Health Inequalities - Access to Services

Deprivation Interest Group

The Lothian Deprivation Interest Group (DIG) welcomes this opportunity to contribute to the discussion on how health services might improve access for people in deprived areas.

DIG believes that primary care has a pivotal role in addressing health inequalities. We also recognise the need to identify what resources and interventions, both universal and targeted on disadvantaged communities, are needed at the primary care level to address unmet meed and reduce the risk of disadvantaged families and individuals from preventable morbidity and premature death. Primary Care and General Practice in particular - with its patient centred approach and seeing the patient in their social context - if properly resourced, offers an ideal service environment in which health inequalities can be addressed. Tackling barriers to accessing primary care is therefore crucial.

Practical Access Problems

Transport

The findings of a community survey looking at health service utilisation in a large deprived area in northwest Edinburgh, highlights that individuals in areas of multiple deprivation identify significant problems in accessing health services. It is also clear that local GP Practices are very heavily utilised and have close ties to local communities (Nicol 2005).

Low levels of car ownership and transport problems were identified as a significant access barrier by this survey. In particular cost implications of long taxi and bus trips, which were made even more difficult for the high numbers of lone parent families who have to take children along due to lack of child care facilities. One area of particular concern was that of access to hospital ante-natal maternity services. The national confidential enquiry into maternal deaths, which examines all maternal deaths, identifies women who are socially disadvantaged as having a twenty fold increased risk of maternal mortality. Therefore, any barrier to their accessing ante natal clinics or in-patient care should be acted on as a matter of priority. Most of these maternal deaths are associated with late booking and poor attendance at ante-natal clinics. In the local survey, issues of access revolved around not only cost, but also difficulty getting taxi companies to courier pregnant women without an up-front £50 deposit for any cleaning costs that might be incurred if she were to go into labour.

This particular transport need would seem to be one that could be met with very little effort. As recommended by the Health Inequalities an Maternity Services report (Lothian Health 2003) either a contract taxi system or a token system for disadvantaged women could be established for those with

transport difficulties. Clinic support workers could also be used to promote service engagement and utilisation and to free up clinician time to concentrate on clinical issues.

Problems with transport are also significant for the elderly and ethnic minority women, including Gypsy /Travellers. Many ethnic minority women are neither able or permitted to use public transport without a male relative in attendance. Gypsy/Traveller women may be parked on roadside encampments without access to their own or public transport while their husbands / partners are working off site.

Disadvantaged individuals are not only geographically limited by transport dificulties, but they tend to be more psychologically bound to their local area often finding movement outwith this threatening. Therefore, the importance of siting services close to disadvantaged communities cannot be over stressed in addressing this important cause of inequity.

Literacy and Language

Low levels of functional literacy in disadvantaged areas is another significant barrier to access and this significantly reduces the ability of an individual to make use of the health service once accessed. This issue has training implications for staff.

There is an increasing move for hospital referral appointments to be 'opt-in', whereby patients are expected to respond to a written notification of an impending appointment. If they fail to do so, then the appointment is not issued. This once again poses problems for those with poor literacy and English language skills, who struggle to respond appropriately. More vulnerable individuals who are less likely to be in secure tenancies and have a significant re-housing rate are also disadvataged in this regard.

Both these issues could be addressed through a simple patient attendance-support worker scheme in deprived practices. This might involve training up and funding one or two GP reception staff to take on added responsibilities. Appointments for appropriate individuals could be issued via the support service who could use telephone, text or have visits to notify and remind patients of appointments. If resourced this local service could accompany particularly vulnerable patients, such as those with agorophobia, to important appointments. This would be hugely cost effective and has been successfully piloted in Westerhailes, Edinburgh.

With higher levels of ethnic minority groups in many deprived communities there is an increased need for readily accessible interpretation services. There is also an increased workload for healthcare workers when trying to work across language and cultural boundaries. This also has important training implications for not only the healthcare workers, but also receptionists. This highlights the additional training requirements of health workers working with disadvantaged groups and also the increased dificulties that these practitioners have in attending educational courses due to excessive workload

commitments (Watt et al 2005). This is one of several relevant areas where training could be enhanced through the health authorities setting up a fund to support training in deprivation related areas. This could include communication using interpreters, managing co-morbidity, signposting and inter-agency working, and alcohol or drug misuse care in general practice.

