Access to Health Care – Taking Forward the Findings from the Scoping Exercise

Report of a rapid appraisal of stakeholder views and review of existing literature

for the Management Board of the National Co-ordinating Centre for NHS Service Delivery and Organisation

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Acknowledgements

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Aims

To make recommendations for NCCSDO on priorities for funding R & D projects into access. The recommendations take into consideration the following factors:

- views of key stakeholders in health care

- the aims and objectives of the NCCSDO

- the scoping exercise on access recently completed by King's College London for the NCCSDO (Gulliford *et al.*, 2001)

- the experience of the three King's Fund authors.

Understanding access

Both the scoping exercise from King's College and the results of interviews highlighted the complexity of the concept of access to health care and demonstrated the lack of agreement about its meaning. This is a serious problem in planning further research and we therefore present a classification of access, based on the literature, around which we structure our interview results and make our research recommendations. We believe the NCCSDO should use this four–component classification to help decide the research programme:

1 'access-entry' (i.e. access into the health system) and 'in-system access' (i.e. treatment of patients once in the system)

2 dimensions of access (including geographical, temporal, financial and other factors)

3 the influence of 'individual', 'community' and 'health service' factors on access

4   'absolute' access (determined by the overall availability of different services) and 'relative' access (i.e. experienced differently by different population groups).

It is also necessary to distinguish between access to health care, and access to *effective* health care, linking the access agenda to initiatives to improve the clinical quality of care. Thus, not all initiatives to increase access to health care will necessarily result in *effective* health care or improved health. Effectiveness also relates to the appropriateness of care, taking into account the different perspectives of community, individuals, professionals and users. The recommendation to commission work on outcomes arises as a result of these tensions.

Views of key stakeholders

Methods

Structured interviews (face-to-face or telephone) were held with 20 informants involved in policy development and/or implementation in relation to access. The majority of interviewees worked at a national level and were chosen for their ability to present an overview of current and future thinking about access. Interviewees were asked questions in the following areas:

- their understanding of access as a concept

- the main national and local policies to improve access

- national and local R & D on access

- the role of existing knowledge from research

- the major gaps in knowledge that R & D could help rectify which would be of practical use

- knowledge of the NCCSDO programme

- suggested criteria for setting priorities in R & D on access.

In addition, R & D directors from NHS Regional Offices, from the Medical Research Council, and from the ESRC were e-mailed to ask for details of current relevant research they were funding.

Findings

The research gaps identified by informants related to:

- organisational innovations to improve absolute access, including research that rapidly feeds back to managers and implementers and reflects the experiences of all involved; cross-discipline research;

- specific areas, including research on outcomes, evaluations of sustainability of current change models, and methods of change; research on workforce issues and on emergency care

- improving relative access, including research on why inequalities exist and how to measure them; research on the effectiveness of measures to reduce inequalities; and on self-care.

Other areas included:

- research on the strength of evidence for current policy initiatives; on change management strategies; and on the impact of new modes of information on health and health services.

Comparison of findings with access scoping study

We reviewed the results of the scoping exercise from King's College. Although this used a different conceptual structure from ours, there was a significant overlap in terms of priorities. The scoping study suggested a need for research in the following seven key areas, which were reflected to differing extents in the views of our informants:

1. help-seeking behaviour – the influence of 'individual' factors on access and the influence of 'health system' factors on access

2. the use of financial incentives to patients and providers to alter patterns of access and improve relative access

3. planning of services to address geographical availability, and the trade-off between equity and efficiency

4. organisational barriers to access

5. fairness in access

6. current trends in policy and service developments

7. access to dental services.

Justification for research priorities suggested

Considering the views of our informants, the scoping exercise, other sources of information and the aims of the NCCSDO, we suggest that

criteria for prioritisation of commissioned research should reflect a balance between:

- absolute and relative access and different dimensions of access
- research and development
- the objectives of the service delivery and organisation programme
- methodological rigour and the practical needs of NHS managers
- timeliness and relevance to policy makers, managers and implementers
- relevance to national policy initiatives on access
- access to different health care services.

Recommendations for further work

We recommend the following actions from NCCSDO.

1   Prioritise the research, development and information needs of operational managers involved in implementing and rolling out current policies on absolute access.

The needs of this group – a core audience for the NCCSDO – could be met through:
- methodological studies on how best to evaluate new, fast-changing management interventions[1]
- methodological support for managers wanting to evaluate organisational innovations locally
- synthesis and dissemination of existing (interdisciplinary) research on, for example, effective change management or rolling out change across multiple organisations.

A detailed discussion of how these functions may be provided is beyond the scope of this report, but our initial thoughts are for perhaps a virtual organisation or an R & D network. This would undertake a limited number of projects (8–10) per year, of relevance to multiple NHS organisations and aiming to avoid duplication of effort and maximise methodological quality.

2   Address the wider needs of policy makers and managers who are concerned with strategic development, monitoring the fairness of service provision and improving relative access.

These needs could be met through:
- methodological studies as to how best to obtain and use routine data and adjust for need when assessing equity of access to health care using routine sources of data; these studies could be focused on specific areas of care, such as dentistry or prison health, or on any of the under-privileged groups identified in the scoping exercise

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[1] Similar in some ways to the need for methodological work on the early evaluation of new clinical technologies and the need to define minimum assessment standards for early evaluations.

- primary research in three key areas:
  - identifying and developing standardised datasets for monitoring access
  - the skills needed to do different types of work in primary care
  - studies on the health impact of recent initiatives to improve absolute access.
- studies to develop and validate 'tool kits' for local organisations (e.g. primary care trusts (PCTs)) to do 'access audits' based on an agreed understanding of the different dimensions of access; a focus could be on how to monitor the implementation of the standards laid down in National Service Frameworks among deprived versus non-deprived populations.
- systematic reviews of existing literature on the nature and impact of inequalities in the doctor–patient interaction and on the content and significance of barriers to patient access to service, including variations in health-seeking behaviour in different social and ethnic groups.

These recommendations are summarised in the following table.

Summary of recommended research priorities on access to health care

	Absolute access	Relative access
Primary research	**In relation to primary care** R & D on the skills needed to do different types of work	**In relation to primary care** Barriers and incentives to recruiting and retaining staff, particularly in problem areas
	In relation to primary and secondary care Studies of the health impact of recent initiatives to improve absolute access (e.g. the impact of NHS Direct, walk-in centres, and two-week cancer waits)	**In relation to other sectors** Research to identify and develop standardised datasets for monitoring access – could be focused on key groups identified in literature review and scope: • dental access • prisons • rural health • minority ethnic groups
Secondary research	Systematic review of: • interdisciplinary literature on change management and disseminating change across multiple organisations	Systematic reviews of: • sociological literature about the nature and impact of inequalities in the clinician–patient interaction • literature on the content and significance of barriers to patients' access to services, including variations in health-seeking behaviour in different social and ethnic groups
Methodological research	Methodological studies on how best to evaluate new, fast-changing management interventions* Methodological studies on the conduct of local evaluations of organisational innovations which would also offer support to managers wanting to undertake such work	Methodological research on how best to analyse data on access *and adjust for need* Studies to develop and validate 'tool kits' for local organisations (e.g. PCTs) to do 'access audits' based on an agreed understanding of the different dimensions of access

* Similar in some ways to the need for methodological work on the early evaluation of new clinical technologies and the need to define minimum assessment standards for early evaluations.

