortages, the experience may reinforce the impression that these are unattractive places to work. Coastal and rural placements need more thought. They must be well supported and long enough for trainees to build connections in the community and see the employment opportunities available to them.

Geography the increasingly hidden and neglected inequality

Deprivation is understandably a public health priority. Deprivation is strongly associated with reduced life expectancy, comorbidities and poor health.

However, initiatives to tackle deprivation must also recognise other factors that affect health and access to care. Communities can experience serious healthcare inequalities despite not being in the most deprived areas. Affluent rural populations may still have a higher concentration of older people, spread across large areas with poor transport infrastructure.

69. NHS England (2025), The Medical Training Review: Phase 1 Diagnostic Report. Available at: https://www.england.nhs.uk/long-read/the-medical-training-review-phase-1-diagnostic-report/

70. NHS England (2025), Medical Training Review, Appendix F: Call for Evidence Summary. Available at: https://www.england.nhs.uk/long-read/appendix-f-call-for-evidence-summary/

Specialist hospitals, A&E departments and other services may be far away or unavailable locally. A small rural GP practice may appear financially viable on paper, but its future may depend on replacing a single GP partner approaching retirement. If no replacement can be found, that surgery could close.

It is also the case that high levels of wealth in some rural and coastal areas can conceal deprivation. Low-paid seasonal workers in coastal areas and tenant farmers who do not own their land can live alongside wealthy retirees. Statistics can disguise some of the most deprived pockets of the UK.

In his report on coastal health, Chief Medical Officer Professor Chris Whitty found that coastal communities had almost 15% fewer postgraduate medical trainees, 15% fewer consultants and 7% fewer nurses per patient compared with the national average. This was despite these areas having greater health needs. He also found that coastal communities faced greater difficulties in attracting healthcare professionals.[71]

It needs to be recognised that geography creates costs which cannot always be addressed by 'working at scale'. Geography affects travel time, access to staff and whether services are viable at all.

Families are a factor in relocation

The NHS has perhaps been naive in treating recruitment as a transaction between a healthcare provider and an individual health professional.

An experienced doctor considering a move will have much more to think about. Will their partner be able to pursue a career? Are there suitable schools for their children? A doctor in the middle of their career may also have elderly parents to consider. Increasing salaries would clearly make a significant difference but there are other factors which also need to be addressed.

Research into rural recruitment has shown that moving to an area and staying there depends on much more than the job itself. The clinician might be attracted to a job opportunity, but the place itself has a great effect on "moving and staying".[72] Some communities understand this and have adapted their approach. They promote their area, involve residents in the recruitment exercise and help new recruits and their families build local connections.[73]

These initiatives are a recognition that there are limitations on what a job advert or salary offer alone can achieve: people need to see a future for themselves and their family in that place which requires a wider look at the attractiveness of relocating to rural settings.

School Standards Matter

When it comes to healthcare recruitment, policy needs to be more open in recognising that schools affect professionals' aspirations about where they want to live.

Parents or those planning families will understandably hesitate before moving to an area if they believe it will have a negative impact on their

71. Chief Medical Officer (2021), Annual Report 2021: Health in Coastal Communities. Department of Health and Social Care. Available at: https://www.gov.uk/government/publications/chief-medical-officers-annual-report-2021-health-in-coastal-communities

72. Maclaren, A. S. et al. (2024), 'Moving to the countryside and staying'? Exploring doctors' migration choices to rural areas. Journal of Rural Studies, 108, 103210. Available at: https://doi.org/10.1016/j.jrurstud.2024.103210

73. Locock, L. et al. (2025), 'Come and work here!': a qualitative exploration of local community-led initiatives to recruit and retain health care staff in remote and rural areas of the UK. Health and Social Care Delivery Research. Available at: https://www.journalslibrary.nihr.ac.uk/hsdr/DJGR6622

children's experience and future opportunities.

