Access to Health Care

Report of a Scoping Exercise for the National Co-ordinating Centre for NHS Service Delivery and Organisation R & D (NCCSDO)

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Executive Summary

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.**

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**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.
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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.
Section 1  Introduction and aims

Access to care is a key consideration in the organisation and delivery of health services. The aim of providing adequate and fair access to services was sometimes considered to be one of the founding principles of the National Health Service, but problems with access remain an important concern for contemporary health decision-makers.

At present there appear to be widespread problems with access to health services. There are wide geographical and social variations in the provision and utilisation of care, and long waits for treatment are common. Patients may have to wait several days or weeks before they can see their general practitioner; waits of months or years for elective surgical treatment are commonplace; there are long delays during hospital admissions for acute medical and surgical conditions; there are well-documented difficulties in accessing critical care services; and for patients needing care in the community, delays in discharge from hospital are common.

The newly established NHS Service Delivery and Organisation R & D Programme identified ‘access to health care’ as a key area for future research. This report was commissioned to scope the background issues that would be important in commissioning research in access to health care. This report aims to discuss the following questions:

- What is meant by access to health care, and how is accessibility related to other evaluative dimensions of quality of care?
- What factors influence patients’ help-seeking behaviour, and how do these influence patterns of service use?
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- How do financial incentives and barriers modify the behaviour of patients and health care providers?
- What considerations are relevant in planning the availability of services?
- What are the organisational barriers to timely care at different levels of the health care system?
- What are the implications for fairness in health care?
- What new methods of service delivery can address problems in access to health care?
- How do these issues relate to the provision of dental care?

We emphasise that our report represents the result of a short-term project; it was completed in three months. We restricted our view of the question of ‘access’ to that of the British National Health Service. Our review of the literature was not systematic.

Our primary objective was to provide a ‘conceptual map’ which might help to guide future explorations in this field.

We recognise that there are large volumes of literature in many of the areas that this review touches on. It was not feasible to review these areas fully in the time available. In many instances it will be appropriate for more detailed systematic reviews to be commissioned before further primary research is considered.

In general, we have not considered the particular needs of specific client groups and services because our brief was to provide a broad overview of the generic issues that are relevant in access to health care. We draw the reader’s attention to the many thoughtful comments sent by individuals and organisations whom we consulted (see Appendix 3), and these often refer to issues that have special relevance for particular client groups or services.
Section 2  Methods

Focus for review

Analysis of ‘access to health care’ is concerned with the initial entry of patients into the health care system. Our first step was to explore the concept of access to health care in more detail, in order to provide a working definition. We then carried out searches and synthesised the information obtained.

Search methods

Two main methods were used for obtaining information.

Literature searches

Owing to the short timescale and the scoping nature of the exercise, it was not possible to conduct a comprehensive systematic review of all of the literature on access to care. Literature searches were restricted to recent articles in the English language. Preference was given to articles based on UK data or conducted in similar health care systems.

We accessed material for review by the following methods.

1  The personal knowledge and personal reference collections of members of the study team were used as a starting point.

2  This was supplemented by electronic database searches including Medline, Cinhal Embase, Web of Science citation indexes, Social Service Abstracts, PsycINFO, the Department of Health web site and the Cochrane Library. Individual members of the research team tailored the searches to their own particular area of interest.

3  Members of the research team hand-searched (electronically and manually) recent issues of journals in the fields of health policy and health services research for their own area. These included the British Medical Journal, Health Economics, Health Policy, Health and Place, Health Services Journal, Journal of Community Medicine and Epidemiology, Social Science and Medicine and selected volumes of Journal of Public Health Medicine and Journal of Health Services Research and Policy.

4  We searched electronic research registers held nationally and regionally.

5  We searched the web sites of known centres of health service research for any relevant publications of current research in progress.
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Contact with researchers, professionals, providers and users

We contacted a wide range of researchers, managers of research, consumer associations, funders of research and users of research in the UK, asking if they would like to make comments in light of their organisation’s experience and knowledge in the following areas:

- recent relevant research studies, including reviews
- current research in progress
- key issues for future research in their field.

A generic letter outlining the background of the exercise was tailored to the individual recipients and sent by post or e-mail (see Appendix 1). Researchers, organisations, providers and purchasers/commissioners contacted included:

- two health authorities/health boards in each of NHS Executive regions; in addition, we contacted the Directors of Public Health of all health authorities in the London and South Eastern regions
- over 50 consultants and academics in dental public health in the UK
- two community health councils in each NHS Executive region (one letter, one e-mail for each region)
- a selection of NHS trusts chosen to give a mix of acute, community, mental health services and specialist tertiary services
- all the relevant health-related organisations listed in the Institute of Health Services Management Year Book 1999/2000, including the professional organisations and associations, and a selection of the larger patient/user associations
- known researchers active in the field of access to care (by direct e-mail or telephone)
- a wider general audience of researchers and public health specialists, consulted via the ‘public health’ and ‘health services research’ mailing lists maintained by Mailbase (www.mailbase.ac.uk/jiscmail.ac.uk).

Given the time available, primary care groups were specifically omitted from the consultation.

For further details of the organisations and research centres contacted, see Appendix 2. A list of the main respondents with a summary of their main points can be found in Appendix 3.

Methods for synthesis

We synthesised the findings into a narrative report, highlighting key issues for future research.
Section 3  Definition of access to health care

Introduction

Access to health care is concerned with the relationship between need, provision and utilisation of health services. Aday and Anderson (1981) suggest that access describes the potential and actual entry of a given individual or population group into the health care delivery system. This notion of access involves different aspects of the relationship between the service providers and clients, which determine patterns of utilisation. The concept of access is centred on the processes determining entry into the health care system.

The term ‘access’ is commonly used in two ways.

- **Having access** denotes the theoretical potential to utilise a service if required. To have access to a service means that the service required exists, is available, and that there are systems in place that would allow service utilisation following a contact with the health care service.

- **Gaining access** alludes to the actual procedure of admission into the processes of utilising the service. Here, if access has been gained it means that the service has been utilised. This definition denotes entry to, or utilisation of, health care services.

Access has sometimes been identified as one of the dimensions of quality of care (Maxwell, 1984), but access is itself a multi-faceted concept. Pechansky and Thomas (1981) suggested that the concept of access described the ‘degree of fit’ between clients and the health system. They identified five relevant dimensions to the client–service interaction.

1. **Acceptability** refers to attitudes and beliefs of users and providers about each other’s characteristics.

2. **Affordability** applies to the cost implications to the patient in relation to need; this includes both direct and indirect costs and perceptions of value.

3. **Availability** refers to the adequacy of supply given by the relationship between volume and type of services (provision) and volume and type of needs (demand).

4. **Physical accessibility** is defined by the suitability of the location of the service in relation to the location and mobility of the patient (geographical and physical barriers).

5. **Accommodation** refers to the way services are organised in relation to the client’s needs and the patient’s perception of their appropriateness (opening times, booking facilities, waiting times).
Pechansky and Thomas’s conceptualisation of access is helpful because it identifies different dimensions of the client–provider relationship and it is not concerned only with entry or utilisation of services.

**Access and utilisation as a continuum**

In order to measure access, it is necessary to consider potential criteria by which to judge whether there is access or not. A further problem arises in seeking definitions for utilisation. Contact with and the utilisation of health care services form a continuum and access might be defined as some point on this continuum. There are many potential events in the processes of contact and utilisation of services that may indicate access.

- An individual resides a short distance from a health care setting.
- The individual becomes aware of his or her need for services.
- The individual becomes aware of the services provided by the health care setting.
- The individual establishes telephone contact with the health care provider.
- The individual establishes internet contact with the health care provider.
- The individual enters the health care setting.
- There is communication between the individual and a health care worker.
- There is communication between the individual and a health care worker in the language of the individual.
- There is registration with a GP.

The availability of services can be measured using indicators such as the number of doctors or hospital beds per 1000 population. However, it is possible for a population group to have access to services and not to utilise them. Patients’ and providers’ attitudes and beliefs may affect the individual’s perceptions of the acceptability and accessibility of services (Cunningham et al., 1998). Utilisation rates have also been suggested as objective indicators of access (Chavkin and St Clair, 1990) but use of measures of utilisation may blur the distinction between utilisation and access. This distinction is relevant because the benefits of services mainly result from utilisation by the appropriate groups, but many of the costs relate to the availability of the service. Patterns of utilisation are also influenced by the effectiveness of services. When a service achieves a favourable outcome in terms of improved health status, the need for health care, and subsequent service utilisation, may be reduced.
Access in terms of health outcomes

The processes of entry and utilisation of health care services are only part of the interaction between supply and demand; the ultimate objective of this contact is to promote or preserve health. The outcome of the service is an essential aspect of the utilisation continuum. The US Institute of Medicine defined access as the timely use of personal health services to achieve the best possible outcome (Millman, 1993). Rogers, Flowers and Pencheon (1999) defined optimal access as ‘providing the right service at the right time in the right place’. These definitions added in the notions of timeliness and geographical availability of services. They went beyond, to encompass the concepts of best possible outcomes or the right service, implying the need for evaluation of the appropriateness of the service and the acceptability of the outcome, both from the provider and the consumer perspectives. In this framework, access could be measured using appropriate objective indicators of mortality or morbidity, or subjective ones, such as patients’ satisfaction with care or self-rated measures of health status. But these measures would be considered more generally as indicators of the quality of care or the effectiveness of services.

Access in terms of patients’ perspectives

An individual’s probability of utilising services depends on the balance between the person’s biological and psychosocial perception of need and his or her attitudes, beliefs and previous experiences with health services. Access to health services implies that individuals recognise and accept their need for services, consent to their role as service user, and acknowledge socially generated resources that they are willing to utilise. From this perspective, access is the experience and command of socially produced resources for the production and promotion of health and well-being. Health care resources, such as resources associated with alleviating a need when it occurs and is identified by the person, or health education and health promotion which frame models of lifestyles that are said to avoid certain patterns of health problems, are by their very nature not inherent to the individual’s culture. Access then also depends on how familiar the individual is with the use of these resources, both in terms of knowledge of how the health care system works and, more importantly, in terms of the assimilation of socially generated resources as usable tools to adapt to the individual’s living environment.

Access relates to the perception and command of resources that, we are told, are becoming increasingly scarce. It results when the individual appropriates and utilises socially produced and available resources. Facilitating access is therefore about helping people to exercise the power to command resources to cope with or adapt to the challenges of their own environment when they perceive they need them, so that the outcome is the preservation or the improvement of their health. However, the processes of access are subject to our socioeconomic and psychosocial backgrounds as well as to environmental constraints. Socially produced health resources, such as
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health promotion interventions, are utilised, processed, incorporated and assimilated differently by different social classes.

Barriers to access

Barriers to access can occur at different points on the pathway involving the processes of contacting, entry, utilisation of effective, appropriate and acceptable services, and attainment of the desired or appropriate outcomes. Barriers include both structural factors relating to the costs and organisation of services, as well as problems with knowledge, cultural beliefs and attitudes concerning medical conditions, and patient preferences and priorities regarding treatments. The following chapters explore some of these barriers in more depth.

Definition of access

Bringing these ideas together, we suggest that 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 services.

2. The extent to which a population ‘gains access’ also depends on financial, organisational and social/cultural barriers that limit the utilisation of services. Thus utilisation is dependent on the affordability, accessibility and acceptability of services and not merely 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 access, have to be considered in the context of the differing perspectives, health needs and cultural settings of diverse groups in society. Facilitating access is then concerned with helping people to command appropriate health care resources in order to preserve or improve their health.
Maxwell (1984) defined accessibility as one of the evaluative dimensions of quality of care. Defining access in terms of health outcomes establishes a relationship between access and the effectiveness of services. For example, the effectiveness of a breast-screening programme will be increased if it is accessible, and is used by those who need it. Access is also linked to other evaluative dimensions. In particular, equity is often defined in terms of access, that is equality of access in relation to equal need. The efficiency of services is also dependent on access. For example, making services accessible to subjects who have less potential benefit will reduce efficiency, even though this may increase equity. Low acceptability of services will reduce utilisation even though services are available (Table 1).

**Table 1  Relationship between access and other evaluative dimensions**

<table>
<thead>
<tr>
<th>Evaluative dimension</th>
<th>Access</th>
</tr>
</thead>
<tbody>
<tr>
<td>Equity</td>
<td>According to one definition, equity will be achieved when services are equally accessible to all with equal need</td>
</tr>
<tr>
<td>Effectiveness</td>
<td>Effectiveness, at the community level, will be maximised when services are accessed by all those with the capacity to benefit</td>
</tr>
<tr>
<td>Efficiency</td>
<td>Efficiency may be compromised when services are made easily accessible to those with little capacity to benefit</td>
</tr>
<tr>
<td>Appropriateness (relevance to need)</td>
<td>Services will be delivered appropriately when access is matched with individual and population need</td>
</tr>
<tr>
<td>Responsiveness (social acceptability)</td>
<td>Services that respond readily to consumer concerns may be perceived to be more accessible</td>
</tr>
</tbody>
</table>

**Organisation of the report**

In the next section, we focus on the way patients’ help-seeking behaviours influence the uptake of services. Initially, quantitative data are used to explore factors affecting the uptake of services by different groups; in-depth explorations using qualitative approaches then help to explain and clarify key issues. Section 5 extends this approach by considering the way that financial incentives influence patients’ use of services. This leads on to a discussion of the influence of financial incentives on providers of services to modify the supply of services. Section 6 then provides a brief outline of some of the key issues in planning the availability of services including rationing, resource allocation and the geographical configuration of services. Section 7 then considers the local, organisational barriers to care. Long waiting times and waiting lists are considered as important indicators of
organisational barriers to care. In Section 8 we bring these separate strands together by considering different aspects of inequity in access to care. Equity measures are considered as key indicators of access to health care. Section 9 then evaluates current initiatives in health policy and service development which are attempting to address problems with access to health care. Finally, in Section 10 we consider how each of these issues relates to the provision of dental care in the UK. Figure 1 provides a schematic diagram which summarises our approach.
Figure 1  Schematic diagram of issues in access to health care

**POPULATION**

- **In need**
- **No need**

**Wider determinants of health**
- Genetic factors
- Ethnicity
- Family
- Physical environment
- Social environment

**Individual and social barriers**
- Help-seeking behaviour, anxiety, previous experiences, cultural beliefs, knowledge, financial resources, social support
  (Section 4)

**Organisational and financial barriers**
- Registration, opening times, waiting times, information provision, costs of care
  (Sections 5 and 7)

**Demand for formal care**

**Interface (1)**

**Primary care** (Chapters 9 and 10)
- Primary care services, community pharmacies, telephone advice lines, doctor and nurse-led clinics, GPs in A & E Departments etc.

**Interface (2)**

**Secondary care** (Chapters 9 and 10)
- Specialist clinics in primary care, integrated and shared care, booked admissions, acute hospital beds, intermediate care etc.

**Health outcomes of care**

**Quality of Care**
- Equity
- Efficiency
- Effectiveness
- Relevance to need
- Social acceptability
  (Chapter 8)

**Availability of services**
- Rationing
- Resource allocation
- Financial incentives
- Service configuration
- Organisational change
  (Chapter 6)

Obtained outcomes

Expected outcomes

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Section 4  Patients’ help-seeking behaviours and gaining access to care

What is known?
The evidence of 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 refugees and asylum seekers, homeless people 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.

**Introduction**

Patients’ decisions to seek medical care generally form the first step in the process of accessing services. Overall, about 90% of person contacts with the NHS occur through primary care. A high proportion of patients engage in self-medication prior to seeking professional help, and increasing use is made of complementary remedies and practitioners to supplement formal services, especially in the management of chronic disease. However, professionals and providers have expressed concerns that patients’ behaviours may result in inappropriate patterns of service use. This comprises the non-uptake of preventive services, delays in the uptake of services for conditions requiring treatment, and ‘inappropriate’ demands on GPs and emergency services.

Policy responses have shifted in recent years from attempting to change patients’ behaviours to acknowledging patients’ needs, and managing their demands by developing a graduated service to reduce demands on GPs and on hospital staff in A & E departments. For example, recent initiatives envisage an increased role for community pharmacies, telephone advice lines and walk-in clinics (Department of Health, 2000a). However, these initiatives need to be informed by patients’ own views of services, their perceptions of the extent to which their needs are met, and their use of available information to inform choices in self-management and use of health care.