The Report

Introduction

The aim of this short report is to make recommendations for the NCCSDO on priorities for funding R & D projects into access. The recommendations take into consideration:

• criteria for setting priorities in R & D on access, identified by key stakeholders in health care

• the aims and objectives of the NCCSDO

• the research knowledge on access as summarised in the scoping exercise completed by a team at King's College for the NCCSDO

• the experience of the three King's Fund authors.

To make recommendations, a new piece of work was needed: obtaining the views and knowledge of key stakeholders in health care. After examining the literature review from King's College it was thought that, before recommendations on R & D priorities could be made, a clearer definition of the concept of access was needed.

This report is divided into five sections.

• First, the concept of access is discussed to provide a framework for analysing the responses of stakeholders, and the knowledge on access found in the literature review.

• Second, methods and results of stakeholder interviews are described.

• Third, the scoping exercise is used to examine whether the gaps identified by interviewees are real or perceived, and to summarise key deficiencies in knowledge about access.

• Fourth, the justification for the priorities identified is presented.

• Fifth, the suggested priorities for R & D in this area by the NCCSDO programme are outlined.

Section 1 Definitions

Access to care is of fundamental importance in the NHS, since the service was founded on the principle of equity of access for equal need. Furthermore, as society changes – and the NHS with it – the public increasingly expects to receive not just fairness in access to care but prompt and convenient services.

Access is a complex concept and there has been much academic work over the last 30 years to dissect its meaning to aid researchers and policy makers. It is crucial for the service delivery and organisation programme to have a clear understanding of access as a concept before commissioning R & D on the subject. There are at least four useful ways to characterise access, outlined below. Subsections (a) to (d) below draw on the as yet unpublished work in the PhD thesis of one of the authors, Jennifer Dixon.

(Note: Points (a) to (d) should not be cited in any further publication without permission from the author; see title page for contact details.)

(a) 'Access-entry' and 'in-system access'

In brief, access to health care is viewed to be something about the way people *enter* the health care system (access-entry), and *their treatment once in the health system* (in-system access).

(b) Dimensions of access

There are various factors that are known to have bearing on 'access-entry' and 'in-system access':

- temporal (e.g. time waited)
- geographic (e.g. distance travelled)
- financial (e.g. cost of using health services)
- socioeconomic (e.g. wealth of the individual, social circumstances)
- educational (e.g. ability to understand how to enter the health system)
- language
- cultural
- gender
- age
- technological (e.g. ability to use the telephone or IT to access information).

(c) The influence of 'individual', 'community' and 'health care system' factors on access

Anderson *et al.* (1983) in the USA put forward a useful model which grouped the factors influencing access (listed in (b)) into whether they related to characteristics of individuals, of the community, or of the health care system. For example, geographic factors might relate to the individual (location of residence, use of a car), to the community (absence of public transport or local social contacts providing transport), to the health care system (location and supply of health care facilities, availability of home-based care).

Individual and community factors were further grouped according to whether they *predispose* an individual to seek care (e.g. education), *enable* an individual to seek care (e.g. possession of health insurance), or reflect the *need* of the individual for care (e.g. severity of illness). Equity of access to care is implied if the predominant factors affecting entry to care (i.e. use of health care) are *need* factors, and inequity is implied if *predisposing* or *enabling* factors determine use rather than need.

(d) 'Absolute' and 'relative' access

There are two broad approaches to thinking about access and policy:

- 'absolute' access, the absolute level of access experienced; recent policies such as NHS Direct, and walk-in centres have been designed to improve absolute access

- 'relative' access, relative levels of access experienced by different population groups; policies to address relative access include using a resource allocation formula to distribute health care resources more according to need.

Recent government policy has mainly focused on the former to produce a fast, convenient service. Policies have been directed at inpatient (e.g. waiting list, booked admissions, the work of the National Patient Access Team (NPAT), cancer collaborative), A & E, outpatient (e.g. two-week wait for suspected cancer), primary care (e.g. walk-in centres, primary care collaborative) and telephone or computerised advice (e.g. NHS Direct, NHS Direct Online). National evaluations of these policies are examining whether absolute access has improved. The two NHS Surveys of Patient Experience (for General Practice and for Coronary Heart Disease) have also sought to assess levels of access.

But much of the research community has focused on examining the latter form of access – 'relative' access or equity of access across population groups or areas. Broadly, there have been two strands of research: one using survey data, and one using routine NHS data combined with census data. The former studies have been able to adjust for need more successfully than the latter. There is no space here to rehearse the results of these studies.

Finally, it is clear that access to care cannot be measured directly. Regarding 'access-entry', researchers have argued that there are two approaches: measuring opportunity to use health care or measuring actual use of health care. For practical reasons measuring use of health care has been the more favoured approach. In 'in-system access', it is more difficult to measure, for example, whether or not a patient receives appropriate care from their GP in a consultation. Most analysis in this area is qualitative, but quantitative studies have again used measures of utilisation (for example, prescription drugs prescribed, referrals to hospital made, referrals for diagnostic tests).

Section 2 Views of key stakeholders

2.1 Rationale

It was thought important to assess the views of key stakeholders in health care, broadly to ascertain:

- how each thought of access as a concept

- what were the main national and local policies to improve access

- what national and local R & D was taking place to assess access

- what was the role of existing knowledge from research, in their view

- where were the major gaps in knowledge, which R & D could help rectify to be of practical use to managers and practitioners

- knowledge of the NCCSDO programme and suggested criteria for prioritising R & D on access.

2.2 Methods

Structured interviews were conducted with 20 people involved in policy development and/or implementation in relation to access. A list of interviewees is presented in Appendix 2 and the interview schedule presented in Appendix 3.

2.2.1 Selection of interviewees

Interviewee selection was guided by the framework presented in Figure 1. The framework aimed to incorporate all the main current strands of policy to promote access, and to ensure that the views of people working across this wide spectrum of initiatives (key policy makers and implementers) shaped the R & D priorities identified. The majority of interviewees worked at a national level and were chosen for their ability to present an overview of current and future thinking about access.

The main thrust of recent policy has been on improving 'absolute access' to health services in different ways. But several national policies include improving 'relative access' to care among their objectives, for example primary medical services (PMS) pilots and health action zones (HAZs). We interviewed three people involved in their implementation: two from local PMS pilots; and one with responsibility for the development of health action zones. Two public health specialists who had had some involvement with these policies were also interviewed.