The coastal and rural county of the Isle of Wight illustrates this disparity. In 2024–25, island pupils were 8.5 percentage points behind the national average for strong passes or better in both GCSE English and maths: 36.7% compared with 45.2% nationally. Among disadvantaged pupils, only 17% reached that standard, compared with 25.6% nationally.[74]

The Isle of Wight whilst a stark case is not alone. The Office for National Statistics found that coastal towns have had lower educational attainment scores than non-coastal towns. [75]

Weak school performance is part of a damaging vicious cycle. The concerns affecting doctors may also deter teachers, making it harder for schools to improve. In turn, fewer middle-class families may choose to move into the area. Schools can then miss out on the support those families might contribute to school life, while fewer pupils benefit from additional resources such as private tutoring. This can make overall attainment harder to improve, reinforcing the concerns that discourage families from moving there in the first place.

Poor educational performance in coastal communities needs intervention. Children should have the same life chances wherever they grow up. Policymakers need to recognise that a rural GP surgery or hospital cannot compete for scarce staff if the wider state is failing their families.

Rural medicine is a career to champion

Part of the strategy to improve recruitment and retention should be a greater emphasis on the rewarding careers rural medicine can offer, with varied clinical work, greater responsibility and strong connections to the community.

Whilst cities and larger urban areas have more healthcare facilities and a wider range of services and specialisms, rural medicine may attract clinicians precisely because care is less fragmented. There is a greater need for generalism, more clinical variety and the opportunity to care for the same patients across a wider range of health needs. Research involving GPs in rural Scotland found that these qualities helped them practise medicine in a way that reflected their professional values. Working in smaller teams also gave them a greater sense of control over their work.[76]

Dr James Tait, a GP partner in Helston and Clinical Director of the South Kerrier and Isles of Scilly Primary Care Network, describes the attraction plainly:

> *"Rural and coastal general practice provides an amazing model of high-quality, personalised care embedded within a community and across its partners. It enshrines a model of continuity, with all of its well-evidenced benefits, efficiencies and satisfaction for both its population and its clinicians. It thrives on pragmatism and localism, serves its population to the best of its ability, and remains a vibrant and rewarding career."* [77]

Medical schools, Royal Colleges and NHS employers should present rural medicine as a prestigious career offering professional independence,

74. Isle of Wight Council (2026), School Attainment Outcomes 2024/25, committee report. Available at: https://iow.moderngov.co.uk/mgConvert2PDF.aspx?ID=20767

75. Office for National Statistics (2023), Why do children and young people in smaller towns do better academically than those in larger towns? Available at: https://www.ons.gov.uk/peoplepopulationandcommunity/educationandchildcare/articles/whydochildrenandyoungpeopleinsmallertownsdobetteracademicallythanthoseinlargertowns/2023-07-25

76. Latham, H. A. et al. (2025), Exploring rural Scottish GPs' migration decisions: a secondary qualitative analysis considering burnout. British Journal of General Practice, 75(752), e187–e194. Available at: https://doi.org/10.3399/BJGP.2024.0494

77. Tait, J. (2026), correspondence with the author, 13 August 2026. Dr James Tait, GP Partner, Helios Health Partnership, and Clinical Director, South Kerrier and Isles of Scilly Primary Care Network.

high levels of responsibility and broad clinical practice. But those attractions must be protected. Shifting limited resources and funding away from rural areas, where economies of scale are harder to achieve, risks making local healthcare unsustainable despite the clear merits of a rural career. This will only make recruitment harder and further widen rural health inequalities.

Weak competition eventually affects standards

When there are several candidates, organisations can look beyond qualifications alone. Experience, values and leadership qualities can all be considered. When only one person applies, there is less choice. Worse still, when there are no applicants for a permanent post, a service must either go without or rely on locums, which can be more expensive and provide less continuity of care.

Vacancies are also stressful for the remaining workforce, who have to absorb the additional workload. Time for supervision and teaching is squeezed, services are stretched and annual leave becomes harder to take resulting in falling morale, higher turnover and even more vacancies.

Rural and coastal communities do not inherently attract or produce less capable professionals, but an inability to compete for staff can ultimately become a problem for the quality of care. The result is that communities already identified as having the greatest health needs may receive a poorer standard of care.