This section mainly focuses on patients’ initial uptake of services. Other aspects of patients’ preferences and behaviours in relation to accessing care, including patients’ views of waiting times, information needs and uptake of outpatient appointments, are considered in later sections.
Non-uptake of preventive services

Non-uptake of preventive services, especially by disadvantaged social groups, has traditionally been a major concern. Improvements in recorded uptake of childhood immunisations and cervical screening have occurred since 1990, and may partly reflect the availability of more accurate registers and reduced list inflation since the introduction of target payments for GPs rather than true increases in uptake.

Currently the uptake of childhood immunisations averages over 90% but there is some evidence that socioeconomic inequalities have continued. It has been suggested that it is only when immunisation uptake in the most affluent groups reaches 95% that social inequalities narrow (Reading et al., 1994). For cervical screening, 84% of women aged 25–64 years resident in England had been screened at least once in the previous five years (Department of Health, 2000b). There has also been some recorded increase in the uptake of breast-screening services. Figures for March 1999 indicate that 67.6% of women aged 50–64 resident in England had attended for X-ray mammography at least once in the previous three years, and 74.1% of women aged 55–64 years (Department of Health, 2000c). There is evidence of continuing inequities in the uptake of breast and cervical screening, with lower rates being linked to higher levels of deprivation at both an area and individual level (Cancer Research Centre, 1994 and 1997). However, a study by Vaile et al. (1993) indicates that if women attend mammography once they are likely to re-attend, the major issue being to encourage initial take-up.

Information on the uptake of preventive services by ethnic minorities provides a mixed picture. The uptake of childhood immunisations is generally higher among the main ethnic minority groups (particularly South Asian) compared with white groups (Smaje, 1995). In contrast, rates of uptake of breast and cervical screening appear to be low among South Asian women, although many studies do not control for socioeconomic factors despite the high association between ethnicity and deprivation variables (Goddard and Smith, 1998).

Research to explain the non-uptake of preventive services has mainly been informed by the Health Belief Model. This has identified the following service-related and individual barriers.

1. Service provision – the poorer provision and organisation of primary care services, including systems for notification and recall, is identified as contributing to lower rates of uptake of preventive services in disadvantaged areas (inverse care law).
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2 **Mobility of populations** – this presents particular difficulties for preventive services in inner city areas, although the extent to which mobile populations receive services in other areas or miss out on services altogether is not known.

3 **Access costs** – low rates of car ownership and time off work are identified as important barriers for poorer groups.

4 **Attitudes and beliefs** – concerns about side effects have formed a deterrent to the uptake of childhood immunisations (and influenza vaccinations for elderly people) among all social groups. A further barrier to the uptake of preventive services among some disadvantaged groups is the existence of a more ‘fatalistic’ approach to health (i.e. a belief that one has little control or ability to influence events).

5 **Knowledge and language** – some ethnic minorities and new immigrant groups experience particular barriers to the uptake of services through language problems and a lack of familiarity with services (e.g. knowledge of eligibility for screening). These appear to be more important barriers among ethnic minorities than negative attitudes to screening (Naish, Brown and Denton, 1994).

Current research provides little indication of the relative importance of different barriers for particular groups in the population, and more detailed qualitative research is needed. Proposals for the introduction of new screening and preventive services also need to be underpinned by knowledge of potential barriers to uptake in terms of patients’ own attitudes and beliefs (and variations among social groups), and perceptions of organisational and service barriers.

**Delays in consulting and lack of access to care**

Evidence on delays in consulting and the influence of patients’ behaviours and patient–provider interactions on lack of access to care is scattered and fragmentary and requires more detailed review. However, current studies identify this as an important influence on outcomes and inequalities in gaining access. In particular, there are concerns about patients’ delays in seeking professional medical advice for conditions that would benefit from early treatment, including cancers of various sites, heart disease and sexually transmitted diseases. For example, 20–30% of women with breast problems do not visit a doctor until three months have elapsed from initial symptom perception. These delays by the patient are often compounded by subsequent provider delays in referrals and hospital admissions (Jones, 1999).

A small number of studies have examined the interaction of patients’ behaviours and clinical decision making in producing delays in hospital use and a failure to gain access to services. For example, Ruston and colleagues (Ruston, Clayton and Calnan, 1998) identified delays in responses to a cardiac event among patients eventually admitted to hospital as being due both to patients’ own uncertainty about the
meaning of their symptoms and to delays attributed to GPs, for patients who chose this initial form of referral.

Variations in access to secondary and tertiary services have traditionally been explained in terms of service availability and provider factors. However, a study by Gardner and Chapple (1999), based on semi-structured interviews with patients and doctors at one general practice in a deprived area of Liverpool, suggested that the lower rate of referral for revascularisation in Liverpool may have partly arisen from barriers to referral that centred in patients within their cultural and social environment and in the doctor–patient interaction. This included patients being unlikely to press for a referral and underplaying their symptoms because of a fear of hospitals, operations and medical tests, their view of angina as a condition to be managed or denied, and holding a fatalistic view of health. Patients’ difficulties in describing angina symptoms, together with the multiple problems and symptoms presented, also contributed to doctors being less likely to make a referral for possible revascularisation. Such studies thus begin to identify the processes involved in clinical decision making and access to specialist services that may help to explain a more general inverse correlation between deprivation and rates of inequalities throughout the UK (Black, Langham and Petticrew, 1995).

Some ethnic groups experience particular barriers to care (primary and secondary/tertiary services) arising from their lack of familiarity with services, language problems, fears of stigma associated with medical diagnosis, concerns about eligibility for services or discrimination of service providers. For example, South Asian migrants (from India, Pakistan, Bangladesh, Hong Kong) have relatively low hospital admission rates for mental illness relative to people born in England (average of 283 admissions per 100,000 population compared with 504) (Goddard and Smith, 1998). Such figures are not adjusted for socioeconomic factors which may partly explain the apparent differences, while rates of mental health problems may in fact be lower among people from South Asian backgrounds (Nazaroo, 1997). Another factor may be the particular negative social meanings and stigma attached to these conditions among the South Asian community, leading to a reluctance of individuals and families to consult for depression and mental and emotional problems and thus an under-use of services (Lipsedge, 1993).

In other cases, ethnic minorities appear to have particularly high rates of service use, which again may be influenced by cultural and behavioural factors as well as by possible differences in disease prevalence. For example, children of South Asian parents have high rates of emergency hospital admissions for asthma, which may reflect differences in the meanings and management of this condition among cultural groups and doctor–patient interactions (Gilthorpe, Lay-Yee and Wilson, 1998). Research undertaken to identify the reasons for high rates of diagnosis of schizophrenia and psychosis among the Caribbean community in the UK also draws attention to the possible effects of variations in patients’ presentation and doctors’ diagnostic and
management practices on recorded rates (Cochrane and Sashidharan, 1996).

**‘Inappropriate’ use of services**

Alongside the problem of delays in consulting is the concern that considerable numbers of patients consult ‘unnecessarily’ with medical ‘trivia’ and thus display ‘inappropriate’ patterns of service use.

**General practice**

Doctors frequently comment about patients consulting for medical trivia. However there are few precise data on the extent to which consultations with GPs are unnecessary. This is an assessment that is influenced by providers’ views of their roles and their implicit and subjective judgements of appropriateness, as well as depending on the availability of alternative services and medical advice (Murphy, 1998a).

The question of the appropriateness of service use has been examined particularly in relation to the greatly increasing demands on out-of-hours services in general practice. A review of studies indicated that between 41% and 60% of out-of-hours contacts were felt to be inappropriate, although only 0–8% of night calls were regarded as inappropriate (Hallam and Cragg, 1994). Actions in response to out-of-hours calls identify varying needs. A recent study of GP co-operatives reported that 45.4% of calls were handled by telephone advice, 23.6% by a home visit, and 29.8% at a centre. Hospital admissions followed 5.5% of out-of-hours calls (Murphy, 1998a).

A small number of qualitative studies have examined decision making by patients or parents regarding the uptake of services, to identify the reasons for their help-seeking behaviours and demands on services. Several of these studies have focused particularly on mothers’ consultations for respiratory problems, which account for 30% of consultations for children aged less than 11 years (Wyke, Hewison and Russell, 1990; Cornford, Morgan and Ridsdale, 1993). This research has drawn attention to complex aspects of patients’ beliefs and their interaction with psychosocial and situational factors. This includes the rationality of parents’ help-seeking in the context of their beliefs and worries (including perceived behavioural changes, worries about difficulty in breathing, fears of serious illness and permanent damage). Reasons for requesting out-of-hours care are similar to day care and include worrying symptoms, responsibility for a child, past frights in which illness had turned out to be serious, and lack of confidence in health professionals, while a period of waiting and self-management is common (Hopton, Higg and McKee, 1996).

Studies of the reasons why adults consult with medically trivial conditions generally identify similar worries. For example, major triggers promoting professional help seeking for dyspepsia were identified as patient’s worries about cancer and heart disease, perceptions of personal vulnerability to serious illness, and previous experience of disrupting or threatening life events that may reduce
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their ability to accommodate symptoms (Delaney, 1998; Lydeard and Jones, 1989).

Traditionally, policies aimed to change patients’ behaviours and encourage service use to conform more closely with professional expectations. This approach had little success. The current emphasis is therefore to manage patients’ demands through GP co-operatives, and by setting up advice lines and nurse-run clinics. However, there are questions of the extent to which they are able to meet patients’ needs (see Section 9).

**Hospital A & E departments**

Estimates of inappropriate attendance at A & E departments range from 6% to 80% (Murphy, 1998a).

Similarly, estimates of the need for primary care by A & E attenders ranges from 10% to 40% (Robertson-Steel, 1998). These variations arise partly as a result of the lack of an agreed triage system and differences in views of legitimate or ‘appropriate’ patient demands on hospital A & E services.

Demands on A & E departments and ‘inappropriate’ service use varies between areas. High rates occur among socially disadvantaged populations and in areas with poorer provision of GP services. Patients presenting at A & E include large numbers of homeless people, and other people who live nearby and use the hospital for their primary care. Attendance rates are also particularly high out of normal surgery hours (Murphy, 1998b). However, the lack of standard definitions of ‘appropriate’ use of services precludes precise comparison between areas.

Recent policies have shifted from their traditional emphasis on educating patients to change their behaviours to the adoption of triage systems and the provision of primary care within A & E departments. However, the costs, staff implications and outcomes of this model of care require further evaluation (Section 9).
Patients’ views of access

Relatively little research has examined the population’s views of access to health care and how this varies between areas and among different social groups. An exception is the recent King’s Fund survey, *What do Londoners think of their General Practice?* (Malbon, Jenkins and Gillam, 2000). This identified high general levels of satisfaction. However, one-half of respondents were unhappy about the time to get an appointment, 1 in 5 people aged 18–30 years were dissatisfied with opening times, and 16% had considered making a complaint (although only 3% had done so). There is a need for more detailed information on the reasons for these views, as well as comparative data for different areas and social groups. More broadly, the development of patient-centred approaches to care requires that patients’ evaluations form an integral aspect of monitoring services and evaluations of innovations in service delivery. This requires that both quantitative and qualitative methods are employed, and that methodological work is undertaken to develop appropriate instruments and approaches.

Marginalised groups and access to care

Homeless people and refugee groups are marginalised groups with high levels of morbidity and ‘needs’ for health care but who have particular problems in gaining access to general health services.

Homeless people

Homeless people are a heterogeneous population. They include young unemployed men sleeping on the streets, mentally ill people, drug addicts and others sleeping rough or in hostels, as well as single mothers in temporary accommodation. In general, the health status of homeless people is extremely poor, with high rates of mental health problems, infectious diseases (e.g. tuberculosis and hepatitis) and other physical problems ranging from cardiovascular disease to accidents and hypothermia (Plearce and Quilgares, 1996).

Homeless people are more likely than other groups to present with disease rather than at preventive or screening stages, and often use A & E departments for their health care needs (Power, French and Connelly, 1999). The main emphasis in terms of the provision of specific services for homeless people has focused on vaccination programmes, mobile screening clinics and the distribution of condoms. As Power and colleagues note, these interventions have tended to concentrate on young homeless people living on the streets or in hostels, whereas the needs of groups such as elderly people and families living in temporary accommodation have been largely ignored.
Evaluations have been conducted of targeted schemes to provide health services for homeless people. Their findings indicate that these schemes are more successful in providing direct services to homeless people than in achieving their dual aim of promoting integration into mainstream services. This suggests that health service provision needs to move away from traditional pattern of primary care based in general practice and greater emphasis should be given to working in partnership with homeless people themselves, their advocacy groups and health professionals in developing and evaluating services (Williams, 1995). Health service provision for homeless people also needs to be set in the context of changing government policies relating to homelessness and the introduction of nurse-run drop-in clinics and other services.

Recent migrants and refugees

In 1997 there were estimated to be 230,000 refugees living in the UK. They were drawn from a wide range of countries including Afghanistan, Sri Lanka, Somalia, and Kosovo (Jones and Gill, 1998). In 1997 it was estimated that 100,000 refugees or people awaiting confirmation of refugee status were living in London, almost half the total for the UK. (Turnberg, 1997). However, recent legislation leading to greater geographical dispersion may present greater difficulties in organising health services.

All refugees are entitled to the full range of NHS treatment free of charge but only a small number of studies have examined the extent to which refugee groups experience particular barriers to gaining access and utilising health services. One study undertaken by the Islington Refugee Working Party (1992) found that 38% encountered problems registering with a GP. However, the prevalence of these problems is likely to vary between areas and requires further study.

There is evidence of differences in GPs’ attitudes to accepting refugees. Negative attitudes are associated with the special needs of these groups, including high rates of psychological distress and language difficulties, which may take up a disproportionate amount of clinic time. In addition, immunisation rates may be low and medical records not available (Ramsey and Turner, 1993).

Proposals to improve provision for refugees’ health and the uptake of services include making available some of the money that has been negotiated for GPs whose work contains additional elements that are not properly rewarded. Other strategies include the commissioning of an information pack that includes a certificate of entitlement to NHS treatment, developing patient-held records for refugees, providing practices with detailed guidelines for the process of registration, and the development of a national telephone interpreting service in a range of languages (Jones and Gill, 1998). For example, a study in Hull identified that almost three-quarters of the Chinese respondents reported difficulties in communicating with their GP and 57% required an interpreter when seeing the GP (Campbell et al., 1998). There is thus a need to identify groups with particular needs and barriers to
access, and to monitor and evaluate the effectiveness of current locally based strategies to develop transferable approaches.

**Institutional populations**

People living in institutional accommodation experience particular barriers to the uptake of services, which here are considered in relation to institutional care for elderly people and the prison population.

**Elderly people**

The number of institutional care places for elderly people doubled to 563,000 between 1980 and 1995. This was mainly associated with the growth of private and voluntary (not for profit) residential and nursing homes, with a downsizing of long-stay provision in NHS hospitals (NHS beds accounted for less than 10% of beds in 1995 compared with 23% in 1980) (Laing and Buisson, 1996).

Residential and nursing homes do not provide for all their residents’ medical care in house, and this responsibility therefore rests by default on GPs. This forms a group with relatively high levels of morbidity and disability and potentially presents substantially increased demands for general practice. There has been a lack of evidence regarding the actual effects. However, Kavanagh and Knapp (1998) have produced workload estimates for GPs based on 595 establishments (nursing homes and residential homes). They suggest that the ‘downsizing’ of NHS provision for elderly people has increased demand on GPs by 160 whole-time equivalents per year in Britain.

A small-scale survey based on telephone interviews with 12 homes indicated that homes often deal with four or five GPs. Regular clinics are held in some homes (usually weekly), open only to patients of the GP organising the clinic. For other residents, GPs visited only when asked to do so by home staff and some homes reported difficulties in getting GPs to visit residents. Payments under the GP contract are small in relation to the level of activity and a few homes pay extra money to GPs for the care of their residents (Kavanagh and Knapp, 1999).

