Health Inequalities - Access to Services

BMA Scotland

Introduction
The British Medical Association is a registered trade union and professional association representing doctors from all branches of medicine. The BMA has a total membership of around 150,000 representing around two-thirds of all practising doctors in the UK. In Scotland, the BMA represents around 16,000 members.

Although Scotland’s post-devolution policy approach to addressing health inequalities has generally been well received, health inequalities have remained stubbornly persistent. Current welfare reforms and economic pressures seem likely to exacerbate health inequalities. Hence, there are still significant challenges to overcome in reducing health inequalities gap between the richest and poorest in our society and improving general population health. It is widely recognised that the most important policy levers for responding to health inequalities are outwith the realm of health policy and include employment, education, fiscal, housing and other welfare-related policies. An integrated approach to health inequalities is essential for reducing these health differences.

However, the focus of this inquiry is on the extent to which inequalities in accessing healthcare contribute to health inequalities in Scotland. We put this question to a number of our GP representatives and the following submission summarises the issues they raised.

What are the key barriers for people in deprived areas accessing primary, secondary and tertiary healthcare?

Time – With only 10 minutes available for each appointment, it is very difficult to fully address some of the complex needs that people from deprived areas tend to have.

Advocacy – Many people from deprived areas and the elderly benefit from having an advocate to help guide them through the system. This is something that GPs do very well but lack the time to do it as properly as they could.

Primary healthcare team – The disintegration of the practice based extended primary care team, including health visitors, can have an impact on health inequalities. By working closely together health professionals are in a better position to share information to ensure that people get the best support from their NHS. In addition, if services are provided in one local place, access becomes easier for those who require a number of services.

Health and social care integration – We believe that greater integration will lead to better communication between the professions and the services. In particular, better links with the mental health team would improve the service for many people.
Extended hours – Often low paid workers are reluctant to take time off from their work to attend their GP practice. Extended practice hours have not addressed this issue because services outwith those provided by the GP surgery are not available during these times. For example, blood tests will not be collected until the following day.

Continuity of care – Homelessness and short term housing arrangements can lead to a higher turnover of patients in deprived areas, which in turn affects the ability of doctors to provide continuity of care.

Availability of local outpatient appointments – If there are no appointments available locally, people have to travel long distances (for example, people in Grampian could be offered an appointment at Clydebank) which can be very difficult for those who are less well off. This can affect their ability to accept such appointments and they lose their place on the waiting list.

Other factors which can create a barrier for people in deprived areas accessing healthcare services include literacy, access to translators and access to transport.

*What barriers exist for specific groups e.g. migrants, older people?*

Older people – Access to transport can be an issue for older people, making it a challenge for them to attend appointments. For those who are unable to drive, the availability of good transport links is required, but many find this difficult to access due to their ill health. In addition, there is limited time for home visits and so acute conditions must be prioritised. Community nursing could provide some support to older people, but again there are inadequate resources to visit all those who would benefit. If more resources were available, then specialists, including dentists, optometrists and secondary care health professionals could provide more home visits, which could improve access to healthcare services. Deafness and visual impairments also act as a barrier, and additional support for these people would be beneficial.

Residential care homes – These homes have a specific population of vulnerable elderly with complex medical needs for which there is no adequate resource for general practice to manage.

Mental health – Currently there are many people with mental health problems who do not have access to support workers in the community. Those who do benefit greatly from this resource and are better equipped to navigate the healthcare system.

Migrants – Migrant workers tend to be relatively low paid and find it difficult to take time off work to see their GP. Cultural attitudes towards health, a lack of language and poor availability of translation services can also act as barriers for many.
Conclusion
There are a range of barriers to accessing health services both for those from deprived areas and those from specific groups such as older people and migrants. Many of these could be addressed by providing additional support and resource to the NHS, but there are wider issues that need to be considered if we are to reduce the health inequalities gap. These include housing, employment and education. An integrated approach to health inequalities is therefore required if we are serious about reducing these health differences.

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