Rural and coastal communities are clearly a distinct case requiring distinct treatment so that they have a fair opportunity to access the same standards and services available elsewhere.

Local by default: Why bigger NHS models risk making rural and coastal healthcare worse

There has been a long obsession in the NHS that working at scale is progress; larger GP surgeries, closing of cottage hospitals, the larger organisations are assumed to be more efficient, more resilient and more able to deliver modern healthcare.

Perhaps this is true of some urban areas, but it's hard to defend this assumption when it comes to rural and coastal England.

There are some services where a high concentration of patients and expertise is clinically necessary. It would not be sensible to expect rare disease services, major trauma centres or highly specialised services in every community. Yet this move towards scale extends well beyond specialist care. There has been a wider drive towards fewer, larger organisations serving larger patient populations. Remarkably, in just eight years, the number of GP practices has fallen by around 1,000 despite an increasing number of patients, leaving fewer organisations responsible for more people.[78]

It is hard to believe the shift to at scale and care further away from home can be progressive for populations which are dispersed and travel is more difficult.

Relocating the cost

When a GP surgery merges into a larger and more central location, services move to a more distant site. Local diagnostic and walk-in centres may close. For all these services, patients will find it both harder to access (and may choose not to) and more expensive to access. The NHS may reduce its estate costs, but older patients become more reliant on relatives to get to appointments. The price for rurality is an increasingly higher cost to healthcare provision.

In the 2026 Future of Rural England Report, the government itself recognised that poor transport and longer journeys prevent rural patients from accessing healthcare. The report found that the drive towards larger, centralised services exacerbates those problems, reducing patient choice and increasing rural workforce shortages.[79] This recognition now needs to manifest in funding formulas and policy.

78. RCGP. Number of GP practices in England falls by over a thousand in under a decade as patient numbers rocket [Internet]. 2025 [cited 2026 Jul 7]. Available from: https://www.rcgp.org.uk/News/Number-of-GP-practices

79. Department for Environment, Food and Rural Affairs (2026), Future of Rural England Report. Published 16 July 2026. Available at: https://www.gov.uk/government/publications/future-of-rural-england-report/future-of-rural-england-report

Neighbourhood health risks becoming centralisation by another name

The rationale behind the government's move to neighbourhood health is right. However, it risks going badly wrong through its implementation.

The 10-Year Health Plan commits the NHS to a major shift from hospital to community,[80] while the Government's rural strategy calls for care to happen "as locally as it can".[81] Both suggest care closer to home and a more local approach. Yet neighbourhood healthcare is simultaneously being developed around much larger organisational footprints, raising questions about how local it will actually be.

In the recently released *Neighbourhood Health Framework*, 50,000 people is used as a guide for a 'single-neighbourhood provider', but 250,000 or more for a 'multi-neighbourhood provider'. These larger healthcare providers will coordinate services across populations much larger than a neighbourhood.[82] These 'neighbourhoods' may already be at odds with what a person considers their neighbourhood to be, and this creates the obvious danger that 'neighbourhood health' could just mean centralisation by another name.

Dr James Tait, a GP partner in Helston and Clinical Director of the South Kerrier and Isles of Scilly Primary Care Network, makes the practical point more bluntly. He warns that recurrent single-hub initiatives can "reinforce rural health inequalities". In practice, he argues, they prioritise access for people who are able - and can afford - to travel to a central hub.[83]

This is where we need to start delinking the design of health services from patient numbers alone, with a separate approach to planning care for rural populations. Serving 50,000 people in central Manchester, with its transport links, patient choice and range of services, is not comparable to serving 50,000 people dispersed across hundreds of square miles. Rural healthcare needs to be designed around its own geography and circumstances from the outset.

Closing three village surgeries and sending everyone to a centre in town would be a curious way of bringing care closer to home. The new organisation may have more capacity, but patients have further to travel. An area might even reach 50,000 patients and fit neatly into the framework's idea of a 'neighbourhood' and yet clearly not feel like one to the people it serves. In rural and coastal areas, care should be local by default.

Protect and make viable the local GP Surgery

General Practice provides good evidence that bigger is not necessarily better.