The current evidence on access to GP services is therefore fairly scanty but identifies substantial variation in access and organisational arrangements, and issues of availability and payment to GPs. There is no information on GPs’ or residents’ own views or preferences regarding organisational arrangements.

**Prisoners**

There are 135 prisons in England and Wales and more than 200,000 people pass through prison each year. Approximately 65,000 people are in prison at any one time, and overwhelmingly they come from some of the most socioeconomically deprived sections of the population.

Particular health problems of prison populations are high rates of mental illness and suicide (Singleton, Meltzer and Gatward, 1998; Reed
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and Lyne, 2000), and high rates of transmission of blood-borne viruses (HIV, hepatitis C and hepatitis B) associated with injecting drugs using shared needles and with homosexual sex (Smith, 1999).

Prisons have had their own medical service since 1877. This service was not incorporated into the NHS in 1948 and has since resisted incorporation (Smith, 1999). The Prison Service in England and Wales has since 1991 aimed to provide health care of the same standard as the NHS. However, it is acknowledged that for many prisoners this right is not met. This is documented in surveys associated with the system of inspections. For example, a review of 19 prisons in England and Wales in 1996–1997 identified the standard of health care as varying widely, with a few providing a quality of care close to that in the NHS but many providing low quality, with some doctors not being adequately trained for the work they faced (e.g. not completing training in primary care or in a specialty), some care failing to meet proper ethical standards, and little professional support available to health care staff (Reed and Lyne, 1997). Problems are compounded by the overcrowding of prisons and the limited training of nursing staff, of whom many are security officers first and nurses second (Smith, 1999). A review of the quality of care for people with mental disorders in prison identified similar problems. It concluded that the quality of services for mentally ill prisoners fell far below the standards in the NHS, and that patients’ lives were unacceptably restricted and therapy limited.

A recent major report (Joint Prison Service and NHSE Working Group, 1999) recommended a formal partnership between prisons and health authorities to assess prisoners’ needs and to plan service delivery, supported by a prison health policy unit within the Department of Health. The joint report defined specific action points and set a timetable. However, there are concerns that any separate service for a marginal group will prove inferior (Smith, 1999).

Traditionally, a large proportion of the data on the health and health care of prisoners was associated with official reviews. However, the Prison Health Promotion Development Project has now been jointly funded by HM Prison Service Directorate of Health Care and King’s Fund with an emphasis on health promotion in prisons. The project is set up to run until July 2001 and is located within the Directorate of Health Care, HM Prison Service. The aims are to provide HM Prison Service with advice and support to promote the health of prisoners and staff, to undertake research and evaluation to assess effectiveness and efficiency in prison health promotion, and to facilitate the Directorate of Health Care’s role as the collaborating centre for the WHO’s European Health in Prisons Project.

Other needs relate to improving the access and quality of care provided for prisoners with physical or mental health problems. In particular, as Birmingham (1997) noted, very little attention has been paid to the opinions of prisoners regarding their health care, although policies implemented without taking these views into consideration are unlikely to be effective.
Section 5  Financial barriers to access

**What is known?**

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 GPs 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.**

**Introduction**

Financial incentives can influence the behaviour of both patients and providers of health care services (such as hospitals and GPs). Financial incentives can dissuade (or persuade) the consumption of services, thus acting as a barrier (or gateway) to services, or they may encourage (or discourage) the provision of services, thus affecting availability. This chapter provides a review of current theory and empirical evidence of the impact of financial incentives on the behaviour of patients and providers in both primary care and secondary care. The review will focus on the different forms of financial incentives and the impact each has on patient or provider behaviour and access to care.
Financial incentives and patients’ use of services

Financial incentives can influence patients because, although the UK system is essentially ‘free at the point of use’, there are charges for specific services including eye tests, dental check-ups, and dispensing of prescription medicines. Charges can act as a deterrent to patients and as a barrier to access. The impact of user charges affects different socioeconomic groups in different ways. For some groups, access may not be compromised by a co-payment, while for others the charge may represent a significant deterrent. The impact depends on the size of the co-payment and crucially depends on the patient’s ability to pay (and therefore directly links with equity considerations, see Section 8). The insurance market (and social insurance-based schemes such as the UK) essentially removes most of the financial barriers to access so that patients do not face the full cost of care. This in itself, of course, creates an incentive, where patients may over-consume services. Where this occurs, other patients with more pressing needs may have problems accessing services (waiting times will become longer and patients who require urgent care may be displaced). Furthermore, it is argued that insurance-based systems create a further problem, which is known as ‘moral hazard’, whereby individuals fail to take full responsibility for their own health because they do not face the full costs of any ill health associated with their behaviour (for example, smokers might not smoke if they had to pay the full costs of cancer treatment). Thus, insurance systems take away barriers to access and this may lead to inappropriate utilisation of services, or may lead to excess demand for services and the subsequent problems this causes with respect to prioritising care.

The theoretical impact of user charges, or fees, levied on services is straightforward. It is hypothesised that if people have to pay for a service they will use less of it. The main impact of user charges is, therefore, on utilisation. The rationale behind user charges is that they can be used to deter frivolous utilisation of services, raise revenue for the health service, and act as a reminder to individuals of the value of the services they consume. There are, however, clear disadvantages in that user charges can have the negative impact of potentially excluding low-income individuals from consuming beneficial health care services.

There have been many studies (mostly from the USA) that have considered the impact of user charges and co-payments. As pointed out in a review of the literature on cost sharing (Rice and Morrison, 1994), most of the research has focused on how cost sharing affects the use of medical services (as opposed to health status, for example).

The RAND Corporation in the USA carried out the most complete examination of the impact of user charges on health service use. The experiments carried out observed the effect of varying the initial amount of cost sharing (the amount paid by patients for services) on health service use. They found, not surprisingly, that utilisation of all types of service (physician visits, hospital admissions, prescriptions, dental visits, etc.) fell as cost sharing increased (Newhouse, 1996).
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The NHS since its inception has aimed to make health care available to all regardless of income, at the same time assuring equitable distribution of resources regionally. Until the reforms introduced by the 1989 White Paper, the NHS was characterised by centralised financing and regulation. There are, however, two main areas where user charges are imposed: dental services and prescription charges. The impact of user charges in these two health care sectors has been examined in the UK.

Recent changes in the NHS General Dental Service have arguably led to a reduction in the availability of NHS dental care and increased charges. A study by Stoelwinder (1994) explored public and user views and experiences of NHS and private dental care in the light of these changes. The study employed a combination of quantitative and qualitative methods. The first phase involved a postal survey of a random sample of adults on the electoral registers in a county in Southern England. Follow-up face-to-face interviews were carried out with sub-samples selected from survey respondents. The evidence shows greater satisfaction with certain aspects of private dental care than with NHS care and suggests that the decline in perceived quality of NHS care is less to do with the quality of dental technical skills and more to do with access and availability. However, there was general support for the egalitarian principles associated with NHS dentistry, although payment for dental care by users was acceptable even though dentistry on the NHS was preferred. The shift in the balance of NHS and private dental care reflects the interests and preferences of dentists rather than of the public. It suggests, however, that a continued shift towards private practice is a trend that the public will not find acceptable, which might limit the extent of expansion of private practice.

Hughes and McGuire (1995) estimated the impact of charges for drug prescriptions in the NHS and found evidence to suggest that user charges reduced the number of prescriptions cashed in the UK. However, the impact of user charges is likely to affect different socioeconomic groups differently. Lundberg et al. (1998) found that price sensitivity decreased with age, income, education and self-rated health status. Furthermore, they found that sensitivity to user charges for drugs varied greatly between different types of drugs; for example, they found that if user charges doubled 40% of antitussive users would reduce their consumption, whereas only 11% of users of drugs for menopausal problems would reduce their consumption. It should be recognised that in the UK user charges are means-tested; low-income families and people over 65 years are exempt, as are individuals with certain chronic conditions, such as diabetes.

Some commentators suggested that user charges could (and should) be extended in the UK. Mufti (2000) suggested that user charges would be an important source of revenue in the UK where services cannot be cut and taxes are not imposed. He argued that user charges in public facilities would curtail over-utilisation and reduce inefficient use of resources by providing a link between financial responsibility and the provision of services. The financial implication facing patients would
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encourage them to be more cost-conscious, and their physicians would be encouraged to limit over-prescribing of drugs and the use of highly specialised diagnostic procedures for routine investigations or minor illnesses. Mufti suggests that the lack of economic incentives has led to a lack of concern for the cost of medical care. User charges would not only encourage both consumers and providers to be cost-conscious, but would raise revenue to ease pressure on the health budget, combat moral hazards and assert priorities. In order to be effective and make a serious impact on the health system, Mufti argues that user charges must be extended to all government sectors and specialist hospitals, and charges must be high enough to discourage inappropriate use of services.

Financial incentives and service providers

Financial incentives to service providers can influence both the availability of services and the types of service available. Payments to GPs for specific services can result in GPs being more willing to provide certain services. If this happens, then access to secondary care may be reduced; primary physicians have an incentive to provide care and may be more reluctant to refer patients to hospitals. Different types of payments to primary care physicians can result in different behaviour. Target payments, for example, where GPs are paid for providing certain services only if they achieve a particular threshold, provide no incentive at all for GPs who know they cannot achieve the minimum target level, thus potentially affecting access to care.

Hospitals themselves are in a similar position; they receive payments for providing different types of services. These payments create incentives that influence the way the hospital behaves and the type of services they provide. Hospitals may be encouraged through the payment system to increase the number or type of patient they admit. This may improve access (or alternatively decrease access). Alternatively the payment system may affect the type of care provided; for example, fixed payments that are made in advance for providing certain services may provide incentives for hospitals to discharge patients early, because the payment is not dependent on the length of time the patient is in hospital.

Paying GPs

It is widely believed that different payment methods create different incentives for providers of care. That is, the way physicians are paid may influence their behaviour and the services they provide. Payment systems have been used to influence the behaviour of GPs to achieve policy objectives. The most recent reform of GPs’ remuneration in the UK, in 1990, aimed to make general practice more responsive to consumers’ wishes and change the emphasis from treatment to prevention by using financial incentives.

In the UK, GPs are paid through a mixture of capitation allowances and fee-for-service payments, plus additional sessional payments and
target payments for providing particular services and achieving certain predetermined levels of service. (For a detailed literature review of studies estimating the impact of these types of payments see Gosden et al., 2000.)

Capitation payments

Capitation payments are payments received by GPs for each patient on their list. It has been suggested that one of main advantages of the capitation method of payment is that it provides GPs with an incentive to encourage patients to join their list (Donaldson and Gerard, 1989). Furthermore, GPs have an incentive to retain patients on their list, and therefore be responsive to patients’ wishes.

However, GPs may only have an incentive to attract low-cost patients (i.e. those with a low risk of disease or illness). The capitation payments are only adjusted very crudely for the likely burden to the practice of providing care (the adjustment is made through the capitation ‘age’ bands). The incentive this provides depends on the cost to the practice of providing care to the patient and the level at which the capitation fee is set. This can impact on access to care. For example, if capitation payments to GPs do not cover the full cost of care for certain types of patient, or if payments are not fully adjusted to take account of costs (the authors use the example of global health-based (risk-adjusted) payment systems, or AIDS-specific reimbursement rates), then this can limit access to care, because GPs will not be fully reimbursed for care provided.

Another advantage attributed to the capitation system is that it is consistent with the independent status of the GP. That is, it provides minimal interference with medical judgement. Furthermore, potentially at least, it provides a link between the income of the GP and his or her workload – represented by the list size. However, GPs may respond to a larger list size by reducing the length of consultations. Although this may improve overall access to care (shorter consultations may improve throughput), it may impact on quality in an adverse way; for example, misdiagnoses may increase and patients may require more intensive follow-up care as a result.

Indeed, one of the criticisms of the capitation-based system is that it may encourage GPs to minimise their own input into consultations by reducing the length of consultations, prescribing more, or referring more patients to hospital. A study by Krasnik et al. (1990) in Denmark, which investigated the effects on GPs’ activities of changing from a wholly capitation-based payment system to a mixed fee-per-item and capitation system, found evidence to support this. They concluded from their study that GPs whose remuneration was not directly linked to workload (i.e. it was capitation-based) were more likely to refer patients to the hospital sector. This may affect access to hospitals by creating extra demand for services and has implications for appropriateness of care.

A study by Leff et al. (1994) described an evaluation of the influences on service access, adequacy, and appropriateness in four capitated
public mental health programmes in the USA. Access, adequacy, and appropriateness were more favourable than the fee-for-service programmes, suggesting that the financial incentive in capitation was not a significant limiting factor. However, it has been suggested that the risks include limited access to certain types of care, lack of continuity of care, or possible conflict of interests between the physician and the patient. Chaix-Couturier et al. (2000) suggested that capitation payments decreased the total volume of prescriptions by up to 24% and hospital days by up to 80% compared with fee-for-service. That is, a cap on doctors’ income results in referrals to colleagues when their ‘target’ income level is reached.

More generally, however, Hughes and Yule (1991) have suggested that GPs may find it less easy to respond to incentives linked to list size, since they may have only limited control over the number of patients on their list, at least in the short run. This questions the overall effectiveness of capitation payments as a means of influencing GPs’ behaviour.

**Per-item fees**

Per-item fees are paid to GPs for providing particular items of service; for example, when GPs provide certain vaccinations they receive a flat-rate fee. Per-item fees have the advantage of rewarding GPs according to the amount of work they carry out and can be used to encourage GPs to provide specific services.

Per-item fees have been criticised as a method of payment because they may encourage GPs to recommend services to patients that will have little or no beneficial impact on the health of the patient, but will remunerate the GP. The extent to which physicians induce demand for their services has received attention in several North American studies. On the whole, the evidence is mixed. Donaldson and Gerard (1993) concluded that much of the evidence is ambiguous. However, some of the North American studies appear to have found strong evidence that the amount of care provided by GPs (or primary care physicians in the USA) is influenced by the level of payments. For example, Rice (1983) found that decreasing the reimbursement rate by 1% resulted in an increase of 0.61% in service intensity, and a 1% decrease in the reimbursement rate for surgical services resulted in a 0.15% increase in service intensity. This suggests that physicians may respond to changes in fee levels, at least in the USA.

Culyer (1989), in a similar review of such studies, concluded that fee-for-service methods result in both more active treatment and higher incomes for doctors, although most evidence once again referred to the USA. In a UK-based study, Horder, Bosanquet and Stocking (1986) suggested that the existence of per-item payments for cervical cytology was one of the influences leading GPs to increase the total number of smears they carried out by over 400% between 1966 and 1980 (although clearly other factors may have influenced this increase, including public awareness and attitudes to smear tests).
A study by Hughes and Yule (1992) employed quantitative techniques to examine the impact that per-item payments had on GPs’ behaviour in the UK over the period 1967–1989. This study considered two services: cervical cytology and maternity care. They found little evidence to suggest that changes in per-item fees have had an effect on the number of treatments provided by GPs.

It should be noted that in a system where the fees are set centrally, as in the UK, the incentive to provide treatments (or induce demand) depends on the level at which fees are set. If fees are set at such a level that they fail to compensate the GP for the cost of providing the service, there may be little incentive to provide the service. A study by Scheffler et al. (1996) estimated a ‘payment elasticity of access’ for dentistry in the USA – that is, the proportionate increase in access that occurs for a specific proportionate increase in payment. For Medicaid dental services the payment elasticity of access was found to be relatively low: while providers increase participation and the level of service they provide, this does not translate into corresponding increases in access. In effect, a 10% increase in payment translates into greater dental participation in the Medicaid programme, but yields less than 1% increase in access. These results have implications for other public service programmes with access issues and suggest that the level of payment, at least for dentistry, does not substantially affect the level of service. Other work by Mayer et al. (2000) in the USA also suggested that increases in the reimbursement rate were only marginally effective in increasing access to dental services for the Medicaid population.

The impact of payments systems may affect different groups differently. Haber and Mitchell (1999) examined whether changes in physician reimbursement under the Medicare Fee Schedule (MFS) had differential impacts on access to care for vulnerable and non-vulnerable patients in the Medicare scheme. The study selected a random sample to ensure adequate representation of vulnerable group members and constructed service-specific measures of the MFS payment change. The authors found that few effects on access were attributable to the MFS. However, they did find substantial utilisation gaps between vulnerable and non-vulnerable subpopulations for primary care services, as well as for high-cost procedures during episodes of care for acute myocardial infarctions.

