

Health Inequalities - Access to Services

NHS Health Scotland

NHS Health Scotland is a national Health Board, working to lead and support the translation into practical action of knowledge for reducing health inequalities and improving health. Our vision is a Scotland where everyone has access to what they need to attain the highest possible standard of personal health.

Health inequalities have increased because the health of the least deprived groups has improved at a faster rate than the most deprived. Health inequalities are strongly influenced by underlying inequalities in power, money and wealth which in turn influence access to other resources, facilities, services and opportunities. The strongest action to reduce health inequalities is to reduce inequality in economic and social conditions but action can be taken at other societal levels to prevent and mitigate the impact of inequalities on health. Effective action by the NHS includes using our research to influence policy change, partnership planning in to improve living and working conditions, focusing on the early years to maximise prevention and resilience, and mitigating the impact of inequalities on health by providing intensive or tailored support in proportion to need.

Healthcare is generally developed and delivered with an assumption of equality of provision. Access to public services and facilities has been described as a determinant of health and this suggests that inequitable distribution of service provision as a whole can be described at least in principle as a contributory factor in health inequalities. Patients come to services from different starting points and require services to be equitable, that is, to be responsive and proportionate to needs and circumstances. Initiatives such as *Have a Heart Paisley* and *Keep Well* found that greater focus and investment for groups considered by mainstream services to be 'hard to reach' resulted in increased access to the services offered. However, evidence from these and other similar initiatives within and outside Scotland has not confirmed a link between access and improved outcomes for the targeted groups (*Keep Well* impact evaluation has not yet reported). Initiatives such as these, reported from Scotland and from around the globe, generally find that despite being targeted in areas of deprivation, they tend to attract better resourced community members than the most deprived people in the community, risking an outcome of greater rather than less inequality within geographical areas.

People living in deprived areas are not a homogenous group. Population groups over-represented in deprived areas in Scotland include people with disabilities and long term health problems, people who define themselves as being not heterosexual, single parents, the majority of whom are young women, and some religious groups. Barriers to access to healthcare for small or marginalised population groups will therefore sometimes overlap with and be compounded by barriers related to deprivation. In addition, the answer to the questions posed separately about barriers for people in deprived areas

and for older people is additionally complex because both these groups are high users of healthcare and can appear to be over-represented in some services particularly in secondary care. A 'barrier' for both of these groups is often that they access services at a later stage of disease requiring more intensive and longer treatment.

The principles of access to healthcare and access to the factors contributing to health are enshrined in international human rights legislation but the Scottish Human Rights Commission (SHRC) believes that these are not translated into visible principles for practice. The SHRC found many reports of good levels of satisfaction with healthcare and good practice for improving access but they also found many accounts of barriers to access existing for a wide range of marginalised groups. Reported barriers included physical and language barriers, costs incurred in getting to or following up consultations, dismissive and discriminatory attitudes of staff, culturally inappropriate or complex services and lack of knowledge among service providers of patients' needs and rights to services. The Scottish Government inpatient survey from 2011, which drew over 30,000 responses, also found that patients with disabilities and long term health problems, communication needs and those describing themselves as not heterosexual reported poorer experiences of in patient care.

Factors found by various studies to be particularly important for access include location and distance from services, availability (for example opening hours), cultural responsiveness, levels of literacy and health literacy, social support available for the patients, and service quality such as continuity of care across or within carers. There are examples reported of specialist services for groups such as Gypsy/Travellers, asylum seekers and refugees, transgender people, homeless people and for the Roma community. Many of these services have been established in response to needs being identified through day-to-day practice by individual healthcare practitioners who then seek funding and multiagency support to develop creative and co-produced responses.

Analyses of routine data rarely lead to the development of access initiatives for marginalised groups as small population groups tend to be invisible within population databases. However, new data linkage research and new developments in routine data analysis in Scotland are offering new understandings of differential service use. For example, analyses of missed healthcare appointments (called Did Not Attends or DNAs) will report in the near future but interim results show a clear social gradient with people living in areas of deprivation more likely to default on appointments. Factors that prevented patients attending services in the *Keep Well* and *Have a Heart Paisley* initiatives included having caring responsibilities, enough time for full discussion and fear of the system.

We are beginning to build a picture of the barriers to healthcare and service responses. The big challenge is bringing this understanding of barriers and expectation of flexible or proportionate responses into mainstream services in order to achieve equity as a matter of course rather than as a series of short

lived projects. Mainstream services are planned for whole populations and can be responsive to expressed needs. Equality analyses, attention to unmet need and planning tools for equity have not yet become established as routine in NHSScotland. The potential for healthcare to strengthen its contribution to mitigating, preventing and making our contribution to reducing inequalities through equitable access has not been fully realised.

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