Clearly there are economies of scale. Research by the Nuffield Trust found that smaller providers had higher fixed costs , and that as list sizes increased, it correlated with a reduction in costs per patient. [84]So larger GP surgeries are less expensive to run, but this does not reflect all aspects of value.

80. Department of Health and Social Care (2025), Fit for the Future: 10 Year Health Plan for England. Available at: https://www.gov.uk/government/publications/10-year-health-plan-for-england-fit-for-the-future
81. Department for Environment, Food and Rural Affairs (2026), Future of Rural England Report. Published 16 July 2026. Available at: https://www.gov.uk/government/publications/future-of-rural-england-report/future-of-rural-england-report
82. Department of Health and Social Care and NHS England (2026), Neighbourhood Health Framework. Published 17 March 2026. Available at: https://www.gov.uk/government/publications/neighbourhood-health-framework/neighbourhood-health-framework
83. Tait, J. (2026), correspondence with the author, 13 August 2026. Dr James Tait, GP Partner, Helios Health Partnership, and Clinical Director, South Kerrier and Isles of Scilly Primary Care Network.
84. 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. London: Nuffield Trust. Available at: https://www.nuffieldtrust.org.uk/research/rural-health-care

There is evidence to suggest that larger general practices may result in a worse experience for patients. Institute for Government analysis of the 2024 National GP Patient Survey found a statistically significant relationship between a larger patient list size and lower patient satisfaction: the larger the practice list size, the worse the reported patient experience.[85] Moreover, the relationship was not confined to patient satisfaction - there was also a significant negative relationship between the number of patients in a practice and the practice's achievement against quality targets.[86]

Given these concerns about quality and patient experience in larger practices, we should question whether greater scale is the right direction of travel. This does not mean that every small practice outperforms a larger one, but policymakers should demonstrate clear benefits for patients before pushing services towards larger organisational footprints.

Unavoidably Small Recognition

A remote rural practice may have only 3,000 patients because that is the entire population of the area it serves. It cannot simply take on more patients to achieve the economies of scale of a larger practice. Rural communities have health needs, including social isolation and the physical and mental health pressures associated with long hours and financial strains associated with farming, with evidence that farmers have poorer mental health than that of the general population.[87] The expertise to recognise and respond to these needs is built through serving that population. It should not be assumed that a larger practice can simply replicate this understanding. A practice may not be able to match the economies of scale available to a 50,000 patient practice in a city or town but that does not make it less valuable. There needs to be provision for **unavoidably small** practices, even if that means accepting a higher cost per patient.

Case Study - Reeth Medical Centre closure

In rural North Yorkshire, Reeth Medical Centre served only 1,600 patients across an incredible 200 square miles. The practice was rated Outstanding by the healthcare regulator, the CQC, in 2018.[88]

Despite its essential and high-quality service, when the GP partner retired, the practice was left to close. The reasons cited by the ICB included a lack of available GPs, the absence of a viable alternative provider and high fixed costs associated with a small patient list size—the inability to achieve economies of scale.[89]

This dispersed rural community faced losing primary care services close to where they lived. In spring 2026, NHS Humber and North Yorkshire ICB was exploring a branch surgery in Reeth run by another GP provider, recognising that patients needed local access to care. The site subsequently reopened as a branch of Central Dales Practice, with services available on limited days.[90]

This raises the question: why was an outstanding practice covering a large rural area, unable to recruit, and what part did the penalty of rural costs and rural workforce shortages play?

85. Hoddinott, S. (2025), General Practice Across England: How Patient and Staff Numbers Are Related to Patient Experience. London: Institute for Government. Available at: https://www.instituteforgovernment.org.uk/publication/performance-tracker-local/general-practice-england/patient-staff-numbers

86. Hoddinott, S. (2025), General Practice Across England: How Patient and Staff Numbers Are Related to Patient Experience. London: Institute for Government. Available at: https://www.instituteforgovernment.org.uk/publication/performance-tracker-local/general-practice-england/patient-staff-numbers

87. Haves, E. (2026), Mental Health of Agricultural Workers. House of Lords Library, 14 September 2026. Available at: https://lordslibrary.parliament.uk/mental-health-of-agricultural-workers/