Nonetheless, providing an incentive for GPs to provide services should not be considered as bad per se. If fees are used to achieve public policy goals, then fees may be the best way of encouraging GPs to provide a particular service and may generally improve access to care.

**Target payments and sessional fees**

Target payments are flat-rate fees that are paid to GPs once they achieve a predetermined level of service (for example, provide vaccinations for 50% of their practice population).

They have the advantage of remunerating GPs directly in line with their workload, based on their success in achieving particular levels of
services and, as with per-item fees, these payments can be used to encourage GPs to fulfil public policy goals.

Target payments have the disadvantage that if a GP cannot reach the ‘target’ level the incentive is not to provide any care at all. Furthermore, once the target level is reached there is no incentive to provide any more care over and above this level, which may lead to individuals who could benefit from a service not being catered for, and access being restricted. For example, a target level for cervical cytologies set at 80% requires that GPs provide smears for 80% of their list within a predetermined population group. However, it is not obvious that the 20% they do not screen would not benefit from the service, or that the 80% they do screen are those who would benefit most – therefore, the target levels are in many ways arbitrary.

Furthermore, while the average coverage of the population may be high, this may mask geographical inequities. In some areas GPs may not be able to reach the lower target. Thus, there is no incentive to provide the service since they will not be paid for any services provided below the lower target level. Consequently, service provision may vary between GPs and between regions.

Since target payments are a relatively new form of payment there is, as yet, little evidence regarding their impact. Some of the available evidence suggests that target payments have been effective in increasing provision. Hughes and Yule (1992), using the model they developed to analyse the impact of fees in the period 1967–1989, estimated the impact of the introduction of target payments. They found that in the first year of target payments there was a 50% increase in the number of cervical cytologies carried out by GPs, relative to the level they estimated would have been performed had per-item payments been retained. However, a recent review of target payments (Giuffrida et al., 2000) suggested that the available evidence was ‘not of sufficient quality or power’ to determine the effectiveness of target payments.

Sessional fees, as with target payments, reward GPs directly in line with the work they carry out. However, at least in the UK where clinics that provide ‘health promotional activities’ attract sessional payments, the incentive may be to undertake ‘clinics’ where previously the work might have been carried out in ordinary consultations. Evidence from a study carried out shortly after the new GP contract was introduced in 1990 suggested that significantly more patients were being seen by GPs in clinics after the new contract than before (Hannay and Usherwood, 1992). Consequently, the costs of providing a service may increase without any corresponding increase in health. Sessional payments may, therefore, encourage GPs to over-provide certain activities, regardless of the impact on the health of the patients.

**Allowances**

Allowances are paid for fulfilling certain requirements, such as providing a minimum number of surgery hours, or operating with a certain minimum practice list size. They have the advantage of
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providing a stable income and can encourage GPs to fulfil certain policy aims (such as encouraging group practice). They have the potential disadvantage of failing to give GPs a direct incentive to respond to patient’s wishes. Furthermore, as with capitation payments, since payment is not linked to workload the incentive may be for GPs to minimise their own workload, although, as with capitation payments, they may be seen to provide minimal interference with medical judgement.

Paying hospitals

There are three main methods of reimbursing hospitals: retrospective at full cost, prospective on a per-case basis, or through a market-based system. Each method has potential implications for hospital activity.

Retrospective payments

Retrospective payments systems involve hospitals receiving payment in full for all expenditures incurred during a predefined period. This system encourages hospitals to do as much work as possible, or to maximise lengths of stay, provision of diagnostic tests and other procedures. Anecdotal evidence from the USA suggests that the method of retrospective reimbursement accompanied a period of substantial growth in health care expenditure.

Prospective payments

The prospective reimbursement system requires hospitals to provide a service within a given budget. The level of payment received can be based on an estimation of the expected workload, and may be broken down into individual case-based payments. The reimbursement level is then set for each case type and the total budget received is based on how many cases the hospital treats (or is expected to treat). This type of system encourages hospitals to minimise costs: this can be achieved through shortening lengths of stay, substitution of less costly inputs for more expensive ones, or reducing quality of care (or a combination of all of these). Furthermore, hospitals may be encouraged to ‘cost-shift’ – for example to long-term care, or to the patient’s own home – whereby they shift patients into other sectors rather than incurring the costs of care themselves. These actions clearly have implications for access to secondary care facilities.

A study by Carroll and Erwin (1987) considered the impact of the introduction of a prospective payment system, hypothesising that prospective payments would result in shorter hospital stays. However, they concluded that there was little evidence that cost-shifting from hospital to other settings took place. However, evidence from Rosko and Broyles (1987) suggested that length of stay had shortened under the prospective payment system.

However, as with any payment system, the level at which the payment is set is crucial. Hamilton (1993) examined the implications of fixed-price reimbursement of providers for access to hospice care by Medicare beneficiaries. Hospices that were offered higher
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reimbursement rates by Medicare were found to be more likely to become certified to provide care under the Medicare Hospice Benefit programme. Each $1.00 increase in the daily routine home care rate raised the probability of certification by 1.7%. In turn, the Hospice Benefit increased access to hospice care by enabling Medicare-certified facilities to serve more patients than they would if they were non-certified. However, Hamilton pointed out that care must be taken to set reimbursement rates appropriately. Failure to correctly adjust reimbursement rates for the real costs of certification across different parts of the country could lead to disparities in hospice certification and differential access to hospice care for Medicare beneficiaries.

Glied (1998) considered the issue of incentives and examined what we know, and need to know, about designing incentives to encourage the production of high-quality care. He suggests that incentives should reduce risk selection, promote collaborative systems of care, and ensure access to appropriate specialty services. Further, he suggests that research findings needed for incentive design include information on the actual working of existing incentive mechanisms as well as information about risk adjustment, mixed payment system, carve-outs, and other mechanisms to reduce risk selection; options for defining service scope that encourage collaboration; and information about the ways in which quality measurement interacts with payment incentives. Design of payments systems is important; side effects may include reduced access to ‘unprofitable’ services.

Nonetheless, changes in prospective payments to reimburse physicians for serving Medicaid patients have been rising in many states in the USA. Policy-makers anticipate that higher fees will increase access to services. Travis (1999) explored whether physicians responded to the increased payment by increasing access differentially by patient type. Empirical tests using Medicaid data from 1988 to 1991 for prenatal care provision in Washington State showed that fees were significant in improving access to care for the average patient, with significantly greater improvement for Hispanic and single patients.

As Lu and Donaldson (2000) recognised, in general, incentive payments could increase health care outputs including access, quantity and effectiveness, as well as reducing costs of care. However, this system also introduces complicated incentives to providers, which makes the evaluation of the effect of payments on health care systems a challenging task, both theoretically and empirically. Furthermore, there are various practical issues, such as measurement of performance, which remain unsolved.

Cameron, Kennedy and McNeil (1999) analysed the effects of the Emergency Service Enhancement Program (ESEP), a system of bonus payments made to public hospitals in Victoria, Australia, to improve access to care for patients attending their Emergency departments. The ESEP indicators of Emergency department and inpatient bed access were: occasions of ‘ambulance bypass’ (Emergency department unable to accept patients arriving by ambulance); emergency waiting times for Category 1, 2 and 3 patients (on the National Triage Scale) compared with agreed national performance thresholds; and ‘access block’ (more
than 12 hours’ waiting time in the Emergency department before admission to hospital). The number of occasions of ambulance bypass per quarter significantly decreased, from 600 in 1994 to fewer than 100 in 1997. Despite an increased proportion of allpatient encounters that were in the more urgent triage categories 1, 2 and 3, zero waiting times for Category 1 patients were consistently adhered to, and adherence to waiting time thresholds for Category 2 and 3 patients improved significantly, particularly for Category 2 patients. The number of patients waiting longer than 12 hours in emergency departments decreased insignificantly. The results indicated that the ESEP produced improvements in all the indicators of access linked with bonus payments.

The market-based system

The market-based system allows hospitals to set their own payments levels. Under this system hospitals are encouraged to compete for patients. The result of competition may be varied. Hospitals potentially have an incentive to attract patients to their facilities; this may be achieved through higher-quality care, but they also have an incentive to minimise costs, which may compromise quality. The outcome depends on whether competition takes place through price or quality. In the USA it has been suggested that competition has resulted in a kind of health care ‘arms race’ where hospitals compete on the basis of high-tech equipment. This may improve access to up-to-date technology and diagnostic aids, but may not be efficient system-wide.

The logic of the internal market is such that hospitals that are inefficient should ultimately close (although there is little evidence of this emerging in the UK). Hospitals would have differential provision of services; some would have spare capacity, while others would have insufficient capacity to treat demand. This situation would persist until some sort of ‘steady state’ was reached. It has, however, been argued (Culyer, Brazier and O’Donnell, 1998) that provider markets can be amenable to measures directed towards geographical equity, since out-of-district purchases of services may release patients from dependence on local availability of services. It is argued that consumer choice may be enhanced through competition and relative efficiency may be enhanced through market forces. Whether this improves access is an open question, although generally improvements in efficiency may improve the number of services provided for the available resources; thus, overall provision may increase.
Section 6  Planning the supply of services: rationing, resource allocation and service configuration

What is known?

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 to 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 of 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 of 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.

Introduction

Geographical variations in the supply of services have been documented using aggregated routine data for different stages of the access–utilisation continuum. For example, the Department of Health’s High Level Performance Indicators show large variations among health authorities in the numbers of GPs per head of population; the proportion of the population registered with dentists; the proportion of women utilising breast and cervical cancer screening services; and the rate for elective surgical procedures, such as coronary artery bypass surgery.

Variations in supply are not the sole cause of variations in the utilisation of services, but it is clear that variations in supply of services impact on access to health care. Such variations raise questions about the level of resources required for health care, the methods used to allocate resources to different geographical areas, and the ways that services should be configured at regional and local levels.

Rationing

The NHS is a cash-limited system in which expenditure is determined centrally through the political process. There is, however, a problem of almost unlimited demand due to nature of health care and definition of ill health (which keeps changing as technology advances). Issues of how much should be spent on health care are often visited in the political debate that surrounds health care funding. Ever-increasing demand in the UK, as in all other countries, means that access to diagnosis and treatment is rationed. One definition suggests that rationing represents ‘societal toleration of inequitable access to health services’ (Hadorn and Brook, 1991).
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Rationing decisions are made in many different contexts and at many different levels. Wherever resources are rationed, access is restricted, either explicitly, for certain groups who may be restricted directly from accessing particular services because of their characteristics (age, type of condition etc.), or implicitly through the notion of opportunity cost, whereby some services are delivered at the expense of others because resources simply run out.

There has been much discussion about rationing of health care and the means and mechanisms by which decisions should be taken. Rationing decisions are highly dependent on the aims of the system. For example, it is argued that, if the aim is to maximise health benefits then resources should be allocated to those patients who will benefit most for a given resource outlay. The measurement of benefits is a highly contentious issue. There is, however, general consensus that the benefits of health care should take into account two dimensions: length and quality of life. It is often argued that those treatments that that most extend length of life, for example (holding all other factors equal), should be favoured over those which extend life by a lesser amount.

This of course has serious implications for individual comparisons; it will, for example, favour young people over elderly people (although evidence suggests that this may reflect societal values (Bowling, 1996)). There are commentators who support these implications. However, there are equally those who reject rationing along these lines. The rejection of rationing on the basis of age (and implicitly rationing with the aim of maximising health care benefits) is usually on the basis of notions of social justice and equity. These principles are strongly based within the National Health Service. The implications for access to health care are equally strong; however, there is as yet little consensus regarding the overriding principle – whether equity or efficiency should predominate. Equity, justice, and fairness are key ethical concepts in rationing. Like patients should be treated equally and unlike patients unequally. The notion of efficiency in the context of rationing health care is as an ethical choice, typically concerned with maximising improvements in health for the population as a whole.

If we take account of the outcome of health care interventions in terms of length of life, individuals who are likely to benefit over a longer period of their life should get resources first. As indicated above, this would have implications for groups such as elderly people, but may also affect other groups, such as smokers. For example, the prognosis for smokers after CABG is worse than for non-smokers. Life expectancy and often quality of life are lower than for the equivalent non-smoker, and it is sometimes argued that since smokers inflict self-harm they are less deserving. However, the implications of these decisions are not trivial. If we extrapolate these decisions to other groups, we could argue that people who put themselves at risk are less deserving – for example, individuals who undertake dangerous sports, e.g. rock climbers and rugby players. The question raised is how do we decide who should be excluded from receiving services, and which services should be excluded?
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That resources are scarce and so must be rationed is indisputable. However, in order to achieve the aims of the health care system, the decisions must be made on an explicit basis. The UK government recently created an organisation called the National Institute for Clinical Excellence (NICE). NICE was set up as a Special Health Authority for England and Wales on 1 April 1999. It is part of the NHS, and its role is to provide patients, health professionals and the public with authoritative, robust and reliable guidance on current ‘best practice’. The guidance will cover both individual health technologies (including medicines, medical devices, diagnostic techniques and procedures) and the clinical management of specific conditions. NICE is developing clear clinical guidelines to help health professionals give their patients the best care the NHS can afford. The overall aim is to be more explicit about rationing decisions.

Some of the decisions made by NICE have already filtered through to service provision. For example, people who are prescribed Viagra on the NHS include those who have undergone radical pelvic surgery or have had their prostate gland removed, people with spinal cord injuries, people with diabetes, and people with multiple sclerosis and other single-gene neurological diseases that cause impotence. Other judgements have been made on drugs and treatments that are being rationed, including beta-interferon, anti-psychotics such as Risperidone and Olanzapine, and the anti-cancer drugs Taxol, Irinotecan and Gemcitabine.

The implications for access are clear. Some individuals are prevented from gaining access to health care as a result of the characteristics, nature, or cause of their disease, or through their own behaviour. Other treatments, while available, are not provided through the NHS, although they may be available privately. For example, only around 18% of all in vitro fertilisation (IVF) treatments are provided through the NHS, which creates a potential inequity of access related to ability to pay. This has recently been the subject of attention for government ministers, who suggested that all patients should have access to first-cycle therapy on the NHS.

The main factors that determine how resources should be allocated, and who should receive treatments, are the aims of the health service, the benefits of treatments, and the costs of treatments.

There may be several objectives of the health service. For example, the aim may be to maximise health gain, or minimise health inequalities (these may be geographical, group, or individual). The objective may be to improve the health of the worse-off, or provide social reassurance. These objectives in practice are likely to be multiple and conflicting. Even if it were possible to narrow the objectives down to ‘improving health’ there are many different groups that may receive priority. For example, it has been suggested by New (1996) that the health service may want to concentrate on improving health of the following groups:

- people most in need (those with greatest ill health)
- particular disadvantaged groups (poor, ethnic minorities)
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- people upon whom others depend (e.g. those with children)
- people whose contribution to society is highly valued (e.g. eminent scientists)
- people who ‘deserve’ it (e.g. those who avoid an unhealthy lifestyle)
- people who have been waiting longest
- particular age groups (e.g. those who have most of their lives before them).

For each of these groups and individuals, it is also important to consider their benefits from treatment. These can be personal benefits, in term of mortality, health-related quality of life, satisfaction, and less tangible factors such as autonomy, moral worth, dignity, etc. There are also wider benefits to society such as security, reassurance and issues of social justice.

The remaining issue that needs to be considered is cost. The notion of cost is central to the rationing decision, and particularly the notion of opportunity cost – that is, that every decision to treat one individual, or group of individuals, involves a loss to others who remain untreated. Cost is an underlying constraint on all the objectives of the NHS. The cost of treatments and the sacrifice made by groups who forgo treatments are central to the whole issue of access.

Rationing involves definitions of efficiency (benefit) and equity (fairness) allocation criteria, and recognition of the trade-off between the two. If equity of access is considered to be the overriding principle determining resource allocation, then we must accept that benefits will not be maximised, although central to this issue is the definition of equity (and whether we are referring to vertical or horizontal equity).

An integrated rationing process requires management of the criteria for patients’ access to the health care system.