Two interviewees were selected in response to gaps in knowledge revealed in the access scoping study, representing health care for prisoners and dental care. In addition, we were contacted by a

researcher on rural health studying access in rural communities, who was also interviewed.

The list of interviewees, and the organisations they represent, is shown in Appendix 2 R & D directors from the Medical Research Council and Economic and Social Research Council (ESRC) and from each NHS Regional Office were contacted by e-mail. They were asked if they were already funding research or development projects on 'access to care', 'inequalities' and 'change management in relation to access'. Titles were requested of any such projects being funded. These are presented in Appendix 3.

Figure 1 Summary of main policy domains and recent initiatives on access to health care that guided interviewee selection
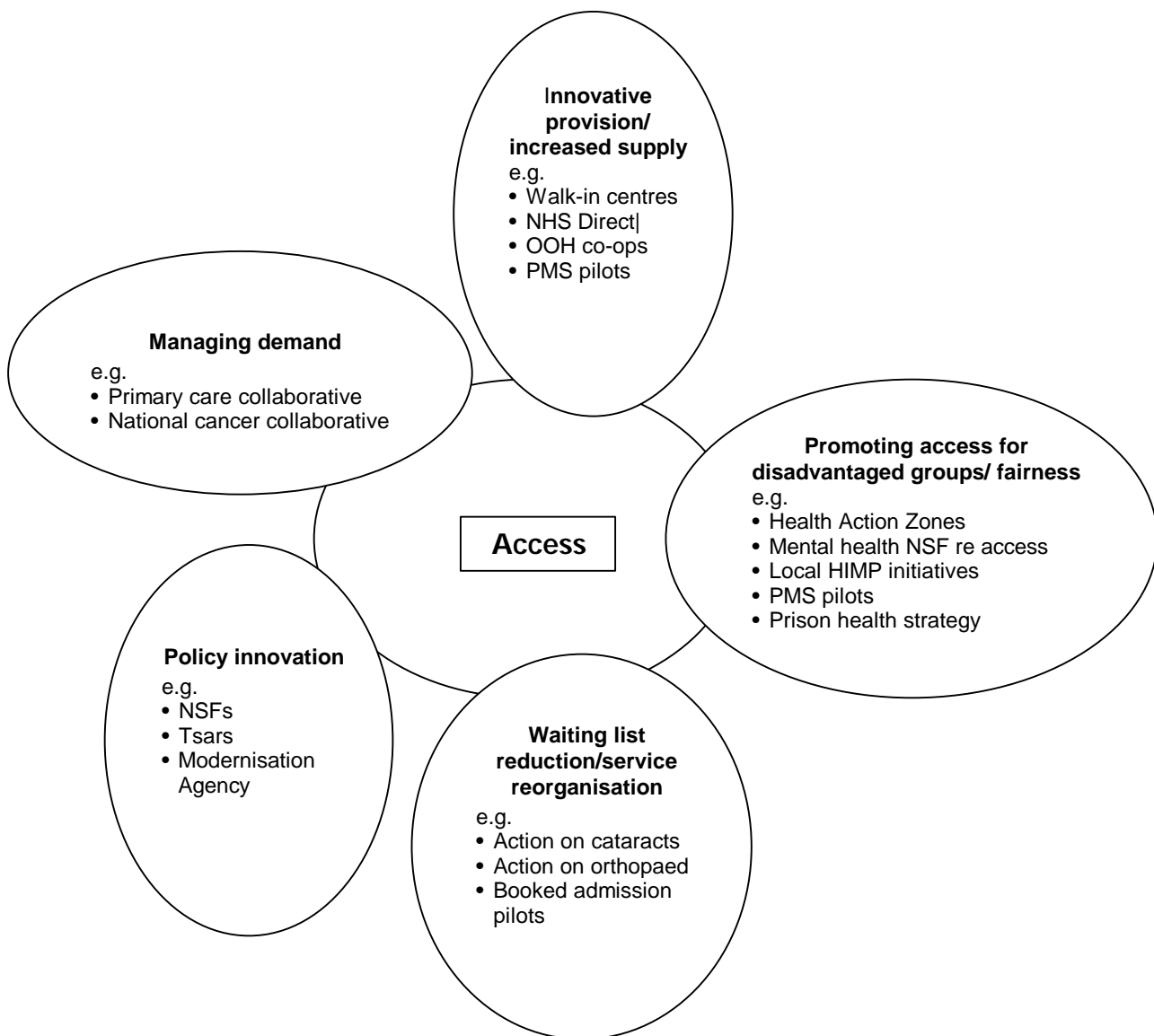
2.3 Findings

It is important to note that we did not reach saturation in capturing information from the interviews. Although common themes were evident in clusters of interviews, later interviews continued to reveal additional views on the meaning of access, the multiple factors that affect it, and the key research and information needed to improve access to care.

2.3.1 Conceptualisation of access

None of the definitions of access provided by individual interviewees captured all of the four core strands of the definition of access provided above. Individual definitions were partial, and typically shaped by the

current role of each interviewee and the objectives each was pursuing. So, for example, senior managers from the Access Task Force and National Patient Access Team described access mostly in absolute terms, emphasising the importance of timeliness, swift progress through primary, secondary and tertiary services, flexibility to fit with patient needs etc. Interviewees with public health roles and responsibilities were more likely to define access in both absolute and relative terms, linking the concept both to initiatives to increase timeliness and convenience and also to determinants of inequalities in access.

Also evident in descriptions of access were some of the dimensions of access in Section 1, but no interviewee included them all. Thus timeliness was widely mentioned because of its centrality in current policy. Cultural, demographic and geographic factors were also mentioned, but others were not.

Most interviewees understandably emphasised a notion of access to care that related to 'health system' factors (such as better supply of services, more appropriate services, better managed services to provide convenient care). However several also were concerned with the notion of 'individual' factors and access, in particular how individuals could be encouraged to access health care 'appropriately'.

In summary, key aspects of the concept of access provided by interviewees were as follows.

- *Related to 'absolute' and 'relative' access to services:*
  – on absolute access, convenience and timeliness were seen to be important
  – on absolute access, access to information as a central component
  – on relative access, equity of access was thought to be important and it was influenced by determinants of inequalities, in particular socio-demographic, ethnic, and other cultural factors; no mention was made of variation in need between social groups, or how this should be assessed.
  – on relative access, it was thought important to reduce the variability of services provided in different areas.

- *Related to dimensions of access:*
  – timeliness and convenience were most often mentioned
  – cultural, demographic and geographic factors were also mentioned.

- *On the influence of 'individual', 'community' and 'health service' factors*:

  in general, respondents focused on health service factors that could be changed to improve access; for example,

  — it would be important to provide services that were acceptable to the local community

  — it was important to reduce the variability in quality of service between areas

  but some focused on 'individual' factors such as

  — access to self-care and self-diagnosis linked to personal decisions whether to use health system or not (based on health care beliefs and culture).