Disability

It is recognised that disadvantaged communities also have higher levels of disabled patients, particularly younger disabled. Given the increased level of transport difficulties in disadvantaged areas, these patients are often in "double jeopardy" and their long term care suffers accordingly. An increased level of district nursing focusing on chronic disease management of the disabled or house-bound would be an obvious means of meeting this need. Access to local transport service , such as contract taxi system or minibus service would also enhance the care of many isolated individuals.

Employment

There is evidence, and our experience confirms, that manual workers have increased problems getting time off work for health appointments. This no doubt reflects issues of job security, short term contracts and hourly pay (Field, Briggs 2001). Thus to reach this group more effectively GP surgery hours may need to be reviewed or supplemented with obvious cost implications and support for services required.

Cultural Barriers to Access

Traditionally practical access barriers have been identified as those amenable to change. However, if we are to move beyond these limitations then we must start to address some of the underlying cultural issues that exacerbate many access problems.

Health Beliefs

There is a growing body of literature of how more disadvantaged individuals under-estimate their health needs and tend to normalise their symptoms leading to later presentation, poorer compliance with treatment and delayed referrals to specialist services (Macintrye et al 2004). These issues of health literacy have a significant impact on health seeking behaviour and ability to utilise available services effectively. This can be further impaired by feelings of guilt due to a perception that their lifestyle has played a significant part in their ill health and worries about overuse of their GP (Richards 2002). These factors also lead to a much lower uptake of health prevention/promotion appointments or services, with a lack of basic understanding of the range of services and what and how to access them (McCormick et al 1993).

Cultural factors have an influence not only an ability or willingness to access primary care services, but also on the ability to utilise those services effectively once accessed. This second point is also influenced by the values

and cultures bound attitudes of the health care professionals. A study from the West of Scotland looking at the social distribution of mental health problems not only identified the higher morbidity rates in deprived areas, but also the shorter consultation lengths of GPs serving these communities. This increased level of morbidity, but decreased length of consultation may in part be due to the higher workload of GPs serving disadvantaged communities, but also raises questions concerning the culture of care provided, which can be significantly effected by clinician stresss (Stirling et al 2001.).

There is evidence, as highlighted by the North-west Edinburgh consultation exercise, that disadvantaged groups often access primary care, and GPs in particular, proportionally equal to more affluent groups with respected to levels of identified need. However, what the evidence repeatedly shows is that differing disadvantaged groups, though often able to access GPs, do not seem as able to maximise the utility of their contact. Thus Asian men respond appropriately to chest pain symptoms, attending their GP surgeries, but are less likely to be referred for a cardiology assessment (Heath 2001). Similarly children from ethnic minorities attend their GP appropriately for their level of self assessment health, but are less likely to receive secondary care. Again it is well documented that for elective surgery, coronary angiograph and surgery hip repairs etc less affluent patients are much less likely to get appropriate secondary care (Dixon et al 2003). This may reflect, in part, the weaker 'health voice' of some groups of patients.

Health Voice

This lack of "voice" in general seems to have various facets. In part it is lack of social networks or connectedness to influence health professionals and so limiting the ability to make effective demands.for the level of care or referral. Secondly there is the cultural and linguistic gap between the patient and health professional.

Disadvantaged groups are likely to be less articulate, less persistent in their demands and less able to "work the system" when dealing with middle class professionals. This limited "voice" allied to lower levels of health literacy represents a further double jeopardy that would seem to provide a particularly problematic barrier to access. We would suggest that this is a further example of the increased training needs of those that work with disadvantaged groups. However, it could be that this is also significant for Practices that have low levels of deprived or disadvantaged patients, as this effect of limited "voice" may be even more pronounced relative to the more affluent majority and so detrimental to the care provided.

There are two ways that the problems of "limited voice" might be addressed. One is to increase the health professionals receptiveness to that voice and the other is to amplify that voice.

The former would entail addressing issues of increased workload in deprived practices and relevant training in culturally-sensitive communication skills.

The latter would focus on increased provision of and access to local health advocacy support services for disadvantaged patients.

Conclusion

Fundamental to addressing barriers to accessing health services and so tackling health inequalities, is the need for greater health resources to be targeted on GP practices serving disadvantaged communities. The hub and spoke model, as advocated by the Deep End project, would seem to offer a realistic and effective way of taking this forward.

Lothian Deprivation Interest Group
March 2014