The reality of the rationing process may differ somewhat from the theoretical aims and processes outlined above. Many decisions about whom to treat are based on ad hoc decision making. The ‘postcode lottery’ that allegedly exists in the NHS has attracted much attention in the media, whereby differential provision of health care occurs within different health authorities. There are serious implications for access and, in particular, equity of access. Doctors who make rationing decisions do not have the time or the information to be able to make fully informed decisions based on the total needs of the population. Although, recently, NICE has aimed to make these decisions more explicit, there are many teething problems. As long as rationing decisions are made in a covert and implicit way, access to health care will be variable, the aims of the health care system will not be fully met, and a proper debate about efficiency and equity will not be possible.

Since rationing is inevitable, the question is not usually about whether we should allow access for all individuals to all services but, rather, how we should decide whose access to certain services should be restricted, and which services should (and should not) be provided within the health care system.
Resource allocation to health authorities

The existence of geographical inequalities in availability of services prompted the establishment of the Resource Allocation Working Party during the 1970s. The basic objective of the working party was to move from the historically based patterns of resource allocation in the NHS to a system in which the allocation of resources was more closely aligned with the health needs of the population. The formula that was devised incorporated measures of the size and structure of the population, weighted for measures of need. Initially, standardised mortality ratios were used as indicators for morbidity (Mays, 1987) but the Jarman score, and other census-based measures of deprivation, have also been used more recently as indicators of need (Mays, 1989). The formula used to allocate funds to health authorities for secondary care has been reviewed and revised on several occasions (Smith et al., 1994; Carr Hill et al., 1994) and the NHS Plan proposes a further review and revision of the resource allocation formula (Department of Health, 2000a). At present there is a lack of transparency in the allocation of funds between different types of service (for example, acute or community) and different client groups (for example, children or older adults). At the local level, allocation of funds may be driven very much by historical precedent and a political requirement to maintain acute services. This may conflict with the need to improve access to specific services, or for specific client groups. A full review of the literature relating to resource allocation is beyond the scope of this review. It should be noted that the Department of Health funds research into resource allocation, mainly at the University of York.

Until now, primary care services have not been included in the resource allocation formula, and the distribution of GPs across the country has been particularly uneven. In order to improve geographical equity in primary care, the NHS Plan proposes to include primary care services within the remit of the resource allocation formula for the first time (Department of Health, 2000a). Personal Medical Services pilots will also be extended in order to promote the development of primary care in deprived areas. An evaluation of Primary Medical Services pilots is also being supported by the Department of Health.

Spatial distribution and configuration of services

Planning the configuration of services at local, regional and national level needs to be informed by evidence, including an understanding of patients’ preferences, as well as the effectiveness, efficiency and equity of different configurations of services. Current policy tends to favour centralisation of specialist services (for example, services for cancer treatment, cardiac surgery, or neonatal and paediatric intensive care) because it believed that higher-volume care is associated with better outcomes. The evidence for this approach is mostly derived from observational studies, which may be biased through inadequate adjustment for case mix. This question was reviewed with respect to
cancer services by Selby, Gillis and Haward (1996) and for cardiac surgical services by Sowden and colleagues (Sowden and Sheldon, 1998; Sowden, Deeks and Sheldon, 1995).

An argument against excessive centralisation of services is provided by the well-established inverse relationship between the distance of residence from a health care provider and utilisation rate. A number of studies have shown that increasing distance from a service is associated with lower use of that service, including uptake of screening and immunisation (Goddard and Smith, 1998), primary care (Nemet and Bailey, 2000) and secondary specialist care (Roderick et al., 1999).

In general, distance from service is a deterrent to use, but there are variations depending on the nature of the service (Gregory et al., 2000; Jones et al., 1998) and for different socioeconomic groups. Recent studies have highlighted that it is not distance per se but rather time and cost of travel and access to reliable private or public transport that are more likely to be the critical factors (Lovett et al., 2000).

Proximity or availability of a service can increase demand (Goodman et al., 1997).

There has also been much debate about the special problems of access in rural areas (Haynes and Gale, 1999 and 2000; Rousseau, McColl and Eccles, 1994; O'Reilly et al., 1998). It has been argued that these are largely due to deprivation, which is known to be associated with higher levels of need; however, it is only recently that studies of geographical access to care have made adequate control for the confounding effect of need (Haynes et al., 1999) and how this effects outcome (Jones et al., 1998).

Much has been written on the theoretical aspects of space and distance on the supply and delivery of relevant health care services (Joseph and Phillips, 1984; Eyles and Woods, 1983), but optimal hierarchical arrangements of services are seldom achieved because of historical distribution of specialist services and referral patterns. However, ‘ideal’ approaches are sometimes used as a basis in planning some new services (Smallman-Raynor, Muir and Smith, 1998). Recently, more accessible near-patient testing centres, community outreach clinics and satellite treatment units have been introduced in order to overcome some of the access problems associated with centralisation of services.

Of course, the configuration of structures and services within the NHS is in an almost continual state of change as health authorities merge or devolve functions to primary care trusts, hospital trusts rationalise services to fewer sites, and community trusts align their services with primary care organisations. Sheldon (2001) has pointed out that this state of perpetual organisational change may often be driven by the political and managerial agenda, with little input from research evidence on the effectiveness, efficiency or equity of different configurations of services. The evaluation of organisational change in the NHS provides a potentially large area for research. There is a risk that ongoing work may be marginalised by future events, but a better understanding of the impact of organisational change on access, utilisation and outcomes of care is desirable.
Section 7 Organisational barriers to access

What is known?
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.
Access to Health Care

Introduction

Organisational barriers to access are most evident in the long waiting lists and waiting times for NHS treatment (Carroll et al., 1995). At the primary care level, patients with an acute condition may have to wait several days for an appointment. At secondary and specialist levels, there are long waits for outpatient appointments and elective or acute admissions. As well as experiencing delays in gaining initial access to the health care system, there are delays in accessing different processes within the system. For example, after their initial appointment, cancer patients may experience delays before diagnostic procedures or definitive treatment. Older people in hospital experience delays before admission to intermediate or home care.

Delays are undesirable because they cause dissatisfaction among patients and staff and they may lead to worsening clinical and patient outcomes (Meier-Kriesche et al., 2000; Berger et al., 1999; Eldar et al., 1999; Beringer, Crawford and Brown, 1996; Weaver, 1995). Delays are also costly (Feldman, 1994) because maintaining a waiting list requires resources, patients will often require interim treatment while waiting and may eventually be treated with more severe and costly conditions, and a high ‘did not attend (DNA)’ rate is common after long waits (Bowman et al., 1996; Stern and Brown, 1994; Houghton and Brodribb, 1989). One survey showed that in the UK on average 4.5 appointments are missed per GP per week, amounting to 8.5 million missed GP appointments per year, with an estimated cost of £150 million (Beecham, 2000). The situation is similar in secondary care (Warden, 1995).

Long waiting times are indicative of organisational barriers to health care which may result from a combination of lack of capacity in the NHS, as well as inefficient use of existing capacity. The NHS Plan set ambitious targets for reductions in waiting times through increased investment and redesign of services, with the replacement of waiting lists with booking systems (Department of Health, 2000a). Waiting times for cancer have been a particular focus (Department of Health, 2000d) but the initiatives involved may sometimes be counter-productive (Berger et al., 1999).

Work on waiting times is being taken forward by the Modernisation Agency including the National Primary Care Development Team and the National Patient Access Team (NPAT). This section of our report was informed by reports from NPAT, as well as attendance at a seminar on Advanced Access organised by NPAT in Manchester on 14 November 2000.
Access to Health Care

Organisational barriers to primary care

The main concerns with access in primary care include ability to register with the GP of choice, ability to obtain a timely appointment, and ability to access care outside working hours.

Registration with a GP

In a survey of 1,139 adults in London organised by the King’s Fund (Malbon, Jenkins and Gillam, 2000), 86% of subjects said that they found it easy to register with their current GP, and 70% said they had registered with their first choice of doctor. However, 20% of women reported that it would be difficult to see a female GP, and the proportion was slightly higher for women registered with a single-handed GP. While these data indicate a fair level of satisfaction with access to GP services, several concerns need to be addressed. In particular, access to GP services in inner city areas may be difficult because of geographical inequalities in the distribution of GPs, and the needs of special groups may not be met adequately.

In a study from inner London, Jenkins and Campbell (1996) found that the geographical catchment areas of general practices varied almost 150-fold in size. The catchment areas of practices with higher indicators of quality of care were much smaller than those with lower quality indicators. The densely clustered catchment areas of better practices suggest that there will be a lack of access to better-quality primary care services in this environment. This issue is being addressed by Personal Medical Services (PMS) pilots which allow for the development of new models of organisation of primary care. A particular aim of PMS pilots is to provide access to good-quality primary care for those who previously had only limited access. PMS pilots are being evaluated jointly by the King’s Fund and the National Primary Care Development Centre and a report on the evaluation of first-wave sites was published recently (National Primary Care Research and Development Centre, 2000).

Discrimination against individual patients and patient groups is an important issue in primary care. Some 83,000 patients are removed from GPs’ lists in England each year and this is a common source of complaints to the Health Service Ombudsman (Warden, 2000). One study from Northern Ireland found that fundholding practices removed significantly more patients from their lists than non-fundholding practices, which suggests that there may sometimes be a financial motivation for removal of patients in some cases (O’Reilly et al., 1998). Other groups who have difficulty registering with general practices include homeless people, drug users and others who are considered to be demanding or antisocial (see Section 4).


**Access to Health Care**

**Appointment times**

Difficulty with obtaining GP appointments is a key concern in the NHS. In the King’s Fund survey (Malbon, Jenkins and Gillam, 2000), only 21% of people said they would be able to get a non-urgent appointment the same day, and 18% on the following day. Most people (55%) would have to wait more than two days, and 28% more than three days. The problem is recognised to be widespread.

At present, general practice appointment schedules are often saturated for a week or more in advance. This causes great difficulties for patients and practice staff (especially receptionists) and capacity is used inefficiently because many patients do not attend for their booked consultation. Often they will have improved, or obtained care elsewhere, before their appointment. Reserving time in the schedule for ‘urgent’ cases tends to aggravate the situation because there is then less time for ‘routine’ cases, and there will inevitably be misclassification of urgent cases as routine.

Murray (2000) argues that most consultation time in primary care should be reserved for use by patients requesting consultations that day. There is then a single queue for treatment, which is short enough to ensure prompt treatment for urgent cases. Only 20–25% appointments need to be reserved for patients requiring repeat (pre-booked visits). Implementing this approach will require additional work to clear the existing backlog, but Murray suggests that fears that the system will be unsustainable because of insatiable demand will prove unfounded. In fact, capacity will be used more efficiently because of a reduced ‘DNA’ rate. However, waiting times will increase if demand and supply are not in balance. In other words, ‘today’s work must be done today’. It is therefore important to have contingency plans to deal with imbalances that might arise through doctors’ absences or periods of increased demand. Murray suggests that improvements in access are not associated with sustained increases in demand. Furthermore, the demand for appointments can be managed by using telephone and electronic consultations or by reducing repeat visits.

Work promoted by the National Primary Care Development Team suggests that this approach to the scheduling of primary care appointments can be successful. General practices in Sheffield and south London have been successful in maintaining short waiting times over periods of several months. The NHS Plan proposes that models of good practice in primary care scheduling should be disseminated within the NHS.

While most practices will be concerned with improving the methods for scheduling patient appointments, a smaller number may be exploring new models for providing care. NHS Direct now offers an alternative first point of contact with the NHS. Other initiatives include the use of nurse practitioner clinics to deal with acute problems on the same day. Two evaluations were recently published and both supported the role of nurses as the first point of contact in primary care (Venning et al., 2000; Kinnersley et al., 2000) (see Section 9).
Out-of-hours care

Access to GP services outside normal working hours has been addressed by a significant amount of research (see also Sections 4 and 9).

The level of demand for out-of-hours care is substantial. One survey of 20 co-operatives in England and Scotland found that there were 159 calls per 1000 patients per year (Salisbury, Trivella and Bruster, 2000). The main individual-level factor predicting demand was age, with children under five years having call rates four times higher than adults. Patients living in deprived areas made 70% more calls than those in non-deprived areas. Co-operatives responded to 83% of calls within one hour, with 45% of calls being handled by means of telephone advice, 24% by a home visit and 30% by a visit to a primary care centre. The level of demand may be higher than these figures suggest because some demand is met by other emergency services, but Carlisle et al. (2000) found that deprived areas generated high workloads for both GP and hospital A & E services rather than one service substituting for another.

In recent years, there has been an increasing tendency for general practices to use deputising services or to group together into co-operatives to provide out-of-hours care. There appear to be significant differences in clinical practice between these different forms of care, with deputising services making more visits and issuing more prescriptions (Salisbury, 1997), but patients appear to be more satisfied with care provided by their own GPs (McKinley et al., 1997).

These conflicting observations have led to attempts to develop new models for organising out-of-hours care (see Section 9). Lattimer et al. (1998) evaluated a system of nurse telephone consultation for out-of-hours advice in primary care and found that this resulted in a reduction in GP workload while providing faster access to information and advice. NHS Direct is now being implemented nationally, but the results of initial evaluations are less positive (Munro et al., 2000).

Cragg, Campbell and Roland (1994) evaluated out-of-hours primary care centres but found that most patients were not currently prepared or able to attend a central primary care centre. This observation points to the importance of understanding patients’ reasons for using out-of-hours care. One qualitative study found that symptoms of illness were not the only reason for using out-of-hours care. Patients’ concerns about illness, their responsibility to others, and previous experiences with self-care and health care also influenced their current use of services (Hopton, Higg and McKee, 1996). The authors suggested that these concerns need to be incorporated into approaches for educating the public in appropriate use of emergency services.
Access to secondary care

Patients may be referred from primary to secondary care by a variety of health professionals including GPs, nursing staff, health visitors, dentists, optometrists and physiotherapists (Jones, Lamont and Haines, 1995). Self-referrals by patients to Casualty and direct access clinics are also important. There are concerns about the appropriateness of referrals to hospital because of the wide variations in referrals between different practices and professionals (Coulter, 1998; Bowling and Redfern, 2000; Reid, Cook and Majeed, 1999; Baker et al., 1999). Variations in referral rates may conceal failures to refer, as well as unnecessary referrals. Reasons for variations in hospital referrals have been the subject of much research and include doctors’ and patients’ concerns about diagnosis and specialist treatment, requests by patients, and fear of litigation, but much of the variation remains unexplained.

Prioritisation and clinical scoring systems

There are large variations in waiting times for elective hospital care across the UK, as well as large variations in hospital utilisation rates for many clinical conditions. This has led to the recognition that clinical uncertainty leads to variations in practice. Variation is undesirable because it leads to random inequalities in access to care, in addition to the systematic inequalities discussed in the next section (Pell et al., 2000; Marber, MacRae and Joy, 1991; Hippisley-Cox and Pringle, 2000; Alter et al., 1999). Recently there have been attempts to define thresholds for treatment more explicitly using clinical scoring systems. Hadorn and Holmes (1997a and 1997b) described a clinical scoring system which estimated a priority score for coronary artery bypass surgery using clinical data concerning the severity of symptoms and the extent of disease on coronary angiography. The method was underpinned by evidence from randomised controlled trials concerning the effectiveness of coronary artery bypass surgery in disease of varying severity. The authors suggested that the approach could be used to bring greater uniformity to referral decisions, and the approach might be particularly useful when capacity was limited. Methods for clinical prioritisation have been explored (Leung, Tregoning and Farrer, 1999) in the UK, and have been endorsed by some professional bodies (Health Policy and Economic Research Unit, 2000). It is important to emphasise that this approach can only be used to rank patients with a single condition at present. However, Lack, Edwards and Boland (2000) described a system for assigning priority across conditions, based on clinical, functional and social characteristics of the patient’s condition. They observed that the implementation of such a system would depend on its acceptability to patients and professionals.
Waiting lists and waiting times

Long waiting times for medical and surgical treatments are a serious problem in the NHS. The analysis of waiting times in secondary care is more complex than for primary care because patients are separated by client group or condition, and there are more complex care pathways and packages of care. While lack of capacity may contribute to delays, inadequate management of existing capacity can also lead to long waits. For example, many repeat visits to outpatient departments may possibly be unnecessary (McKee and Waghorn, 2000; Teale et al., 2000; Frankel and Faulkner, 1994).