- *On 'entry-access' and 'in-system access':*

  interviewees were concerned with access to the whole health care system, not just entry to it; for example, it was thought inadequate to target policies to improve access to entry points into the health system — policies must address the patient journey though the whole system (i.e. from referral through investigation to diagnosis, treatment, and after-care).

2.3.2 Current policy initiatives and ongoing evaluations relating to access

No interviewees named all the initiatives listed below, so a composite response is presented. The majority of national policies address absolute access, focusing mainly on improving timeliness and convenience for patients. The identification of projects aiming to improve relative access to care is more difficult, since there are few national policies or development initiatives explicitly addressing this area.

Most such projects — including selected PMS pilots from which we drew interviewees — are locally developed and run, contributing to a tapestry of initiatives scattered across the country, for which at least one of the aims is to improve access. Provision of a comprehensive overview of such work is beyond the scope of the current work. Two interviewees mentioned the newly formed regional inequalities task forces as examples of developments which, though not specifically about access, include improving access among their aims. Table 1 summarises the main current policies and service developments relating directly to improving access to health services.

Table 1 Summary of recent national initiatives on access to health care and associated evaluations

	Initiative	Facilitating body/organisation	Evaluation* by:
1	Access targets (outpatient and inpatient)	National and Regional Access Task Forces	
2	Waiting list reduction	Modernisation Agency	
3	Regional implementation of NHS Plan		
4	Emergency care in A & E	National Patient Access Team	Department of Health-funded evaluations by HSMC, University of Birmingham (on cancer and orthopaedic collaboratives and booked admissions)
5	*Action On* programmes		
6	Booked admissions scheme		
7	Collaboratives (cancer and primary care)		
8	Work with performance-challenged clinical departments and hospitals		
9	Walk-in centres		Department of Health-funded evaluation
			National: University of Bristol
			Local: at each walk-in centre
10	NHS Direct		Department of Health-funded evaluation
11	NHS Direct Online		Sheffield University, ScHARR
12	National Service Frameworks	Tsars	
		Modernisation Agency	
13	Dental access centres		HSMC, University of Birmingham
14	Primary Medical Services (PMS) projects		King's Fund/National Primary Care R & D Centre, University of Manchester
			University of Birmingham
15	Selected activities within Health Action Zones		University of Kent
16	Equalities task forces (through Regional Offices)		

*   Evaluation here means national evaluation by independent organisations. All initiatives are monitored to a greater or lesser extent by the NHS Executive and local NHS organisations.

2.3.3 Role of existing research

Mixed views were evident about the role of existing research in shaping current policy on access. Research was seen by many interviewees to have had only limited impact, competing particularly with political imperatives for influence on policy. Overall, comments reflected what is now well known about the complex relationship between research and policy. Thus, three people referred to the National Survey of NHS Patients (General Practice) as a form of research that had informed the government's commitment to improving access but had not directly influenced any specific policy. One (public health) interviewee noted that the plethora of academic research on, for example, gender difference in access to cardiac care, contributes to our background understanding about relative access without necessarily influencing specific policies. In contrast, a senior manager from NPAT argued that the organisational redesign initiatives they are promoting are based on well-researched theories from organisational and change management studies.

There were specific complaints from three interviewees that there was insufficient research to assess the impact of specific, and currently high-profile policies on health outcomes and demand for services, for example, the two-week waiting times for cancer investigation and treatment and the extension of NHS Direct to include outreach work and walk-in centres.

Over half the interviewees commented on the problems of using routine NHS data to monitor and/or evaluate access. Problems noted include inaccuracy of the data, the lack of data (e.g. nothing on occupational therapy and physiotherapy), and the lack of consistently collected data (e.g. no routine dataset in general practice, outpatients and A & E). People also noted a lack of skilled individuals able to analyse and interpret data, and a lack of knowledge of existing work (methods and results) by those commissioning studies locally, with the combined result of much duplicated effort on small local surveys in multiple health authorities and primary care groups and trusts (PCG/Ts), of varying methodological quality.

2.3.4 Gaps in current research/information about access

Once again, each interviewee described a different cluster of gaps in research and other forms of information. The following is a summary of gaps mentioned by at least three interviewees.

(a) *Gaps relating to organisational innovations to improve absolute access*

General approach to research:
1 research that adequately integrates expectations and requirements of all those affected by the study – specifically patients, clinicians, managers and policy makers
2 research that allows rapid feedback of findings to managers/implementers (action research)
3 reviews of literature on important topics covering a number of disciplines.

On specific areas:
4 evaluations of the impact of organisational innovation on patient outcomes
5 evaluations of (sustainability of) current change models (collaboratives and booked admission schemes etc.)
6 research to deepen understanding of how to achieve change, motivate professionals and spread learning
7 R & D into workforce issues – the employment and retention of staff to increase access (especially in primary care in inner cities); developing the roles of primary care staff
8 emergency care – how different providers (out-of-hours co-operatives, NHS Direct, primary care, and casualty care) should develop, what they should each deal with and how they fit together; how to reduce waiting times.

(b) *Gaps relating to improving relative access*
1 Why inequities exist and how best to measure them. Methodological studies on how to capture, synthesise, analyse and interpret NHS and other routine information sources in order to describe access in terms of service use (especially in the areas of primary care, hospital care, dental care, care in rural areas, health care for prisoners).
(No reference was made here to a key concern in the literature – how to adjust adequately for need in analysis.)
2 What works to reduce inequities in access, in particular in reducing geographical inequity in provision of primary care.
3 Self-care and understanding patient behaviour regarding self-management, in particular population groups.

(c) *Other research/information/development gaps, mentioned by one or two interviewees*
1 The strength of the research evidence for current targets and policy initiatives – e.g. two-week waits, NHS Direct and walk-in centres.
2 The effectiveness of different change management strategies for PCG/T chief executives to achieve change across a cluster of local organisations (GP practices).

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3 Understanding changes in access to, and use of, information on health and health services. For example, the impact of recent policies such as NHS Direct and NHS Direct Online, and of emerging Internet information sources on equity of access.

It is important to note that the gaps described here reflect the particular perspectives of interviewees selected for their knowledge of and involvement in current policy on access.

2.3.5 Future developments in access to health care

Not all interviewees commented on potential future developments in access. Some felt that future policy would be trying to tackle 'more of the same' issues as at present, i.e. absolute access with an emphasis on timeliness and convenience. Others focused on the access to information and possible changes in the way people use health services:

- use and impact of IT-based information and advice services as a potential additional first line of access to primary care

- in relation to dentistry, how improvements in the dental health of young people will affect their use of dental services.

2.3.6 Knowledge of NCCSDO and criteria identified for prioritisation of research topics

Six (out of 18) interviewees had not heard about the NCCSDO research programme. One (a hospital chief executive/regional Access Task Force lead and an academic) had heard of the programme but had not seen any of its outputs.