88. Care Quality Commission (2018), Reeth Medical Centre: Inspection Summary. Published 21 March 2018. Available at: https://www.cqc.org.uk/location/1-554698595/inspection-summary

89. NHS Humber and North Yorkshire Integrated Care Board (2026), Reeth Medical Centre Closure, Stakeholder Bulletin, 13 April 2026. Available at: https://humberandnorthyorkshire.icb.nhs.uk/wp-content/uploads/2026/03/14-Stakeholder-Bulletin-13-April-2026.pdf

90. Healthwatch North Yorkshire (2026), Reeth Medical Centre: Latest Updates on Healthcare Provision in Reeth. Updated 10 July 2026. Available at: https://www.healthwatchnorthyorkshire.co.uk/news/2026-07-10/reeth-medical-centre-latest-updates-healthcare-provision-reeth

If the 10-Year Health Plan is serious about moving resources into the community, it cannot allow the disappearance of existing primary care infrastructure already embedded in that community.

To prevent this, the Government must introduce **an unavoidably small practice adjustment.** This would not be a subsidy for inefficiency, but as recognition that providing access to healthcare in more difficult geographies will sometimes cost more.

Community hospitals are essential to rural healthcare

Beyond general practice, community hospitals provide an essential service in rural locations. Through the lens of economies of scale, their small size can make them look inefficient compared with acute hospitals but they provide essential outpatient clinics, step-up and step-down care, palliative care, minor procedures and diagnostics. They are also popular with patients, and some research suggests that certain services can be delivered as effectively and cost-effectively as in larger general hospitals.[91]

Therefore, as part of the Government's shift towards neighbourhood healthcare, commissioners should be compelled to consider how these community hospitals can be used to provide care more locally. Any further move towards centralisation must be weighed against the additional travel time, costs and barriers to accessing care faced by patients and their families.

Digital supporting local care, not replacing it

The Government's 10-Year Health Plan is right to emphasise the potential of technology, but at times it seems to treat it as a magic wand and underestimate the practical difficulties of implementing technological solutions in rural areas.[92]

The Government's own 2026 Rural England Report records that only 66% of rural homes had access to gigabit capable broadband, compared with 89% nationally, and some rural areas still have extremely poor connections.[93]

Digital healthcare can enhance and strengthen provision, but it cannot replace local services. Patients will still need physical examinations, diagnostic tests and hands-on care, with healthcare professionals available locally to provide them. Those unable to access digital services should not fall behind or have unequal access to healthcare. Investment in technology is right, but it must be accompanied by local workforce and facilities.

Conclusion

The Government's focus on shifting care from hospital to community must not fall into the trap of centralisation by default.

There is evidence that improvements in quality and patient satisfaction, alongside some efficiencies, can be achieved in smaller services, on which some rural and coastal communities depend. Some practices and community hospitals will remain unavoidably small.

Before pursuing a 'bigger is better' narrative, commissioners should

91. Pitchforth, E. et al. (2017), Community Hospitals and Their Services in the NHS: Identifying Transferable Learning from International Developments. Health Services and Delivery Research, 5(19). Southampton: NIHR Journals Library. Available at: https://www.journalslibrary.nihr.ac.uk/hsdr/HSDR05190

92. Department of Health and Social Care (2025), Fit for the Future: 10 Year Health Plan for England. Available at: https://www.gov.uk/government/publications/10-year-health-plan-for-england-fit-for-the-future

93. Department for Environment, Food and Rural Affairs (2026), Future of Rural England Report. Published 16 July 2026. Available at: https://www.gov.uk/government/publications/future-of-rural-england-report/future-of-rural-england-report

have to demonstrate clear benefits for patients and account for the costs imposed on them and their families by larger, more distant facilities.

Continuity of Care in Rural and Coastal Communities. The unintended consequences of an urban-centred policy framework

The needs and patterns of urban settings may have helped drive the move towards working 'at scale'. This can bring benefits to providers, particularly in areas with younger populations and good transport links, where it can make economic sense to reduce duplication in premises, administration and equipment, and the associated costs. Rural and coastal communities have been expected to adapt to these models, despite differences in geography, transport links and the needs of their populations.