A basic problem with existing systems is that they have seldom been planned from the perspective of patients. An extreme example might be provided by an outpatient clinic at which all patients are asked to attend at clinic start time. They then all have to wait until there is an opportunity to see a doctor. Availability of a doctor acts as a bottleneck. Efficient scheduling of the clinic obviously requires the arrival of patients to be matched to the availability of doctors. This can be difficult to predict, because doctors may be responsible for dealing with emergencies during clinic time.

Improving the flow of patients through pathways in secondary care requires patient pathways to be mapped so that bottlenecks can be identified and arrival of patients scheduled appropriately. Resources can be directed to increase the capacity of critical points of the system, or to alter patterns of demand. For example, maintenance of equipment might be organised to take place outside working hours, or diagnostic tests might be organised to be done during a single visit to hospital (Jain et al., 1997). Contingency plans need to be made to cope with unexpected variations that might affect the capacity of the system (equipment failures, staff absences) or patient flows (unexpected complications that increase length of stay). This is particularly important for inpatient care, because elective and acute cases are in competition for the same resources. For example, smooth scheduling of elective orthopaedic cases may be disrupted by acute admissions of patients with fractured neck of femur requiring immediate treatment. A recent report from the Cancer Services Collaborative (National Patient Access Team, 2000a) provides examples of changes to service delivery which have improved patient flows and shortened times to treatment.
Access to Health Care

Hospital booked admissions

The NHS Plan includes a commitment to introduce booking systems covering all hospital appointments and admissions by 2005 (Department of Health, 2000a). It is argued that this will increase patients’ choice, as they will be able to select a time convenient to them; reduce patients’ uncertainty; and improve the organisation of hospital clinics, beds and theatres because there will be a requirement to ensure that adequate capacity is available to meet the scheduled demand.

Currently, booking systems have been piloted in 24 sites. Systems covering day case and inpatient admissions have been piloted in 23 sites and 17 sites respectively; 14 sites have piloted systems that allow GPs direct access to booking systems for consultant outpatient clinics and day case lists (Kipping et al., 2000).

Results to date have demonstrated that it is feasible to introduce booked admission systems. For both day case and inpatient admissions, initial results indicate that booking systems can lead to reductions in the number of patients waiting for admission, the number of DNAs on the agreed date, and the number of patient-initiated cancellations. For inpatient care, the pilots also led to a reduction in hospital-initiated cancellations, although such events increased amongst the day case systems that were introduced. Results from the pilots also suggest that patients (Kipping et al., 2000) and hospital doctors (Department of Health, 2000a) have positive attitudes towards booking systems.

Future challenges

However, the initial pilots have covered only a limited number of specialties and sites. A number of challenges will have to be tackled if there is to be a comprehensive system of booking covering all admissions and appointments.

Booking systems require that hospital demand and capacity (in terms of, for example, beds, theatres, and staff) are matched. This matching is less difficult for day case admissions because the key resources required tend to be based within dedicated facilities. The findings from the pilot sites support such an assumption (Kipping et al., 2000). However the task of matching capacity and demand is more difficult when booking systems are introduced for inpatient admissions (Kipping et al., 2000; McGauran, 2000) because the types of hospital capacity required are more varied and these can be spread throughout and beyond the hospital.

Results from the pilot sites (Kipping et al., 2000) indicate that the difficulties of introducing inpatient booking systems are greatest for specialties which have a high proportion of emergency and urgent admissions, because these may utilise capacity previously allocated to booked admissions. The sophistication of booking systems also needs to be greater for specialties that use high-dependency and intensive care beds and staff from a variety of disciplines, such those providing rehabilitation or ongoing care following hospital discharge.
NPAT are facilitating and supporting the development of the booked admissions programme (National Patient Access Team, 2000b). They have commissioned staff from Cranfield University to develop a decision support system for identifying and scheduling the resources required by outpatient, day case and inpatient admissions. The results of this research should be available in 2001.

Developments in information technology will also be required to support the introduction of systems that allow the direct booking of hospital appointments and admissions by GPs (McGauran, 2000; Meredith, Ham and Kipping, 2000). To date, methods such as fax and e-mail have been used.

Finally, clinicians have expressed concerns that direct booking may lead to an increase in referrals from GPs. This is an issue that is being addressed in the evaluation that is being conducted by staff from the University of Birmingham (McGauran, 2000).

**Access to acute hospital care**

There is currently an upward trend in emergency admissions to acute care, and in particular admissions among those aged over 65. Between 1989 and 1994, the number of emergency admissions per head of population increased by 2.1%, and by 3.3% for those over 65. From 1994 to 1998 there was an overall increase of 2% in emergency admissions, 2.7% for those over 65 (Department of Health, 2000e).

Although there was a downward trend in bed numbers over this period there was also an upward trend in bed occupancy rates and a reduction in average lengths of stay. These latter two effects helped to offset the effects of the rise in admissions.

However, in recent years this downward trend in lengths of stay has flattened and possibly reversed (Coventry Business School, 1998). Research also indicates that when average occupancy rates exceed 85%, the difficulties that hospitals face in responding to the peaks and troughs of demands for acute care increase rapidly (Emergency Services Action Team, 1998; Bagust, Place and Posnett, 1999). The vast majority of hospitals currently function at average occupancy rates above 85%.

As a consequence, acute hospitals have struggled to cope with the continuing rise in emergency admissions, particularly during the winter months. These ‘winter pressures’ have traditionally manifested themselves as a shortage of acute beds for emergency medical care and as delays and trolley waits in hospital Casualty departments. Difficulties in obtaining access to beds for specialist intensive care have also been experienced (Emergency Services Action Team, 1998; Scrivens, Cropper and Beech, 1999).

In recent winters, health authorities have received special allocations of funds to develop schemes for offsetting the effects of winter pressures and for maintaining patient access to acute beds (Scrivens, Cropper and Beech, 1999). One approach to tackling potential shortfalls in the
availability of acute and specialist beds is to increase capacity by opening or extending hospital wards. This tactic has commonly been used, although the shortage of specialist nurses has hampered plans to increase the number of intensive care beds (Emergency Services Action Team, 1998).

However, an increase in acute and specialist beds is not seen as the only mechanism for improving access to emergency care. Local winter pressures planning teams have been encouraged to adopt an analytical perspective which covers the whole system of health and social care (Rogers, Flowers and Pencheon, 1999; Department of Health, 2000e; Social Services Inspectorate and NHS Executive, 2000). The rationale for this broad perspective is the belief that investments beyond the acute setting might help to prevent some acute admissions and facilitate the discharge of patients from acute hospital beds. It is argued that the release of this ‘inappropriately’ used bed capacity would effectively increase the availability of acute beds. In this way, access to beds for emergency care would be improved.

To support the National Beds Inquiry, McDonagh, Smith and Goddard (2000) conducted a systematic review of current literature relating to the inappropriate use of acute beds. Key findings were that:

- documented rates of inappropriate bed use by adult medical patients ranged from 15–50%
- it was likely that at least 20% of acute beds occupied by elderly patients were inappropriately used; patients occupying these beds mainly needed ‘moderate’ nursing care or long-term care
- around 20–30% of beds occupied by stroke patients were likely to be occupied inappropriately; waits for home adaptations or nursing home placements were the main reasons for delayed discharge.

As a result the authors of the National Beds Inquiry (Department of Health, 2000e) concluded that:

Current inpatient services do not match patients’ needs as well as they should …. The Inquiry has found evidence of significant inappropriate or avoidable use of acute hospital beds and of shortages of service alternatives to acute hospital care that could reduce admissions and bring care closer to or into patients’ homes.’

The reports of the Emergency Services Action Team and Millennium Executive Team have also highlighted local concerns that inadequate primary care out-of-hours services may lead to inappropriate referrals to acute hospitals (Emergency Services Action Team, 1998; Social Services Inspectorate and NHS Executive, 2000). The appropriateness of referrals from nursing and residential homes has also been questioned.
Section 8  Fairness in access for different groups

What is known?

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 may be 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.
Access to Health Care

Introduction

In the last section, we identified lack of timeliness of care as a key indicator of organisational barriers to health care. In this section we identify inequity as a key indicator of problems with access to health care. We have suggested that problems with access, and inequity in access, may result from a range of factors including patients’ help-seeking behaviours; financial incentives to both patients and providers; the extent, distribution and configuration of available capacity; and organisational barriers to care. Inequities in the health care system provide an important summary measure of the overall impact of these different factors on the population’s access to health care. This section should therefore be read in conjunction with the preceding sections. There is an extensive literature on many aspects of inequalities in health and access to health care. This section does no more than suggest a few key areas for future work. The reader is also referred to a recent review of equity in access to health care by Goddard and Smith (1998). Other reviews and policy documents are cited later in the section.

Definitions

Inequality denotes the existence of systematic variations, but inequity goes further and introduces the ideas of lack of fairness and social injustice. In this report we are mainly concerned with inequality and inequity in the delivery of health care, but inequality and inequity in the financing of health care also influence the accessibility of services.

Evaluation of equity in health services presents methodological difficulties. Although it has been proposed that ‘equity audits’ should be routinely conducted (Department of Health, 1995), few good-quality studies have been reported. Methodological advice on the evaluation of equity in health services would therefore be desirable.

Equity in the delivery of health care

Equity of resource

Equity is also an important consideration in the allocation of resources for health care. Based on considerations of equity, health care resources should be distributed according to need. To the extent that resource allocation is inequitable, this will negatively impact on a population’s access to health care (see Section 6).
**Equity of access**

Here, the term ‘equity’ is used to describe the extent to which different groups have equal access in relation to equal health care needs. Equity in access to services has two aspects.

1. **Horizontal equity** exists when groups with equal needs have equal access to health care.
2. **Vertical equity** exists when groups with different needs have appropriately different access to health care.

Horizontal equity is the form of equity which is more often evaluated. Horizontal equity exists when variations in service access are explained by need and not by income (or measures of socioeconomic status). Need is strongly associated with measures of socioeconomic status and income, so evaluation of equity should allow for confounding. When indicators of access are included in multiple regression analyses as dependent variables, both ‘need’ and ‘income’ variables should be included as explanatory variables. Equity exists when utilisation is only explained by need and not by income or socioeconomic status (Wagstaff, van Doorslaer and Paci, 1991). Based on our definition, appropriate indicators of access may include measures of service availability, service utilisation or health outcomes of care.

**Equity of outcome**

The health needs of different groups may differ qualitatively as well as quantitatively. Although generic measures of health status may be used to assess need, it is generally recognised that these may be insensitive to aspects of specific health problems. Furthermore, in a given state of health, different groups may rate their perceived health differently. There is a particular problem when making comparisons across age groups because older people tend to rate their health more favourably than younger subjects. In other words, when faced with different groups with differing health needs, it may not be possible to make a precise judgement of the equity of service access. It is then important to identify groups whose needs are not being met, and this will be achieved by comparing health outcomes (see below).

**Equity in the financing of health care**

When considering the financing of health services, equity refers to the extent to which equal contribution is made in relation to ability to pay (Wagstaff and van Doorslaer, 1992). Two aspects can again be distinguished.
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1. Horizontal equity exists when groups with equal ability to pay make equal contributions.

2. Vertical equity exists when groups with different ability to pay make appropriately different contributions.

The NHS is mostly financed from general taxation, which is considered to be the least regressive method of financing health care (Wagstaff and van Doorslaer, 1992). However, user charges for prescriptions and other specific services are usually paid for out of pocket and are likely to be regressive, unless exemptions are sufficiently broadly based. Private care may be used by those who are able to pay, or who have health insurance. In the context of this report, inequity in the financing of health care is important because it represents a barrier to accessing health care. The relationship between financial incentives and equity of access was discussed in Section 5.

Socioeconomic status

Inequalities in health in relation to socioeconomic status are very well documented, and many measures of health are associated with lower socioeconomic status (Carr Hill et al., 1994; Department of Health, 1995).

Tudor Hart (1971) outlined the ‘inverse care law’ which described a situation in which people in deprived areas tended to have greater health needs but were less likely to access health care. This generalisation has received much empirical support, particularly in the context of screening, preventive care in general practice, and uptake of specialist services (Goddard and Smith, 1998). Evidence is particularly clear when analyses are carried out for clearly defined condition–treatment pairs. For example, Payne and Saul (1997) found that symptoms of angina were more prevalent in less affluent electoral wards but people living in deprived wards were less likely to receive coronary artery revascularisation. Similar observations were reported from Scotland by Pell et al. (2000). Chaturvedi, Rai and Ben Shlomo, (1997) reviewed evidence to show that people of Indian origin were more likely to have symptoms of angina or myocardial infarction but were less likely to receive specialist treatment and their treatment was less timely.

Not all evidence concerning inequalities in health care utilisation gives a consistent picture. Some studies do not show reduced access to specialist care. For example, MacLeod et al. (2000) found that women from affluent and deprived areas had equal access to treatment for breast cancer. McNiece and Majeed (2000) and Goddard and Smith (1998) found that aggregated data on health care utilisation generally showed higher utilisation of services in association with deprivation or ethnic minority status.
Health needs

Goddard and Smith (1998) point out that health care needs of different social groups are not homogenous. Deprived social groups experience more numerous and complex health problems than affluent groups and these are unlikely to be described adequately by using simple indicators of morbidity or self-rated health status. Even when health needs can be measured accurately, service needs may differ. For example, the prevalence of cigarette smoking shows a strong inverse association with socioeconomic status, but smoking cessation interventions may possibly need to be more intense in groups with lower socioeconomic status because of additional barriers relating to education or income. In other words, service needs for a given health problem may differ in different groups.

Since health problems and needs for services differ in different groups, there is a stronger argument for considering access in relation to health outcomes. This is a view put forward by Culyer and Wagstaff (1993) who proposed that ‘equity in health care should entail distributing health care in such a way as to get as close as feasible to an equal distribution of health’. It is clear that access to opportunities for health are more limited in deprived social groups, but it is not known to what extent lack of access to effective services contributes to inequalities in health (Acheson, 1998). Inequalities in health need to be addressed by health care services as well as other agencies, but currently there is a lack of evidence for effective interventions (Centre for Reviews and Dissemination, 1995).

General practice consultations

Consultation rates are significantly higher for disadvantaged groups (as shown by indicators such as lack of access to a car, unemployment, living in council housing) (Goddard and Smith, 1998). Special deprivation payments to general practices based on the Jarman UPA score were designed to compensate for the resulting increase in workload in deprived areas. However, there is an ongoing debate as to whether the higher consultation rate among lower socioeconomic groups adequately compensates for their higher morbidity and mortality rates and hence greater ‘need’ for services.

Hospital services

Considerable attention has focused on broad equity issues in relation to hospital care, in terms of the relationship between the level of ‘need’ among populations at a geographical level and access to hospital services. In addition, there is some evidence of differences in treatment rates by age, sex and ethnicity, with cardiovascular conditions factors being a particular focus given the prevalence of these problems and the availability of effective treatments (Shaukat, De Bono and Cruickshank, 1993).

Some of the social and cultural barriers to uptake of services for deprived groups are discussed in Section 4 and some considerations in
the supply of services to deprived populations are discussed in Section 6.

**Ethnicity**

There are several reasons why inequities might exist in relation to ethnicity. Some health care needs of ethnic minority groups are qualitatively different from those of the white European majority. For example, sickle cell disease in the UK is mainly confined to ethnic minority groups. Other health needs are quantitatively different. For example, diabetes is two to four times more prevalent in ethnic minorities in the UK than in white Europeans. Ethnic minority groups may experience different barriers to health care. Examples might include language, knowledge of services, or discrimination from service providers. Individuals from ethnic minorities are also more likely to be unemployed or to have low-income jobs. Ethnic minority groups are generally concentrated in inner city areas and may have poorer-quality primary care services and worse housing. Confounding of ethnicity and socioeconomic disadvantage is therefore important, but the extent of social exclusion varies among ethnic groups in different parts of the country.