Collectively, the criteria suggested by interviewees for prioritising research topics reflected what is currently known about promoting the link between research and policy. Four interviewees stressed the importance of presenting research priorities in the context of a clear definition of the meaning of access. These priorities are listed below, using the definitions presented in Section 1.

- *Relevance*
  Should focus on main current policy initiatives. Should not neglect 'relative access'.

- *Timeliness* (of results)
  Ensure results can feed into ongoing policy development – a one-year time frame for some studies was suggested by two interviewees.

- *Pragmatism*
  R & D work commissioned should fulfil the NCCSDO objective of producing material that is useful to managers and implementers.

- *Design*
  There were mixed views on the balance between academic rigour and short-loop feedback action research, and between methodological or evaluative research and developmental projects.

- *Integration of patients' priorities*
  Topics should reflect the priorities of patients in as much as they differ from professional ones.

- *Development and dissemination*
  Current knowledge on a specific topic (including knowledge from other disciplines) should be drawn together and disseminated.

Section 3 Comparison of findings from interviews with main messages from the review by King's College

In this section we attempt to compare the gaps identified by interviewees (Section 2.3.4) with the research recommendations made by the researchers at King's College London (KCL). Are the gaps identified in our work supported by KCL's recommendations? Have our interviewees made suggestions that are in fact already addressed in the literature? This would suggest a need for better dissemination of existing knowledge rather than further research. Does the KCL report make suggestions that are not echoed in the comments of our interviewees? The differences between the two sets of findings reflect the fact that the KCL work, while being very comprehensive, was weighted by the published research literature which inevitably reflects fewer of the very current policy concerns expressed by our informants.

Also, although the KCL work is not framed around the particular definition of access we use in this report (notably the key distinction between absolute and relative access), nevertheless it does cover similar territory. In the paragraphs below we take the headings used in the summary of the KCL report, and try to frame the ideas they encapsulate in our concepts of access.

The KCL report suggested research should be carried out in seven key areas, which are described in Sections 3.1 to 3.7.

3.1 Patients' help-seeking behaviour

3.1.1 The influence of individual factors on access

Research into help-seeking behaviour by patients was suggested by both KCL's and our informants ((b)1, (b)3). Further research in this area should reflect the large body of knowledge that already exists. The KCL report saw this area as relevant both to absolute access (e.g. to A & E) and relative access (e.g. nurse-run clinics and NHS Direct for different ethnic groups).

3.1.2 Help-seeking behaviour — the influence of health system factors on access

A & E was a specific research priority from KCL's work, reflecting concerns about appropriateness of services with respect to patients' needs and demands. Our interviewees also supported research analysing the appropriateness of NHS services for self-care and self-management ((b)3).

3.2 Use of financial incentives to patients and providers to alter patterns of access (ultimately to improve relative access)

This recommendation was not reflected in our interviews, perhaps because financial incentives (particularly for users – in order to change help-seeking behaviour) do not play a significant part in many current initiatives to improve access in which our informants are involved. However, a number of financial incentives for providers have been announced recently with a view to increasing relative access to primary care (e.g. incentives to GPs to work in more deprived areas). The impact of such incentives should be monitored. Our interviewees did suggest the need for research into how to motivate professionals to achieve change ((a)5, (a)6) – which would include financial considerations – as well as research aimed at improving the equality of distribution of primary care resources (a7), but not specifically through the use of financial incentives.

3.3 Planning of services to address geographical availability and the trade-off between equity and efficiency

This priority was reflected in the views of our informants concerning inequalities in the distribution of primary care resources ((a)7) leading to differences in relative access, as well as the gap identified in knowledge about which interventions 'work' to reduce inequities in use ((b)2) which could include measures to plan services to reduce geographical inequalities. Our informants did not suggest research into users' views to look at underlying values and trade-offs around rationing.

3.4 Organisational barriers to access

This area is reflected in several of the gaps identified by our informants, particularly concerning recent innovations in the health system to improve absolute access, specifically in the dimension of timeliness of care. Suggestions to evaluate the impact of such innovations on outcomes ((a)4), research on the rationale for particular targets such as the two-week wait for cancer investigation and treatment ((c)1), research on the sustainability and spread of particular approaches ((a)5 and (a)3), and into methods for rapid feedback of results for those implementing change ((a)2, (a)6), are all coincident with recommendations by KCL. Suggestions made by our informants but not specifically mentioned in the scoping exercise include research on effective change management ((c)2), but this is probably best seen as a generic issue rather than specifically linked to access. The scoping exercise suggests a need for research into demand management, particularly to reduce queues for treatment, coinciding with our informants' suggestions for research on self-care and self-management ((b)3).

3.5 Fairness in access

The suggestions of the scoping exercise in this area focus on monitoring access for ethnic minorities and other deprived groups, and ways to make the service more accessible to these groups. Several of our informants made suggestions for research on relative access which coincide with these priorities, including methodological research into using routine NHS data to monitor inequalities in service use ((b)1) and monitoring arrangements that need to be set up to monitor access to information via new technologies ((c)3).

3.6 Current trends in policy and service development

The scoping exercise makes some general comments about the need to evaluate recent developments aiming to increase absolute access in terms of timeliness (e.g. NHS Direct and walk-in centres). Among the more specific suggestions that are also reflected by our respondents are the need for research into human resources, and organisational and role flexibility ((a)8, (a)7) and into relative access issues such as socio-cultural barriers to care ((c)3) after organisational innovation. The scope's suggestion of the need for research into the organisation of primary care to improve access was also reflected in our interviews ((a)7).

3.7 Access to dental services

The scoping exercise proposed several dental research priorities including the drift away from NHS provision and problems with both absolute and relative access. Our informants identified a need to monitor use of dental services by different groups, reflecting the concern about relative access ((b)1).

Section 4 Justification for research and development priorities identified

4.1

It is evident from our interview findings and the summary of the scoping study that there was no shared framework or taxonomy for considering access. Attention is therefore drawn to the definition of access presented in Section 1, combining the concepts of absolute and relative access with considerations of different dimensions of access, and whether the factors or initiatives to improve access focus on the health system (which they do in the main) or the individual or even the community. Although the boundaries are often blurred, we argue that the concept of absolute access is most closely related to current national policy initiatives 1–13 in Table 1, and relative access to initiatives 14–16. The recommendations that follow reflect the broad definition of access presented above.

4.2

There is considerable overlap between the gaps revealed in the KCL scoping exercise and those identified by interviewees. The scoping study also identified established bodies of literature in areas where interviewees described knowledge gaps, raising important questions about the dissemination of knowledge about access to care, a subject to which we will return later.

4.3

The interviews revealed clear differences in research and information needs identified by people working to improve absolute access (NPAT, Access Task Force, collaboratives etc.) and those focusing more on relative access. The needs of the former group reflected an operational agenda, in particular the desire rapidly to evaluate the impact (on process and outcome) of organisational redesign and to feed back learning to achieve change. They also identified 'generic' (relevant to areas other than access) needs about evidence for effective change management strategies, motivating professionals, and sustainable change.