These communities often have older populations, more patients living with multiple conditions and less access to additional and specialist services. General practice has therefore frequently acted as a coordinator of patients' care beyond the standard GP consultation. Yet the value of continuity is rarely measured or promoted.

Continuity of care should be more clearly recognised as a strategic asset. Many rural and coastal communities have experienced continuity through a lack of alternatives, but this is also a strength that has helped make local health and social care more resilient and effective.

Defining Continuity of Care

Haggerty's taxonomy of continuity defined three forms of continuity in clinical practice:[94]

1. Relational continuity, an ongoing relationship between a patient and a clinician or stable team, built over repeated contacts.
2. Informational continuity, the use of data on past events and circumstances so care is appropriate regardless of who delivers it.
3. Management continuity, a consistent, coordinated approach across providers and time, independent of any single relationship.

This framework has subsequently been developed[95] to reflect the growing involvement of multidisciplinary teams and care delivered both in person and increasingly remotely as technology allows. Nevertheless, its core principles remain relevant: patients need those caring for them to know their history and work together consistently.

94. Haggerty JL, Reid RJ, Freeman GK, Starfield BH, Adair CE, McKendry R. Continuity of care: a multidisciplinary review. BMJ. 2003;327(7425):1219–1221. doi:10.1136/bmj.327.7425.1219.

95. Ladds E, Greenhalgh T. Modernising continuity: a new conceptual framework. Br J Gen Pract. 2023;73(731):246–248. doi:10.3399/bjgp23X732897.

Continuity has long been associated with improved patient and health outcomes. Evidence consistently links higher levels of continuity with improved patient satisfaction,[96] reduced hospital admissions[97] and lower mortality.[98] Continuity can also improve uptake of vaccination and screening programmes,[99] strengthen adherence to treatment, and facilitate earlier planning for frailty and end-of-life care. Despite the Royal College of General Practitioners and others advocating for its importance,[100] continuity continues to receive relatively little policy attention compared with other aspects of access and service delivery.

Continuity in Rural and Coastal Communities

In rural communities, relationships between patients and clinicians are often long-standing, as are the links with carers and local voluntary organisations. Together, they have an in-depth knowledge of the small communities they serve. This knowledge can help identify when early intervention is needed, anticipate future care needs and coordinate decisions around a patient's care. Here, continuity extends beyond the GP consultation. Sustaining this level of continuity can be harder at scale, with larger workforces, especially where staff turnover is high.

When there is continuity, clinicians can detect subtle changes that may only become apparent over time. This could be a gradual decline in a patient's ability to manage everyday tasks, increasing frailty or signs that a carer is becoming stressed and struggling to cope. Familiarity with a patient can reveal things that notes on a clinical system alone may not capture. Picking these up early can help patients before their needs become more difficult to manage, potentially reducing the need for urgent care, hospital admissions and social care. The sustained focus of health policy on access, whilst important, may also be contributing to weakened continuity.

Current Access Policy

Politicians and NHS policy have increasingly judged general practice by how quickly patients can obtain an appointment, shaping how services are designed and delivered around this measure.[101] The next available appointment is however not always the most appropriate, especially for patients with complex or long-term conditions. Offering an appointment with whichever clinician is available may satisfy NHS England's access requirements and be popular with patients, but it can also inadvertently undermine relational continuity, with consequences for the quality of care and patients' health over time.

Three structural and policy trends can reinforce this effect where continuity is not built into their design:

1. Workforce models favouring flexible multidisciplinary teams.[102]
2. Service consolidation into larger multi-site organisations.[103]
3. Centralisation.

This may be an efficient way to organise care, but it can mean patients

96. Saultz JW, Albedaiwi W. Interpersonal continuity of care and patient satisfaction: a critical review. Ann Fam Med. 2004;2(5):445–451. doi:10.1370/afm.91.