Some ethnic variations in health needs (Rawaf and Bahl, 1998) and utilisation of health care have been reviewed previously (Goddard and Smith, 1998; Hopkins and Bahl 1993). It is unwise to make generalisations about access to care among ethnic minority groups because of the diversity of their needs and the inconsistency of the evidence. Some studies show low uptake of screening services, but this is not true of all conditions. Some studies suggest that consultation rates are increased among ethnic minorities, but not in all groups (Goddard and Smith, 1998). Some studies have shown reduced uptake of specialist services (Chaturvedi, Rai and Ben Shlomo, 1997), but in other groups uptake of specialist services is increased (for example, mental health care and renal replacement therapy). Goddard and Smith (1998) make the point that increased utilisation of services merits evaluation as much as low uptake. This is because low-quality care, leading to poor health outcomes, can contribute to increased service utilisation. Some explanations for differences in uptake of services in relation to ethnicity are discussed in Section 4.

In areas with significant ethnic minority populations, health service organisations have made efforts to increase accessibility and acceptability of services to ethnic minority groups. Such experience is mostly poorly evaluated and has not been generalised.

Concerns are repeatedly expressed at the potential for discrimination in the NHS workforce (Esmail and Carnall, 1997), which suggests that discrimination against patients may also be occurring (Chaturvedi, Rai and Ben Shlomo, 1997; Maxwell, Streetly and Bevan, 1999).
Gender and age

Men’s and women’s health care needs are qualitatively different, and their utilisation of health care is quantitatively different, with women being higher users of health care services than men. Goddard and Smith (1998) observed that many studies of access to health care had standardised for sex, making it impossible to identify sex differences. In an extensive review, Raine (2000) found some evidence for gender inequalities in treatment for certain conditions, including coronary heart disease, but unequivocal evidence of inequity was harder to identify. She suggested that better quality studies were needed in this area in order to evaluate the existence and extent of inequities.

Many studies of health care utilisation provide results after standardising for age, making it impossible to detect inequities in relation to age (Goddard and Smith, 1998). However, it is clear that two distinct types of inequity exist in relation to age. For a given condition, older people appear to be less likely to receive intensive treatment than younger people. Some health needs of older people are qualitatively different from younger people. For example, older people are more likely to have multiple health problems or to have physical or mental impairments. Some evidence suggests that there is a lack of access to appropriate services for older people. In other words, the health needs of older people are not being met effectively by current services. A National Service Framework for older people was published in early 2001 in order to address some of these issues.
Section 9  Current trends in policy and service development

What is known?
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 include not just 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 their accessibility 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.

Introduction
The government responded to widespread concerns about access to health care with the NHS Plan (Department of Health, 2000a), published in June 2000. The NHS Plan provides a policy framework for developing services with the aim of resolving some of the problems of access in the NHS. The Plan brings together many current and proposed initiatives in health policy and service delivery into a unified approach to the development of NHS services over the next decade.

Service developments are aiming to improve access to health care in two main areas: the interface between the individual, or community, and primary care services, and the interface between primary and secondary care services. These are represented as the two interfaces in Figure 1 in Section 3. The interface between health and social care is also the subject of much work, but as this latter subject relates to
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access to social care it was considered to be outside the focus of this review.

‘Access’ in the NHS Plan

The authors of the NHS Plan argued that there was currently a wide gap between health needs and health services. This was because chronic underfunding had resulted in a service with too few staff, hospital beds, and other resources. In other words, it was accepted that a lack of capacity was contributing to problems with access to care. But the NHS Plan also suggested that there were major problems with the organisation and delivery of services. It was argued that patients experienced too much waiting, that their care did not meet their individual needs, and that there was too much variability across the country in levels and quality of service. The NHS Plan set out a vision of a modernised NHS which would be better able to meet consumer demands for ‘fast and convenient care’ delivered to consistently high standards. Services would become available ‘when people want them’, and would be tailored to meet their individual needs.

Investment

The NHS Plan proposes that NHS funding will grow by 6.3% in real terms. This increase in funding will be used to increase investment in a range of services including new hospitals, new diagnostic and treatment centres to increase elective surgery, new primary care facilities especially in inner cities, new one-stop primary care centres, new equipment, new information systems, and more staff.

Changing systems

The NHS Plan also proposes to modernise the NHS by changing the systems of service delivery so as to promote patient empowerment and public education, early intervention in the community, the provision of care closer to home, with an adequate number of acute beds, and greater integration with social services.

The Plan suggests that key elements in the modernised NHS will include: non-appointment drop-in facilities; fast access to diagnostic facilities and pathology; multidisciplinary teams focused on particular groups and conditions; mix of nurse, therapist, consultant and GP-led services; fast access to acute settings when needed; access to non-acute inpatient settings where appropriate; timely discharge into appropriate settings.

Care pathways will be redesigned around patients to promote what is convenient and what works well. National standards will be promoted through National Service Frameworks and guidance from the National Institute for Clinical Excellence. The Modernisation Agency (including NPAT) will spread good practice and service redesign techniques. Intermediate care for older people will be promoted.
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Cutting waiting for treatment

The Plan also sets out specific targets to reduce waiting in the NHS: by 2004, patients will be able to see a primary care professional within 24 hours and a GP within 48 hours; NHS dentistry will available to all who want it by September 2001; by 2004, no patient will wait more than 4 hours in an A & E department. Medical assessment and admissions units will be introduced in all hospitals to end waits on trolleys; booked appointments for surgery will be used to eliminate waiting lists; maximum wait for any stage of treatment will be three months by end-2008; by 2004, every patient will have a discharge plan, and there will be an end to bed blocking.

Inequalities

While the primary focus of the Plan is to meet consumer demands and expectations, a later chapter of the Plan indicates a concern with meeting population needs for health care, and with promoting population health. The Plan proposes new targets on inequalities in health. The Plan also proposes to reduce inequalities in access to health care with a new review of the resource allocation formula. Equity in health and access to health care will be measured and managed through the NHS Performance Assessment Framework. Access to opportunities for health will be promoted through an expansion of the Sure Start programme, expansion of smoking prevention and smoking cessation, and the introduction of free fruit in schools.

Access to primary care: managing patients’ demands through alternative provision

A key question to be resolved in improving access to primary care is how can patient’s needs and demands for care be most appropriately managed? This has led to a number of new primary care initiatives. The main alternatives to traditional GP services are:

- community pharmacies
- telephone advice lines
- doctor- and nurse-led clinics
- GPs in A & E departments.
Community pharmacies

Over the last decade the government has emphasised the role of community pharmacists in advising on minor illness, as part of an emphasis on the self-treatment of minor conditions (sales of over-the-counter medicines are now equivalent to one-third of the NHS drugs bill). This has been associated with a growing body of research on the use and activities of community pharmacists. A project by the School of Pharmacy and Pharmaceutical Sciences and the National Primary Care Research and Development Centre has examined the public’s use of community pharmacies as a primary care resource and a number of review papers are available (Tully, Hassell and Noyce, 1997; Hassell et al., 1997).

Studies indicate that the use of pharmacies for advice and treatment of minor illness is related to proximity and convenience, and the immediacy of advice, and that they are mainly used for common (‘trivial’) conditions that people are familiar with. The overall use of pharmacy care as an alternative to the GP is currently quite small.

Advice mainly relates to dosage and safety and, in the case of over-the-counter medicines, is mainly about the effectiveness of products, and it is consumer-led. Pharmacists in the UK provide advice personally to, at most, about a quarter of clients who present with a prescription and on less than a quarter of medicines purchased (Tully, Hassell and Noyce, 1997). However, there are questions of the quality and outcomes of advice giving by both pharmacists and assistants, especially with the further deregulation of drugs to general sales list status.

There is some evidence of an inverse care law operating in relation to the nature of services in poor urban localities compared to those in rural areas (Rogers et al., 1998). A deterrent for some groups of patients is also the cost of treatments that would be exempt from charges if prescribed by the GP.

Pharmacies can assist greater patient self-management but there are questions of what level of transfer from GP to pharmacy is achievable and cost-effective, what are the implications for single-handed pharmacies, what additional training and support is required by pharmacy staff to provide extended advice, and how information can best be provided for patients.

Telephone advice lines

Nurse-led telephone advice systems are increasingly being developed. These use some form of decision support software to guide questioning and inform the advice given. Advice lines were initially mainly developed in relation to out-of-hours care associated with GP co-operatives. A more comprehensive development of a nurse-led telephone and advice service was launched in the spring of 1998 as NHS Direct. This service operates 24 hours a day and will be available throughout England by 2001 (Wales and Scotland had their first sites in 2000). The nurse is supported by Clinical Decision Support Software
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and either directs callers to the most appropriate service, advises home care or gives relevant advice. An initial evaluation of first-wave sites has been undertaken by the University of Sheffield (Munro et al., 2000; Munro and Nicholl, 1998), and the King’s Fund has evaluated the London experience (Pearce and Rosen, 2000). Some of the main findings of these evaluations are given below.

Users

In the Sheffield evaluation, 72% of calls were out of hours. Typically, 45–50% of all calls were about children. There are particular questions about the safety and effectiveness of telephone triage for the problems of young children. The Sheffield report raised the issue of a need for more specialist nurse training (e.g. in paediatrics), and whether children under one year old should be excluded. There are also questions of the ability of this type of service to respond appropriately to mentally ill people and people with multiple chronic health problems.

Organisation

Currently local differences exist in organisation (including recruitment and training, IT provision and support, including local protocols and call handling) with implications for acceptability, quality, and outcomes. The best process and content of guidelines need to be established (Pencheon, 1998). Rapid information transfer is also necessary to ensure continuity.

Demands and safety

There was little impact by NHS Direct on demands on emergency ambulances or A & E services, and there was a slight reduction in the use of GP co-operatives. The appropriateness and safety of advice requires monitoring.

Satisfaction

Overall people who use the service appear to be satisfied. Some 97% of those interviewed were ‘generally satisfied’ and 64% said the service could not be improved, although satisfaction is known to be influenced by people’s needs and prior expectations. There are also questions relating to those who choose not to use the service or attempt unsuccessfully to use the service. The accessibility and acceptability of the service for particular groups also require assessment, including elderly people who are currently low users, those who lack access to a private phone (particularly homeless people), people with communication disabilities, and some ethnic minorities and recent immigrant groups who have difficulty discussing in English, especially by telephone (for example, there are approximately 150 different ethnic groups in the London population). Possible responses that require piloting include placing dedicated freephones in hostels, and the use of interpreters and Language Lines (Pearce and Rosen, 2000).
Future role

NHS Direct is still evolving, and is now developing plans to form alliances with GP co-operatives and other services. A longer-term intention of NHS Direct is to become a ‘gateway’ to all local health services. This has the potential to become prescriptive rather than merely facilitatory and raises questions of who sets the ground rules, how they are prioritised, what other agendas are entrained, and the implications for primary care and other parts of the NHS (McLellan, 1999).

Doctor- and nurse-led clinics

Out-of-hours primary care centres

These centres staffed by a doctor are regarded as a way of relieving individual GPs of out-of-hours care. However, an evaluation of five centres indicated that only 22% of people who telephoned for help agreed to attend. The main reasons for non-attendance were lack of transport and believing they were too ill to travel. Those who agreed to attend were highly satisfied with the service (Cragg, Campbell and Roland, 1994).

Nurse-run clinics

Following the 1997 NHS (Primary Care) Act, nurses are increasingly substituting for traditional GP practices through the development of Primary Medical Services pilot sites which may be led by a nurse or GP, or involve both as equal partners (Jones, 2000).

A series of nurse-run walk-in centres are also being piloted. These are open seven days a week (7 a.m. until 10 p.m.), can be used on a ‘drop-in’ basis, and provide minor treatment, health information and self-help advice (Department of Health, 2000g). They are seen as an alternative to some GP appointments and as easing pressure on A & E departments.

The Canadian health care system has had drop-in centres for over 20 years. It operates two models – centres with ‘extended’ opening hours and an ‘after hours’ service (similar to GP co-operatives in the UK). However, an important difference is that in Canada both models are a doctor-led service and can provide an extended range of investigations and treatments. Issues that arise from the Canadian experience are reviewed by Jones (2000). Aspects of particular relevance for the nurse-led clinics in the UK are as follows.

• There were problems of lack of continuity, with inadequate communication with the patient’s GP (although new computerised information systems should in time assist in overcoming this problem).

• Major reasons for use were convenient location, minor medical problems and convenient hours. However, there is no information on the extent to which these centres increase total medical care.
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demand rather than reducing demands on other services, which raises issues of cost-effectiveness.

- Centre users appear to be predominately female, aged 20–29 years and not working, and therefore the clinics do not necessarily cater for all groups in the population.
- There appears to be a high satisfaction among users. However, there are questions of the extent to which these demands could be more effectively managed in other ways, such as through telephone advice lines and extended hours for GP surgeries.

GPs in A & E departments

Attempts to discourage ‘inappropriate’ attendance at A & E departments have not been successful. Emphasis is now given to an alternative approach, which involves employing GPs within A & E departments to manage patients with primary care needs. This was shown by Dale and colleagues (1995) to reduce rates of investigations, prescriptions and referrals compared with their management by A & E medical staff. In contrast, Gibney et al. (1999) reported that care provided by GPs to non-emergency patients in a suburban A & E department in Ireland involved a greater use of resources, because GPs prescribed significantly more often and referred more patients to hospital. This identifies the need for an audit of these initiatives, with the use of common definitions and measures to facilitate comparison and recording of the type of workload.

New forms of service delivery are currently evolving, and there is a need for further evaluation of process, acceptability and outcomes, and their implications for demands on other services. The initial broad-based evaluations thus need to be complemented by a more detailed focus on particular groups of users (e.g. ethnic minorities, older people, or parents with young children), and on particular issues such as the impact on demands on other parts of the system. This also needs to be complemented by further evaluation and development of traditional GP-based primary care, especially in deprived areas. This includes questions of the extent to which services meet the needs of local populations, including the organisation of preventive services, the availability of special clinic sessions (e.g. for asthma, stroke and blood pressure).
Meeting patients’ needs for information

A major aspect of the government’s strategy in modernising the health service is to provide access to good information for patients and staff through the use of Electronic Health records and new on-line technology (NHS Executive, 1998). It is also recognised that there needs to be easily accessible information for all groups in the population regarding the provision of local services and how to obtain them, and the availability of local support groups. In addition, there is increasing demand for information about how the service is performing in terms of efficiency (e.g. waiting times) and outcomes. Information about services can use various formats including posters, booklets, newspaper adverts, teletext and the Internet but needs to be up-to-date, easily accessible and patient-centred.

The emphasis on increasing people’s ability to engage in self-care also requires increased information to assist in recognising and responding appropriately to symptoms. This needs to be based on detailed knowledge of patients’ questions and worries, and requires the testing of content, acceptability, comprehensibility, and methods of accessing information (see Centre for Health Information Quality, 2001; Coulter et al., 1998). However, there is evidence that written information does not influence service use by some groups, such as parents with a young child (Thomson et al., 1999). This may reflect the failure of written information to respond adequately to parents’ worries and meet their psychosocial needs. Similarly, levels of knowledge and cultural beliefs vary among different social and ethnic groups. However, studies examining the content of the beliefs and practices of ethnic minorities are fairly sparse, and there is a need for further information on the perspectives and health actions of different social groups to inform service providers (e.g. training for nurses providing telephone advice lines).

With the rapid expansion in access to information there is a need to guard against the development of a widening gap between the ‘information-poor’ and ‘information-rich’. This involves considering the requirements of special groups of consumers such as older people, ethnic minorities, people with mental or physical impairments, and the socially excluded. Key questions are: what are the specific information gaps regarding the availability and use of services? what are the best formats for presentation and the best ways of delivery? how does information influence people’s choices and help-seeking behaviours?

Access at the primary–secondary interface

The primary–secondary interface is important because of its place in the regulation of access to, and from, hospital services. The definition of the primary–secondary care interface presents some difficulty, but is generally accepted as the interface between the primary care team and, through their referrals, hospital and community care specialist services. The GP’s gatekeeper role has contributed to the efficient utilisation of specialist services in the UK, but consideration of
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effectiveness and equity in access to specialist care will depend to a significant extent on the regulation of patient flows at the primary-secondary interface.