The concerns of the latter (relative access) group reflected more of a research agenda, in particular:

- data limitations (inability to adjust data adequately for 'need' – although this was not explicitly mentioned)

- ignorance about the research findings of existing work examining relative access

- the lack of information on the effectiveness of interventions to reduce inequities

- deficiencies in our understanding of the health-seeking behaviour of individuals and specific population groups.

4.4

The demand from several managerial interviewees – a core constituency for research into service delivery and organisation – for iterative studies to evaluate the effectiveness of organisational innovations (collaboratives, booked admission schemes) and of knowledge dissemination processes reflects findings of the NCCSDO listening exercise but creates a conundrum. Such work must be timely and able to adapt its methods as the innovations themselves adapt and evolve. Yet evaluation of the impact of such initiatives on patient outcomes requires rigorous methodological standards and longer-term designs which are incompatible with the needs of the managers who are leading these changes. A clear distinction is needed between developmental evaluations and action research projects which meet these (and other) needs and methodologically rigorous research to evaluate the impact of such innovations on clinical outcomes.

4.5

The recommendations made here aim to reflect the points raised in interviews and to integrate them with findings of the scoping exercise and with our own knowledge and experience of research and practice on access to health care. In addition, we have tried to integrate them with the aims of the NCCSDO. We have thus attempted to achieve a balance between:

- projects addressing absolute and relative access
- NCCSDO aims to
  – commission research and development
  – develop an evidence base for managers
  – develop R & D methodologies
  – disseminate knowledge
- methodological rigour and the practical information needs of NHS managers
- timeliness and relevance to policy makers, managers and implementers
- relevance to national policy initiatives on access and other issues
- access to different health care services.

Section 5 Recommendations for research and development priorities

Our recommendations to NCCSDO are as follows.

1   Prioritise the research, development and information needs of operational managers involved in implementing and rolling out current policies on absolute access.

The needs of this group – a core audience for the NCCSDO – could be met through:

- methodological studies on how best to evaluate new, fast-changing management interventions[2]
- methodological support for managers wanting to evaluate organisational innovations locally
- synthesis and dissemination of existing (interdisciplinary) research on, for example, effective change management or rolling out change across multiple organisations.

A detailed discussion of how these functions may be provided is beyond the scope of this report, but our initial thoughts are for, perhaps a virtual organisation or an R & D network, combining the skills and knowledge of specialists in health services research (HSR), organisational research/diffusion science, health care evaluation etc. The virtual group or network might work in partnership with, for example, the Modernisation Agency or the Commission for Health Improvement. It could undertake a limited number of projects (8–10) per year, selected for their general relevance to multiple NHS organisations, with the specific aim of avoiding duplication of effort and maximising the methodological quality of work undertaken in a short time frame.

This suggestion would address the need identified by many interviewees for practical developmental support for access initiatives, while also improving the evidence basis of such projects. It would also provide the national focus that the subject deserves, could raise the national profile of the SDO, and could provide a critical mass for partnership working at a national level with national stakeholders such as the Commission for Health Improvement and the Modernisation Agency.

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[2] Similar in some ways to the need for methodological work on the early evaluation of new clinical technologies and the need to define minimum assessment standards for early evaluations.

2　Address the wider needs of policy makers and managers who are concerned with strategic development, monitoring the fairness of service provision and improving relative access. These needs could be met through:

- methodological studies as to how best to obtain and use routine data and adjust for need when assessing equity of access to health care using routine sources of data; these studies could be focused on specific areas of care, such as dentistry or prison health, or on any of the underprivileged groups identified in the scoping exercise

- primary research in three key areas
  - identifying and developing standardised datasets for monitoring access
  - the skills needed to do different types of work in primary care
  - studies on the health impact of recent initiatives to improve absolute access

- studies to develop and validate 'tool kits' for local organisations (e.g. PCTs) to do 'access audits' based on an agreed understanding of the different dimensions of access; a focus could be on how to monitor the implementation of the standards laid down in National Service Frameworks among deprived versus non-deprived populations.

- systematic reviews of existing literature on the nature and impact of inequalities in the doctor–patient interaction and on the content and significance of barriers to patient access to service including variations in health-seeking behaviour in different social and ethnic groups.

Table 2 Summary of recommended research priorities on access to health care

	Absolute access	Relative access
Primary research	**In relation to primary care** R & D on the skills needed to do different types of work	**In relation to primary care** Barriers and incentives to recruiting and retaining staff, particularly in problem areas
	In relation to primary and secondary care Studies of the health impact of recent initiatives to improve absolute access (e.g. the impact of NHS Direct, walk-in centres, and two-week cancer waits)	**In relation to other sectors** Research to identify and develop standardised datasets for monitoring access – could be focused on key groups identified in literature review and scope: • dental access • prisons • rural health • minority ethnic groups
Secondary research	Systematic review of: • interdisciplinary literature on change management and disseminating change across multiple organisations	Systematic reviews of: • sociological literature about the nature and impact of inequalities in the clinician–patient interaction • literature on the content and significance of barriers to patients' access to services, including variations in health-seeking behaviour in different social and ethnic groups
Methodological research	Methodological studies on how best to evaluate new, fast-changing management interventions* Methodological studies on the conduct of local evaluations of organisational innovations which would also offer support to managers wanting to undertake such work	Methodological research on how best to analyse data on access and adjust for need Studies to develop and validate 'tool kits' for local organisations (e.g. PCTs) to do 'access audits' based on an agreed understanding of the different dimensions of access

*   Similar in some ways to the need for methodological work on the early evaluation of new clinical technologies and the need to define minimum assessment standards for early evaluations.

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Appendices

Appendix 1 Executive Summary from report of scoping exercise *Access to Health Care*

Introduction and aims

This report summarises the findings of a scoping exercise commissioned by the newly established NHS Service Delivery and Organisation (SDO) R & D Programme. The report aims to provide a 'conceptual map' of key issues in access to health care.

Methods

The work was carried out by a multidisciplinary team. We searched electronic databases, consulted with researchers in relevant fields, and contacted key stakeholders in the NHS and in patient, professional and charitable organisations. The findings were synthesised into a narrative review which first discussed a definition of 'access to health care' and then identified seven key areas for future research. Research recommendations are divided into those for methodological, secondary and primary research. The priorities to which we attach greater importance are identified in bold type.

The scoping exercise was completed in three months and it therefore provides only a brief overview of some of the most relevant issues. There are large volumes of literature in many of the key areas which need to be reviewed more systematically.

Definition of access to health care

Facilitating access is concerned with helping people to command appropriate health care resources in order to preserve or improve their health. There are at least four aspects.

1   If services are available, in terms of an adequate supply of services, then a population may 'have access' to health care.

2   The extent to which a population 'gains access' to health care also depends on financial, organisational and social or cultural barriers that limit utilisation. Thus utilisation is dependent on the affordability, physical accessibility and acceptability of services and not merely the adequacy of supply.

