ACCESS TO HEALTH CARE OCTOBER 2006

Briefing *Paper*

Vulnerable groups and access to health care

Access to health care is an important goal of the NHS, but there are concerns that some vulnerable groups in the population have poorer access than others. This briefing paper, based on work led by Dr Mary Dixon-Woods at the University of Leicester on behalf of the NHS Service Delivery and Organisation (SDO) Research and Development Programme, reports on a comprehensive review of the evidence about vulnerable groups' access to care (Dixon-Woods, 2005). It found that a range of factors influenced access to health care for vulnerable groups – sometimes people are disadvantaged when they seek services because they may present late, have difficulty in getting their issues across, or have problems such as obesity and smoking that mean that they are judged unsuitable for some forms of care. Sometimes too, there is not enough capacity in the system to meet everyone's needs. This briefing paper is aimed at patients, all those working in the NHS, and charities.

Key messages

- There is some evidence that some groups – including the poor and those of black and minority ethnicity – may be disadvantaged in terms of access, but the evidence is not consistent.
- People are more likely to use services that they consider to be high quality. People may be less willing to use services that make them feel they are considered a 'burden' or a 'timewaster'.
- To make use of health services, people need to mobilise knowledge and information resources, as well as language resources and practical needs such as cars, childcare, telephones and time away from work. These resources may not be equally available to all. Services that require more work to use them tend to disadvantage socially excluded groups.
- There is some concern that professional decisions about people's health needs may sometimes disadvantage people of black and minority ethnicity, different genders, older people, and poorer people.
- People's access to services can be affected by lack of capacity within local health services, variations in quality, differences in resource allocation and how services are organised. High levels of non-attendance at services should be treated as a signal of a service that is difficult for people to use.
- Dedicated services for particular patient groups are often popular with those patients but such services can have unwanted consequences, and require further debate and evaluation.

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Background

A driving aim of the NHS is to provide good and easily accessible health services to the whole population. The reality, however, is that access is not uniform across the country and across sections of the population.

There is a widely-held view that vulnerable groups such as socio-economically disadvantaged (less wealthy) people, people from a black and minority ethnic background and older people face greater difficulties in accessing health care.

The aim of this study was to explain why these groups may face difficulties in accessing health services and to help inform solutions to those problems so that access becomes fairer and more uniform across the NHS. The researchers studied the very wide literature in this area to try to identify evidence about why problems in access may exist and what might be done to address them.

The research team had an 18-month timescale in which to review a large amount of literature and their original aim was to study access to health care within five areas – poorer people, people from black and minority ethnic groups, children and young people, older people and both genders.

The team asked the following questions.

1. How does help-seeking behaviour affect access to health care?
2. How does provision of services affect access to health care?
3. What organisational features of health services affect access to health care?
4. How can access to health care be improved?

Main findings

- Some studies suggest that some vulnerable groups have a different experience of access to health care, but the evidence does not consistently point to poorer access for poorer people.
- A person's suitability for treatment is constantly being negotiated and re-negotiated between themselves and the health service.
- A person's ability to attend health services can depend on several factors such as language, available transport, and childcare support. Help with these is variable.
- People will think of services in terms of how easy or how much hard work it is to access them. It can feel like very hard work for people who have to 'navigate' the system by gathering information about what services are available and then finding practical resources to help them before they are able to access those services. Homeless people, travellers and young people especially can be unaware of where to find help.
- People of black and minority ethnicity may feel alienated from organisations that seem to stereotype them or treat them insensitively.
- Communities living in more deprived circumstances are ready to seek help with their health care, but ill health may be seen as 'normal'. They may be more likely to manage their health as a series of minor and major crises rather than as something that can be maintained positively.
- People who are residents of a nursing or residential home can face greater barriers to accessing mainstream and specialist NHS services.
- Health professionals' judgements about a person's health needs sometimes disadvantage people of black and minority ethnicity, different genders, older people and people living in more deprived areas.

Practical *findings*

Socio-economically disadvantaged (less wealthy) people

It is perhaps surprising how difficult it is to identify evidence that consistently demonstrates poorer access to health care for poorer people. There is evidence, however, that the quality of services available in deprived areas may be lower than elsewhere.

Poorer people make high use of primary care and emergency departments, but lower use of screening and immunisations as well as other preventive services. This may be because they see health as a series of minor and major crises, rather than something that needs maintaining and preventing.

There is a need to distinguish between provision of health services and use of health services (supply and demand) and to understand better how professionals make judgements about people's suitability for health care and how people respond to 'offers' of care.

The study suggests that more research is needed into exploring how systems can be organised to make it easier for these patients to start using services and to seek or accept an invitation for a health appointment.

Ethnicity

In such a diverse group as this, it is difficult to have a clear idea about any inequities experienced by people, the study argues. However, it concludes that people of black and minority ethnicity are at risk of poor access. In particular, those who do not speak English well are more likely to have worse access due to problems such as gaining information, transport and time away from work or family commitments.

Some people of black and minority ethnicity can feel alienated and uncomfortable with the way health services are provided and organised. There is a tendency to make higher use of primary care, probably because that is considered to be the easiest service to use and access.

Two approaches to improve access for people of black and minority ethnicity have been proposed in some of the literature reviewed by this study. The first focused on making mainstream services more acceptable and fitting for minority groups, the second on providing specialist services to address particular defined minority groups. However, dedicated services can have unfortunate consequences such as stereotyping, so caution is needed to avoid unwanted effects.

Childhood

Children and young people (aged 12 to18) are also a largely diverse group who are high users of health services, particularly emergency resources. They benefit from a range of screening and vaccination services.

