Health Inequalities - Access to Services

Greater Glasgow and Clyde Primary Care Deprivation Group

1. Introduction

This document provides the written evidence to support NHSGGC’s participation in the evidence session on 1 April. It draws on the work of the NHSGGC primary care deprivation group\(^1\) as well as the Board’s wider activities to address inequalities.

NHSGGC’s approach to inequalities is based on the premise that health inequalities and their root causes cannot be resolved by health services alone, but that the NHS has a vital role in understanding, responding to and mitigating inequalities. Health services also have a responsibility to ensure that they do not exacerbate inequalities, for example through the unequal impact of health improvement approaches, or through differences in access to or uptake of services. Primary care has a particular role to play both through the services and support it provides directly to patients, and its role as a gateway to wider services.

Inequalities in access to health services may relate to the availability and accessibility of services, ability to benefit from the services provided, and the nature of the services themselves. While there is clear patterning across SIMD quintiles for most services, with higher use by the most deprived quintile (particularly for A&E, primary care, mental health and addictions), this masks lack of engagement by some groups and may indicate a lack of impact on complex problems.

2. Barriers to access: deprivation

Work with front line staff and patients has identified a series of barriers relating to the organisation and the nature of services. These include:

- Practical and financial barriers, e.g. cost of travelling to appointments, ability to access transport, ability to attend appointments around work or caring commitments. Charges for calling NHS24 from mobiles remain an issue, although this is now being addressed. Some of our services also charge for calls from mobiles, a historical legacy of introducing 0800 numbers to make costs free from landlines.
- Complexity of services. The presence of multi morbidity is higher in more deprived areas, and results in higher numbers of appointments for different services and greater complexity of response. The episodic nature of many services does not fit the growing burden of chronic disease and multimorbidity. Barriers may also include lack of awareness of how to access services.
- Communication issues including literacy and language may be a barrier both to attending services, and to understanding / benefitting from consultations and treatment plans.
- Wider social circumstances including the priority placed on health in context of challenging or chaotic life circumstances. This may include drug or alcohol misuse, or gender based violence impacting on freedom to act.
- Previous experience, including negative experiences of service attitude and impact. This includes a fear of being ‘blamed’ for ill health through excessive focus on behaviour change.
- Stigma, particularly associated with some services such as mental health and addictions.
- High thresholds or waiting times for access to some services, exacerbated by level of demand associated with deprivation.
- Services failing to recognise or address underlying issues (e.g. gender based violence, financial difficulties, impact of welfare reform, discrimination) which are impacting on health and / or service use (e.g. high rates of A&E attendance).

3. Barriers to access: specific groups

In addition to the barriers above which are common to many groups, some additional barriers have been highlighted through work with specific marginalised groups and those with protected characteristics:

- Attitude and discrimination.
- Understanding of individual circumstances. A preference for accessing services where the individual is known and doesn’t have to repeat their story (usually primary care where long term relationships can be developed).
- Expectations and cultural norms: asylum seekers and refugees report a preference for hospital attendance.
- Physical barriers to access for those with disabilities, such as use of intercoms which acts as a barrier to Deaf people.
- Appointments systems which do not take account of visual and hearing disabilities, for example appointments sent by letter or requirement to phone and make an appointment.
- Stress related to the complexity and uncertainty of welfare / benefits processes including asylum application and disability benefit reviews.

4. Effective approaches

The following are examples of where improvements can be made to improve accessibility and appropriateness of services:

- Enabling good access to Primary Care services and ensuring that these are supported and resourced to deal with the levels of demand and complexity associated with deprivation. The current constraints of the GMS contract and QOF limit GP time and flexibility to deal with complexity and vulnerability. NHSGGC is pursuing the development of 17c contracts with a group of practices to enable greater flexibility, but the wider issue remains for the majority of practices.
- Resource allocation which takes account of deprivation and need. Within GGC, resources for community services are allocated through a capitation based formula weighted for deprivation, but resources for general practice are
allocated nationally with a relatively flat distribution of resource as highlighted by the Deep End work. We would encourage review of the Scottish Allocation Formula to take greater account of deprivation.

- Flexible arrangements for referral and return to services which are better able to respond to long term conditions.
- Better information sharing including transfer of information about patients from primary care to secondary care (additional needs such as communication preferences or use of Personal Assistants) and information to enable follow up of DNAs, particularly for children and vulnerable groups.
- Inequalities Sensitive Practice and Person Centred Care: routine inquiry into wider circumstances (e.g. money worries, employment issues, gender based violence) and ability to refer on to appropriate services with clear pathways. Our Healthier Wealthier Children approach has raised £6.5 million for children and families since 2010 from 6000 referrals, largely from Health Visitors and Midwives. Routine enquiry needs to be supported by tools, training and support for staff.
- Health services which are able to connect effectively with wider community services and support.
- There is substantial evidence from the way Keep Well has been implemented in NHSGGC including effective approaches to enabling engagement with services, and effectiveness of service response based on person centred consultations.
- Using the opportunity of A&E attendance to prompt review and development of longer term care plans for underlying issues.
- Different models of access, for example the Sandyford sexual health ‘hub’ approach.

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NHS Greater Glasgow and Clyde
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\[1\] The NHSGGC primary care deprivation group was established in 2011 following the development of the Board’s primary care framework which identified health inequalities and addressing the impact of deprivation as one of the major priorities for primary care in Greater Glasgow & Clyde. The primary care deprivation group is a multi disciplinary forum which aims to share grass roots experience, provide education and support, identify current good practice, engage all disciplines in partnership and develop and lead change through joint working.