3   The services available must be relevant and effective if the population is to 'gain access to satisfactory health outcomes'.

4   The availability of services, and barriers to utilisation, have to be evaluated in the context of the differing perspectives, health needs and the material and cultural settings of diverse groups in society.

Patients' help-seeking behaviours

There is evidence of a significant mismatch between professional expectations, patients' needs and patterns of uptake of services. This is exemplified by the low uptake of preventive services by some groups, the delays in accessing care for serious conditions, or over-utilisation of emergency services for what is deemed medical 'trivia'. Current policy responses have shifted from trying to change people's behaviour, to trying to address users' concerns more appropriately through new forms of service provision. However, there is fairly limited evidence of the influence of psychosocial factors and health beliefs on consumers' patterns of service use, and more information is needed to inform the delivery of care. There are particular problems in gaining access to health care for marginalised groups, including homeless people, new immigrant groups and institutionalised populations. The needs and concerns of these groups need to be studied more thoroughly and locally based initiatives require reviewing to develop transferable models of care.

Methodological research

- **There is a need to develop better methodologies and instruments for eliciting patients' views of services.**

Secondary research

- **There is a need for systematic reviews of the content and significance of barriers to patients' access to services including variations among different social and ethnic groups, leading to longer-term primary research.**

Primary research

- **More information is needed about health beliefs and patients' worries in relation to common medical conditions and for this to inform provider—patient communication, thus increasing the acceptability and effectiveness of new forms of primary care services.**

- **Evidence is needed on registration with primary care and the uptake of preventive services by mobile populations (including refugee and asylum seekers, homeless and new immigrants) in inner city areas to establish rates of utilisation and thus assess the extent of unmet need more accurately.**

- Information is needed on the perceived acceptability and accessibility of health care by institutional populations, especially elderly people in residential accommodation, and for the evaluation of different models of primary care delivery.

- **There is a need to conduct second-wave evaluations of new forms of primary care services (e.g. nurse-run clinics and NHS Direct) focusing on groups with particular needs, such as parents of young children, older people, or marginalised groups, to examine issues of uptake and satisfaction with services and outcomes of care.**

- There is a need for the audit of the appropriateness of use of accident and emergency departments using common criteria as a basis for planning the development of primary care services within A & E departments.

Financial incentives to patients and providers

Financial factors may encourage or inhibit patients' use of services, and may also encourage or discourage the provision of services. There is evidence to show that prescription charges are negatively associated with the uptake of prescription medicines but there is little evidence for effects of user charges on access to primary care services more generally. The indirect costs of utilising health care may act as a barrier to access, especially for more deprived groups and in rural areas (see next section). Some evidence suggests that different payment systems affect the provision of services (in particular target payments and per-item fees), but the evidence is limited and it is difficult to generalise from these results. There is little evidence from the UK on the impact of different reimbursement methods on provision and utilisation of hospital services.

Primary research

- There is a need to research and evaluate whether the evidence from the study of prescription charges also applies to other items of care, especially primary care services.

- More evidence is needed on the general impact of financial incentives in the NHS – for example, whether financial incentives can be used to modify patients' uptake of services. The implications for different socioeconomic groups should be evaluated.

- **More research evidence is needed on how different methods of paying general practitioners influence quality of service and patients' access to care.**

- **Consideration could be given to piloting different payment systems in order to provide incentives to different stakeholders.**

Planning the availability of services

Rationing

Resources are limited and decisions to limit access to services are taken at different levels and in different contexts. Rationing decisions should ideally be explicit and related to the objectives of the health service. In general, there will be a trade-off between equity and efficiency, such that achieving greater equity will be associated with lower efficiency. This is because achieving greater equity will often result in utilisation of services by those with lower capacity to benefit.

Resource allocation

There has been a great deal of work both to develop and evaluate formulae to allocate resources to health authorities but there is a lack of transparency in the allocation of resources to different client groups and services. Geographical inequalities in service provision remain important and this is especially true for primary care services.

Service configuration and organisational change

Problems of access in relation to the location and configuration of services have been the subject of much work, especially for rural areas. In general, the distance from a service is inversely associated with utilisation, especially for specialist services, but travel time, costs and availability of reliable transport are often more important than physical distance per se. Current policies favour the centralisation of specialist services in order to deliver higher-quality care and better health outcomes, but the evidence to support this approach is limited and inconsistent. There is much activity to reconfigure services but there is little evidence for the impact of organisational changes on access to care.

Methodological research

- **There is a need for a methodological review to provide advice on the use of geographical methods and models in the evaluation of access to health care.**

Secondary research

- There is a need to consider how cost-effectiveness analysis fits with considerations for equity and access.

- Research needs to consider the different values used in health care decisions and the ways public, patient and professional values and views should be elicited and fed into the decision-making process.

- **A review is needed of existing evidence on the effects of distance and geographical configuration of services on access to different levels of care.**

Primary research

- **The consequences for access and quality of different geographical configurations of services need to be evaluated, as do the effects of changes in service configurations brought about by mergers or centralisation of services. There is a need to evaluate the trade-off between geographical equity in access and the efficiency and outcomes of services.**

- The effects of changes on the supply side on demands for services need to be evaluated.

Organisational barriers to access

Organisational barriers are important in determining the timeliness and acceptability of care. At primary care level, problems are experienced in registering with GPs, obtaining a timely appointment, or accessing advice out of normal working hours. At secondary level, there are long waiting lists and waiting times for elective hospital care, but there is less evidence available on the value of reducing waiting times for different conditions, or the effectiveness of strategies to reduce waiting times. There are problems in accessing acute hospital beds, especially during the winter.

Organisational barriers result from lack of capacity and inefficient use of existing capacity. Services are seldom designed from the patient's perspective. Some of these problems are being addressed through initiatives included in the NHS Plan, and through the work of the National Patient Access Team.

Primary research

- **Research is needed to determine whether patient outcomes deteriorate while waiting for treatment for different conditions, and at what rate. Evidence is also needed on optimal times to treatment for different conditions.**

- Information is needed about the factors that determine the success or failure of attempts to reduce waiting times. The contributions of inadequate capacity and inadequate management of existing capacity to long waiting times need to be clarified. We need to know about the generalisability of success stories.

- The ways in which diagnostic and therapeutic procedures can be organised into pathways that will optimise patient flows need to be evaluated.

- Research to define explicit treatment thresholds in different conditions may be useful as an aid to reducing variability in hospital utilisation rates.

- **There is a need for research on the ways that demand for services may be managed so as to reduce queues for treatment. Possible interventions include providing information or guidelines to providers and the public, to inform decisions on utilisation of primary, emergency or specialist services.**

Fairness in access

It is well known that there are substantial inequalities in health and health care utilisation in Britain. Fewer studies have allowed for differences in needs, but there is evidence of inequity in access in relation to place of residence, socioeconomic status, ethnic group, age and gender.