97. Barker I, Steventon A, Deeny SR. Association between continuity of care in general practice and hospital admissions for ambulatory care sensitive conditions: cross sectional study of routinely collected, person level data. BMJ. 2017;356:j84. doi:10.1136/bmj.j84.

98. Pereira Gray DJ, Sidaway-Lee K, White E, et al. Continuity of care with doctors—a matter of life and death? A systematic review of continuity of care and mortality. BMJ Open. 2018;8(6):e021161. doi:10.1136/bmjopen-2017-021161. See also: Baker R, Freeman GK, Haggerty JL, et al. Primary medical care continuity and patient mortality: a systematic review. Br J Gen Pract. 2020;70(698):e600–e611. doi:10.3399/bjgp20X712289.

99. Saultz JW, Lochner J. Interpersonal continuity of care and care outcomes: a critical review. Ann Fam Med. 2005;3(2):159–166. doi:10.1370/afm.285.

100. Royal College of General Practitioners. Five steps to improving continuity of care in the modern general practice. 2019. https://www.rcgp.org.uk/getmedia/d77f39b7-3745-4942-acef-20f4a3118c31/RCGP-continuity-of-care-guide-141119.pdf.

101. Department of Health and Social Care and NHS England. Better access to GPs with same-day appointments for urgent care. 24 February 2026. https://www.gov.uk/government/news/better-access-to-gps-with-same-day-appointments-for-urgent-care.

102. Royal College of General Practitioners. Fit for the Future: A vision for general practice. 2019. https://www.rcgp.org.uk/getmedia/ff0f6ea4-bce1-4d4e-befc-d8337db06d0e/RCGP-fit-for-the-future-report-may-2019.pdf.

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see someone different at each appointment and have to start again, despite what might be in their notes. In a rural community, bringing services together can also mean travelling further.[104] Patients with complex needs stand to lose the most from not seeing someone who knows them. If their health declines, any early savings may be swallowed up by the cost of the care that follows.

Continuity is not all or nothing, however. Where it isn't possible for patients to see the same clinician each time, the information and management of their care can still be joined up through shared records, good care plans and a named clinician responsible for coordination. **Continuity should be treated as a specific objective when services are designed, rather than something that happens by accident.**

Currently, access has too often been equated with speed. This may be because waiting times are easy to count and manage and also quick to be complained about. A fuller view would recognise that continuity and timely access are not at odds. Particularly for people with frailty, multiple conditions, or complex health and social care needs in rural and coastal communities continuity will have an impact on quality of care. There needs to be a broader measure for access than speed alone, which is whether patients see the right professional, who has the right information, at an appropriate time—not just how quickly an appointment was made and a patient was seen.

Whilst acknowledging that continuity is more complicated to measure, validated tools do exist to assess how well a GP surgery is performing through a 'continuity score'.[105] It could therefore be made more prominent if there is the will. Current guidance, contracts and incentives have contributed to a decline in continuity of care. If policymakers used those same levers to prioritise continuity, there is every chance of improvement.

The 2026/27 contract now requires PCNs to identify and prioritise groups of patients for continuity of care.[106] This is a welcome step, but it needs to translate into the way appointments are organised and care is measured.

Conclusion

The relentless pursuit of efficiencies from working at scale, coupled with the false economies of prioritising rapid access over continuity, risks leaving patients in rural and remote coastal areas with the worst of both worlds. Practices are pushed towards a model that does not suit their geography, while losing the continuity of care that has helped them meet their patients' needs.