The study report says that parents play a crucial role in advocating on their children's behalf, in terms of seeking medical advice or getting a diagnosis or securing the right treatment.

Parents are expected to be guardians of their children with growing emphasis on being vigilant about meningitis, for example. There are, however, often disputes between parents and health professionals over children's access to health and treatment. Parents sometimes feel that their intimate knowledge of their child is ignored by health professionals.

Older people

Older people's needs are diverse. They make high use of health services, but there is some evidence of ageism. *A National Service Framework for Older People* (Department of Health, 2001) is aimed at addressing such concerns.

There is evidence that suggests older people's expectations of treatment are lower as they assume their age is the cause of feeling ill.

This group, their carers, and the health professionals looking after them have to navigate complex organisational structures to secure medical treatment and help and this effort is seen by some as so 'overwhelming' that older people may prefer to use 'easier to access' services such as seeing their GP.

There is a tendency for older people to be investigated and treated less intensely for certain conditions such as cancer or coronary heart disease. It is possible that older people face barriers more than other age groups in terms of a lack of social support, difficulty in getting information and access to transport.

People in nursing or residential homes, the study adds, are often physically or mentally frail and are overlooked or denied NHS services. Some older people feel it is important to be seen as fit, healthy and not a burden to health providers.

Gender

Women make greater use of health services than men, but no clear evidence exists to say whether a person's gender determines whether or not they are advantaged or disadvantaged over access to health care. According to the study report, there is a lack of research on the issue of gender.

There is also no certainty that greater use of services is automatically a sign that women are more advantaged than men because using services is not itself an indication of real need.

Health care that is sensitive to a person's gender is a major concern for understanding and improving health and health care delivery internationally. A lot of evidence argues for an awareness of gender to be more central in health care at all stages – in formulating health policy, implementing that policy, delivering services, in educating health care professionals and in health promotion education.

An example of how social and moral issues are taken into consideration by health professionals when they make judgements about a patient's suitability for treatment and how this could work against socially disadvantaged people.

Surgeon: "*...Any patient of 20 stones plus is high risk for any chest surgery.*"

Senior registrar: "*Perhaps the best thing would be to bring him in for three weeks for monitoring and try to get his weight down...*".

Surgeon: "*Donald, you've had four years to educate this guy... There is no point in operating on this guy if he is going to carry on working in a smoky atmosphere, if he won't modify his lifestyle.*"

An example of how able people are to attend health services can depend on making arrangements in relation to language, transport, and care of others.

"*Decisions on who gets access to patient transport services (PTS) seem arbitrary. Sometimes it's a case of who shouts the loudest, although I can understand that GPs do not want the hassle. I know of cases where the practice manager makes the decision not the GP,*" said an accessible transport officer.

Recommendations and implications for practice and policy

The study report makes several recommendations, including those listed here.

- Information about illness should be available in forms that people find easy to use, but health information and promotion are likely to have only a limited impact on people's behaviour.
- If a service has a poor record for attendances, service providers should investigate the reasons and be sensitive to the impact of poverty, gender, ethnicity, or age on attendance.
- Services should investigate just how much work is involved for people to use them fully and how comfortable people are with the service.
- Health professionals should reflect on how they respond to people they see and how they use 'rules of thumb' to make judgements about people's health needs.

Conclusion

Access to health care is difficult to measure accurately. It is not a static thing and cannot be measured by looking simply at the number of appointments in the system – the whole story is far more complicated. Access is highly dynamic and influenced by features of both services and patients and how these interact.

All potential users of health care services have vulnerabilities when it comes to access, but their vulnerability can be magnified if they are less wealthy or because of their ethnicity, age and gender.

Future *research*

While the study makes it clear that problems with access are widespread, it also clarifies the need for more research to be done to investigate this issue from several different approaches.

It recommends there be investigations into why there are differences between different age, gender and social and cultural groups when it comes to the kinds of work that people have to do to use health services. This could include evaluating how systems can be organised to reduce the work that patients have to do to use them.

It also proposes that others evaluate how people themselves contribute, or try to contribute, to decisions about their treatment and how language and culture affect people's ability to deal with the health service.

Specific research should be carried out into distinctive issues related to ethnicity, being less wealthy, gender, and age that arise in meetings between patients and health professionals.

Research is also needed into children and young people's view of services, men's use of services and how medical services are provided to nursing home residents.

Dedicated services for particular patient groups need further evaluation, the study says, because this can have unwanted consequences such as stereotyping or provoking resentment.

About the *study*

To investigate access for vulnerable groups in society in their 18-month timescale, the researchers were faced with a vast amount of literature – several thousand separate pieces – which came in different forms. Their aim was to interpret all of this evidence to come up with plausible conclusions.

They developed a new approach to reviewing evidence, calling it 'critical interpretive synthesis' which involved extensive searching, sampling strategically from the literature, appraising and assessing those included papers and coming up with concluding arguments from them.

Members of the research team

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References and further reading

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Further *information*

The full report, this briefing paper and details of current SDO research in the field can be downloaded at: www.sdo.lshtm.ac.uk

For further information about anything included in the report, please contact lead researcher Dr Mary Dixon-Woods, Reader in Social Science and Health, Department of Health Sciences, University of Leicester. Tel: 0116 2523204 Email: md11@le.ac.uk

Feedback

The SDO Programme welcomes your feedback on this briefing paper. To tell us your views, please complete our online survey, available at:
www.sdo.lshtm.ac.uk/briefingpapers.html

About the SDO Programme

The SDO R&D Programme is a national research programme managed by the National Co-ordinating Centre for NHS Service Delivery and Organisation Research and Development (NCCSDO) under contract from the Department of Health's R&D Division, and is a constituent of the National Institute for Health Research (NIHR).

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Addendum