Methodological research

- **Methodological guidelines for evaluating equity in health services are needed.**

Secondary research

- **There is scope for a systematic review to identify potential areas where interventions to improve access may impact on inequalities in health.**

- There is a need to systematically review existing evidence on access to health care for ethnic minority groups. A review needs to address the main health needs of different groups, the available information on access and utilisation of services, and the evidence for different intervention strategies.

Primary research

- **Research is needed to identify interventions through health services that can promote and protect health for deprived social groups. In other words, what can the NHS do to deliver access to better health outcomes in deprived populations?**

- Primary research is required to improve access to culturally appropriate services for ethnic minority groups, particularly high-quality primary care services in inner city areas.

- **There is a need for research to evaluate discrimination and perceptions of discrimination in service delivery in the NHS, from the perspective of both patients and staff.**

- **In view of apparent discrimination against older people, the appropriateness of clinical decisions for older people needs to be examined carefully.**

Current trends in policy and service development

The NHS Plan provides a framework for service development which includes many innovative strategies to improve access to primary care, and across the primary–secondary interface. This innovative work implies a large agenda for evaluation. Evaluations of new services should consider the issues raised in previous sections of the report, and should consider not only measures of clinical and cost-effectiveness but also patients' perceptions of their needs and the financial, organisational and social/cultural barriers to care. The needs and perspectives of different groups should be evaluated in the context of inequalities in health and health care utilisation. The influence of the availability and configuration of new services on access and utilisation should be considered, especially in areas with special problems such as inner cities and rural settings.

Primary research

- **There is a need to evaluate new strategies to improve access including, for example, community pharmacies, walk-in clinics, or telephone advice lines.**

- **The development of intermediate care requires evaluation.**

- Strategies for information provision need to be informed by evidence on people's information needs and the effectiveness of different ways of presenting information.

- There is a need to provide generalisable evidence on methods of organising primary care services so as to facilitate registration with the GP of choice, with timely scheduling of appointments, and accessible out-of-hours advice.

- Evaluation is also needed at the primary–secondary interface to evaluate methods for improving access to elective and acute hospital services.

Access to dental care

There is an apparent drift away from NHS dentistry leading to a service which is 'patchy and unreliable'. Basic information on office hours, waiting times, cost, quality and availability of services is not available. Only limited evidence is available on the effectiveness of measures to improve uptake, such as the use of reminders of the need for check-ups. There are substantial inequalities with respect to need and uptake, but virtually no information with respect to marginalised groups.

Secondary research

- There is a need to review the evidence in relation to methods for improving access to dental care.

Primary research

- Alternative methods for measuring access to dental services need to be developed.

- The current government strategy has resulted in a number of innovative structures designed to improve access to dental services. There is a need to evaluate the impact of these arrangements on access.

- There is a need to evaluate the implications of innovative information sources for access to dental services.

- **We need to know more about the decision to utilise private dental services. To what extent do services lead demand and what is the role of patients' preferences?**

- **Work is required to evaluate the needs and service perceptions of marginalised groups, and the professional barriers to the development of services for these groups.**

- There is a need to evaluate the uptake of dental care in systems with different payment mechanisms.

- There is a need to develop and evaluate methods to address inequalities in oral health and utilisation of dental services.

Conclusions

A consistent theme running through this report is a concern to ensure that health care resources are mobilised to meet the needs of different groups in the population. Thus equity is a key indicator of 'access', whether access is measured in terms of health service availability, health service utilisation, or health care outcomes. There may be a tension between the desire to provide universal standards, in contrast with the recognition that different groups have different priorities and values in health care. A primary objective for researchers is to make explicit the consequences of different strategies in the provision of health care in order to inform policy decisions.

Appendix 2 List of interviewees

	Name	Telephone/face to face
1	Barbara Stocking Modernisation Agency	Face to face
2	Sue Jennings National Patient Access Team	Face to face
3	Helen Bevan National Patient Access Team	Face to face
4	Mike Pringle Royal College of General Practitioners	Face to face
5	Chris Reed National Access Task Force	Face to face
6	Jocelyn Cornwell Commission for Health Improvement	Telephone
7	Cliff Howells Prison Health Directorate	Face to face
8	Alan Glanz Policy Research Programme	Telephone
9	Nick Hicks (in place of Simon Stevens) (Richmond House)	Face to face
10	David Pencheon University of Cambridge	Telephone
11	Peter Sheridan Director of Public Health, East London and City Health Authority	Face to face
12	Sue Atkinson Regional Director of Public Health, Thames Regional Office	Face to face
13	Chris Dowse National Health Action Zone Team	Face to face
14	Paul Batchelor Eastman Dental Hospital	Face to face
15	Philip Brigham University of Plymouth	Telephone
16	Michael Scott Chairman, Thames Access Task Force	Telephone
17	Jane Schofield Greenwich PCT, North Lambeth PMS Pilot	Face to face
18	John James Isleworth PMS pilot	Face to face

E-mail communication with: Joan Box, Medical Research Council; Chris Caswell, Economic and Social Research Council; all NHS Regional Directors of R & D

Appendix 3 Questions for access interviews, March/April 2001

1 Conceptualisation of access

- What do you understand by the term access?

- What aspects of access are you currently working on?

2 Current policies/development concerning access

- (Thinking beyond your own work …) What do you see as the main *current* policies and developments which are designed to improve access?

- Where do you think are the main gaps?

3 Future policy on access

- What do you see as the key factors that will affect access of the public to health care in the future?

- What policies are emerging or need to be developed to influence access to health care in the future?

4 Role of existing research

- To what extent do you think existing R & D (or other forms of knowledge) about access has shaped the work you and your immediate colleagues are currently doing?

- If R & D has had an effect, which source of information was most useful?

- If R & D has not had an effect, why not?

- Do you think R & D on access will have any more or less influence on your work?

5 Map views on research/evaluation in progress

- Is there any research underway to evaluate the developments in which you are personally involved?

- If so, which dimensions of access they exploring?

- What do you think about the research – for example, the appropriateness of methodology, quality of execution, timing of results?

- Are you aware of other research studies on other major current initiatives promoting better access to health care? Which ones?

6 Views on key information gaps

- What do you think are the most important knowledge deficits – and here you might include research findings, development reports, raw data, management information etc. – which might impede current policy and service developments in the area of access:
  (a) in your own area of work?
  (b) more broadly?

- What do you think are the key knowledge requirements for effective future (three- to five-year) policy development?

7 Contextualise impact of current knowledge gaps

- What do see as other key factors either helping or hindering policy/service developments in your field?

- How far is a gap in knowledge from R & D a key factor?

8 Knowledge of NCCSDO programme/criteria for prioritisation

- Do you know what the NCCSDO programme of research is?

- What criteria do you think should determine the type of R & D or information project on access to be funded by the NCCSDO programme? (For example, size of population affected, fit with national priorities, methodological importance etc.)

- Which other R & D programmes do you think the NCCSDO should consult with before commissioning projects on access?

Disclaimer:

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