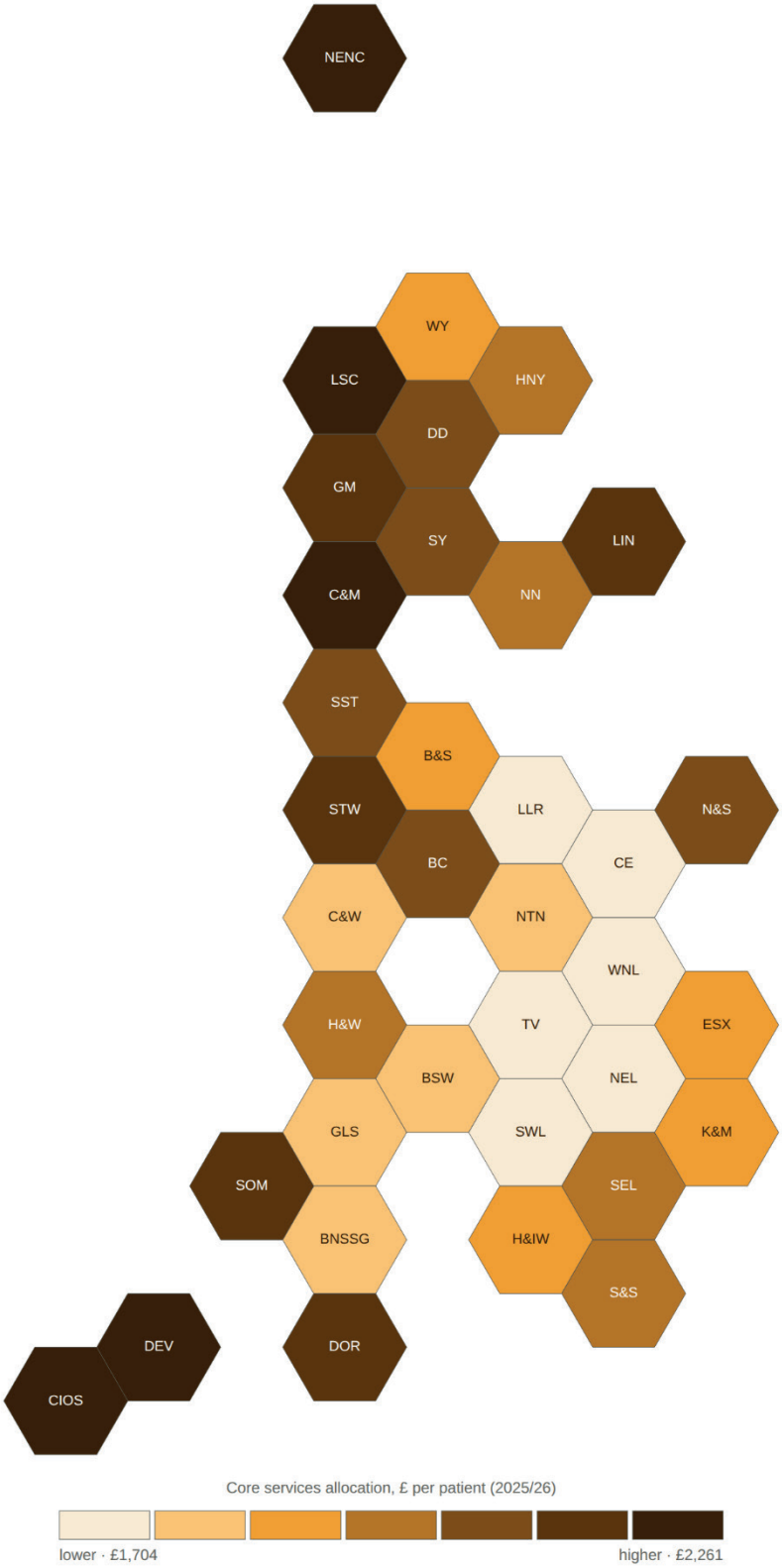
Policymakers need to recognise that rurality requires a different approach to how care is organised and funded.

104. Mungall I. Trend towards centralisation of hospital services, and its effect on access to care for rural and remote communities in the UK. Rural Remote Health. 2005;5:390. doi:10.22605/RRH390.

105. Hersch D, Klemenhagen K, Adam P. Measuring continuity in primary care: how it is done and why it matters. Fam Pract. 2024;41(1):60–64. doi:10.1093/fampra/cmad122. Measures include the Usual Provider of Care index and the Bice–Boxerman Continuity of Care index; each captures a different aspect of continuity.

106. Department of Health and Social Care. General Practitioners: Contracts. Written parliamentary answer, question 15808, tabled 3 July 2026. https://questions-statements.parliament.uk/written-questions/detail/2026-07-03/15808.

Appendix 1 NHS Funding Heatmap



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