There is increasing interest in including patients’ and public perspectives in the provision and planning of integrated care pathways across the interface. The NHS Plan envisages new ways of organising care across the interface, including integrated care pathways in which good access arrangements are seen as crucial (Department of Health, 2000a). Current policies are also shaping a primary care-led NHS which aims to bring care ‘closer to patients’ (Department of Health, 1997). By transferring more patient care from secondary to primary care, it is anticipated that costs will be contained and more devolution and patient empowerment will result. But the benefits of a primary care-led NHS are not unequivocally clear, and policy attempts to improve care at the interface need to address obstacles including professional barriers to change (Somerset et al., 1999).

Ongoing research

During the 1990s the NHS Research and Development Programme organised a specific research programme for the ‘Primary Secondary Interface’ which was managed in the London region. The main priorities identified for research at the time of the second call for proposals were as follows:

- communication across the interface
- evaluation of guidelines for the direct access of hospital-based diagnostic facilities by the primary health care team
- the information needs of patients
- evaluation of urban community hospitals
- the relationship between A & E and primary care
- interventions directed at carers and the effect on the use of services
- factors within primary and secondary care which affect entry to and exit from secondary care.

Shifts in balance of care

There have been recent changes along the spectrum of primary and secondary care, giving rise to new models including integrated or shared care, specialist outreach services, and direct access clinics (Coulter, 1998). The clinical and cost-effectiveness of these new models of care is under evaluation. The development of Primary Care Groups and Trusts (PCG/Ts) may well encourage cross-referrals within the PCG/T because they will contain a greater range of professional expertise, and ultimately may develop and run their own specialist services. Evidence from a randomised trial of in-house referrals compared to traditional secondary care referrals found that this approach was more satisfying for patients, increased collaborative working among GPs, and resulted in no difference in health status.
between the two groups (Kinnersley et al., 2000). Some of these care models are complex and include many interventions such as the use of new technologies to facilitate communication and information exchange across the interface. It is important to note that many new interface models have not been evaluated adequately and this has implications for policy development and research. Areas of difficulty include cost-effectiveness and the acceptability of these developments with patients, the public, and health professionals.

**Integrated care and disease management**

Integrated care (IC) is known by a variety of terms including disease management (DM), care pathways and care maps. All these terms refer to a particular approach that seeks to co-ordinate resources across the health care delivery system and has wide appeal as a way to contain costs, change practice, develop clinical governance, and improve outcomes (Hunter, 2000). The theory behind DM is that resources can be used more effectively if the patient becomes the pivot around which health care is organised. DM pathways are structured, multidisciplinary care plans which detail essential steps in the care of patients with a specific clinical problem (Campbell et al., 1998). DM views patients as entities experiencing the clinical course of disease rather than as a series of discrete episodes or as fragmentary encounters with different parts of the health care system (Hunter and Fairfield, 1997). So, in place of functional divisions between primary and secondary care or different clinical specialities, the divisions are instead between diseases. Thus, a single organisation conducts prevention, screening, diagnosis, treatment and follow-up for a particular disease.

DM started life in the USA as a way of controlling costs initiated by pharmaceutical companies. These companies were concerned that health maintenance organisations (HMOs) would reduce the amount they paid for drugs and so they began to offer a range of services to patients to secure their revenue (Bodenheimer, 2000). Here in the UK it is thought that there are potential benefits for the NHS in commercial partnerships, provided the interests of private and public sectors coincide (Greenhalgh et al., 2000). The NHS Plan (and National Service Frameworks) envisions IC pathways designed around patients and also encourages a closer working relationship between the private sector and the NHS (Department of Health, 2000a).
DM is a structured systems response to a set of problems that are seen to some degree in all health services: unco-ordinated delivery of care, bias towards acute treatment, relative neglect of primary care, and inappropriate treatment (Hunter, 2000). DM has three components:

1. a knowledge base that quantifies the economic structure of a disease and includes guidelines covering the care to be given, by whom, and in what setting, for each part of the process
2. a care delivery system without traditional boundaries between medical specialities and institutions
3. a continuous improvement process which develops and refines the knowledge base, guidelines and delivery system.

By its nature, DM is more suited to the diseases about which most is known, for which it is easy to develop evidence-based protocols, and in which it is possible to measure outcomes. Typically, chronic conditions are favoured, such as diabetes, asthma, mental health (depression), cancer, stroke, and heart disease. A combination of patient education, practice guidelines, appropriate consultation, and supplies of drugs and services is the essence of DM.

DM is largely untested: evaluations are needed so that claims of cost savings, changing practice, and improved outcomes can be shown. Most published literature refers to experiences in developing IC pathways and perceived benefits and barriers.

In the USA only a few good evaluations have been done, with some showing that DM can reduce costs, improve communication and improve outcomes (Bodenheimer, 2000). In the UK, the few IC pathways that have been evaluated have shown an equivocal picture. For example, a randomised controlled trial of a diabetes integrated care scheme found it to be ‘at least as effective as conventional hospital care’ and was more popular with patients (Diabetes Integrated Care Evaluation Team, 1994). The Southampton Integrated Care Project (an RCT for GP patients with angina and myocardial infarction) found that the programme did not improve health outcomes but was effective in promoting co-ordination and follow-up in primary care (SHIP Collaborative Group, 1999). An RCT of IC for stroke patients found that it offered no benefit over conventional multidisciplinary care, but that IC improved communication with patients and GPs (Sulch, Melbourn and Kalra, 2000). IC pathways have been shown to be effective in improving clinical practice and reducing variations in care (Campbell et al., 1998).

US experience suggests DM should be integrated with primary care and performed within health care institutions rather than be outsourced to specialised commercial organisations (Bodenheimer, 2000). Also, some doctors dislike the lack of clinical autonomy that results from DM, and patients dislike the lack of choice over their treatment. Limited UK experience shows that the NHS can work with private sector organisations offering DM if all parties are explicit about potential conflicts of interest. A set of standards could be drawn up to provide...
definitive guidance for health authorities and primary care groups (Greenhalgh et al., 2000).

**Exit from secondary care: intermediate care**

The findings of the National Beds Inquiry prompted the development of several forms of provision which act as alternatives to acute hospital care. These fall under the umbrella term of ‘intermediate care’. The recent development of these services began with the allocation of funds to offset the effects of winter pressures. The continued expansion of intermediate care is now seen as an essential component of an integrated, whole-system, and multi-agency package of services for emergency care (Department of Health, 2000a and 2000e; Gazdar and Pettit, 2000).

The National Beds Inquiry (Department of Health, 2000e) defined intermediate care services as those:

*designed to prevent avoidable admissions to acute care settings, and to facilitate the transition from hospital to home and from medical dependence to functional independence.*

A range of interventions might fall within the remit of intermediate care. Those highlighted and supported by the NHS Plan are:

- multidisciplinary rapid response teams which aim to prevent hospital admission by providing care in a patient’s home
- intensive rehabilitation services to help older patients regain their independence
- recuperation facilities, using nursing home or other ‘step-down’ beds for the ongoing care of patients who can be discharged from acute care but are not yet ready to go home
- one-stop clinics for older people, to facilitate rapid access to services for health and social care
- integrated home care teams to help patients live independently at home following hospital discharge.

The types of interventions listed above might provide care to individuals in order to prevent an acute event, or during or following an acute event. Hence each service will have its own specific goals.
However, in terms of improving access to acute beds, the Millennium Executive Team Report on Winter 1999/2000 (Social Services Inspectorate and NHS Executive, 2000) states that the overall aims of intermediate care services are to:

- as far as possible, provide care in patients’ homes or their communities
- prevent avoidable admission to acute care
- facilitate prompt discharge from acute care
- prevent inappropriate admission to long-term care.

The extent to which intermediate care services achieve these aims will govern their impacts on improving access to beds for emergency care.

**Existing evidence about the impacts of intermediate care**

Concerns raised about the impacts of intermediate care interventions include:

- consumer attitudes about alternatives to hospital care
- whether or not such services are capable of maintaining or improving the clinical outcomes of care
- the extent to which intermediate care will successfully reduce the prevalence of ‘inappropriately’ used acute beds
- the relative costs of pre-existing and intermediate modes of care (Department of Health, 2000e).

The status of current evidence in relation to each of these areas of concern is explored below.

**‘Scientific’ evidence**

Although the amount of evidence surrounding the role and merits of intermediate care is increasing, the current consensus among the scientific community is that more research is needed to inform the development of interventions for intermediate care and to assess their impacts (see box). Steiner (1996), Godber, Robinson and Steiner (1997), the authors of the West Midlands Emergency Admissions Project (Coventry Business School, 1998), and Parker et al. (2000) reached their conclusions after undertaking systematic reviews of relevant literature.
'Scientific’ opinions about the evidence base for alternatives to acute care

In reviewing the literature on intermediate care’s effectiveness, an effort has been made to select exemplars of research on a wide range of intermediate care services, as well as a set of services that overlap with the intermediate care services. ... with only a few exceptions, observed themes have not been tested in rigorously designed evaluations.

Steiner (1996)

Our literature review confirms that few economic evaluations have been carried out in relation to shifts in the balance of care ...

Godber, Robinson and Steiner (1997)

Primary research is urgently needed on the effects of almost all strategies designed to affect the rise in emergency admissions and of approaches used to diminish the effect on organisations.

(Coventry Business School, 1998)

... available research does not offer sufficient insights into the precise nature of care needed to facilitate (acute) discharge to allow us to conclude that the extension of the alternatives will have a substantial impact on the demand for beds.

(Goddard, McDonagh and Smith, Annex E of Department of Health, 2000e)

There is a need to develop high quality evidence on patient preferences for alternatives to traditional local hospital in the British context.

(Luff et al., Annex F of Department of Health, 2000e)

Despite considerable recent development of different forms of care for older patients, evidence about effectiveness and costs is weak ... evidence is also weak for longer-standing care models.

(Parker et al., 2000)

These represent general concerns about existing scientific evidence. Intermediate care covers a broad spectrum of interventions and has a range of objectives. Hence, it is helpful to disentangle the current evidence base in order to highlight both those intermediate care schemes which appear to be most beneficial and the key areas where further research would be beneficial.

- Acute admission avoidance schemes (e.g. hospital at home, rapid response/assessment teams).
  - Assessment by a multidisciplinary team and hospital at home may reduce acute admissions and the costs of care but more research on this topic is needed (Department of Health, 2000e; Parker et al., 2000).
  - Falls prevention programmes do not appear to reduce acute admissions (Department of Health, 2000e).
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- Early discharge from acute to community-based care (e.g. hospital at home, rapid response teams).
  - Health outcomes appear to be equivalent.
  - The suggestion is that patients favour the alternatives to acute care, although uncertainty remains and there may be discrepancies between the attitudes of patients and their carers.
  - The alternatives reduce patient use of acute beds.
  - The schemes seem to have a neutral effect on costs but uncertainty remains about their cost-effectiveness (Department of Health, 2000e; Parker et al., 2000; Hensher et al., 1999).

- Transfer from acute care to nursing and residential homes.
  - Care in a nursing or residential home may be more cost-effective than continuing care in an acute setting (Department of Health, 2000e).

Evidence from the 'grey' literature

In the absence of scientific ‘proof’, additional informational about the impacts of schemes can be found in the ‘grey’ literature. This literature tends to offer descriptive accounts of the nature, utilisation and effects of schemes and initial assessments of their performance against objectives. For example, reports by the NHS Confederation and Royal College of Physicians (1997), Department of Health (Gazdar and Pettit, 2000), and the Audit Commission (2000), have included accounts of interventions for intermediate care.

Methodological considerations

There is a need for more scientific evidence about the impacts of interventions to improve access. However, there are difficulties in generating this evidence if study designs which meet conventional criteria are to be adopted. Some of these problems have been highlighted in the context of intermediate care, by Coast et al. (2000) and Campbell et al. (2000). They include:

- the difficulties of generating appropriate control situations; the control situation tends to be acute care but ideally different forms of intermediate care which target similar patient groups should be compared
- the problem of knowing when to evaluate; the innovative nature of intermediate care schemes means that they take time to stabilise in terms of, for example, the services that they provide and the patient demands for those services
- the difficulties of knowing what to measure; for example, until the client group has been identified it is not possible to define the relevant measures of outcome
• the appropriate way of presenting information about the relative costs of schemes; for example, different conclusions about the relative cost-effectiveness of a scheme are likely to be reached if it is seen as a means of increasing overall demand (comparator, the costs of achieving this with extra hospital beds) rather than a means of maintaining demand by using existing resources in an alternative manner (comparator, savings from reductions in hospital beds).

The Medical Research Council suggests a phased approach to evaluating the types of interventions that fall under the umbrella of intermediate care (Campbell et al., 2000; Medical Research Council, 2000). The suggested phases, in chronological order, are:
• defining the intermediate care intervention, its purpose, and the key areas of uncertainty surrounding its impacts
• monitoring the initial performance of the intervention in terms of, for example, the client group and their use of services
• designing the main experimental study, including the appropriate control situation, and relevant measures of cost and outcome
• conducting the main experimental study
• for successful interventions, monitoring their ongoing effects.

Within the framework a range of qualitative and quantitative approaches to data collection are suggested. The framework also embraces descriptive and experimental and non-experimental study designs. Useful methodological guidance is also provided by a series of methodological reviews from the NHS R & D Health Technology Assessment Programme. These can be accessed on line at http://www.hta.nhsweb.nhs.uk/. The findings have also been summarised in two recent books (Black et al., 1998; Stevens et al., 2001).

Generating scientific evidence using the above framework represents a long-term agenda. A challenge for researchers will be to balance these timescales and those of policy makers and health and social service professionals who require guidance to support the strategic development of intermediate care. A further challenge surrounds the difficulties of ‘postponing’ the ongoing evolution of both the intermediate care intervention and control situation during the main experimental study.

If the research community is to provide timely information about the impacts of interventions for intermediate care, a more liberal attitude might be required about what represents suitable ‘evidence’ to support decision making. As a means of generating this evidence, although experimental designs might be regarded as the ‘gold standard’ approach, the potential of findings from descriptive studies and studies using non-experimental designs will need to be maximised.
**What is known?**

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.

**Introduction**

While patterns of use and access to dental services are important issues, wider public health interventions such as fluoridation are considered to be of greater significance for access to oral health in general (Watt and Sheiham, 1999). It is therefore within this context that issues concerning access to dental services should be considered.

Access to dental services needs to be understood in relation to the current general dental services contract which was initiated in 1990 (Department of Health, 2000f). This contract formalised the dentist–patient relationship with the aim of developing a process of continuing care for patients. The result was that access to dental services depended heavily on the maintenance of the patient’s registration. An
unintended consequence of the registration system was that registration became an end in itself (Department of Health, 2000f).

It is known that significant proportions (40% in England in 1998 (Kelly et al., 2000)) of the UK population report that they do not attend the dentist on a regular basis. When a patient’s registration is allowed to lapse, there is the possibility that their dentist may not accept them back for treatment. The result is that these people may find it increasingly difficult to access NHS dental treatment (Department of Health, 2000f). They may find themselves in the position of receiving only emergency treatment. Emergency treatments are outlined in the ‘occasional’ treatments list and are temporary in nature and for the relief of pain only, i.e. temporary restorations as opposed to permanent restorations.

Concern is also currently being expressed concerning the working patterns of dentists; for example, increasing numbers of the profession are women. While some useful work has been conducted (Newton, Thorogood and Gibbons, 2000a and 2000b; Gibbons, Corrigan and Newton, 2000; Gibbons, Newton and Corrigan, 2000), little is known about how this may impact on future resources. In response to this challenge the government has commissioned a study concerning future patterns of service provision (Department of Health, 2000f). It is also important to note that while the numbers of dentists have increased there are indications that dentists are spending more time doing private dentistry (Calnan et al., 2000), this having direct implications for access to NHS dentistry in general (Department of Health, 2000f).

The current general dental services system is therefore described as patchy and unreliable in places, with one-third of health authorities reporting serious problems getting NHS dentists for their residents. The government has estimated that the current level of unmet need is around two million people (Department of Health, 2000f).

Finally, also of note is that changes in the way people access dental services mean that registration rates are becoming unreliable indicators of access to dental services as a whole. There is therefore a need to consider new ways to measure access to such services (Department of Health, 2000f).
Patients’ perspectives

The current government strategy to dental services has resulted in the development of a number of innovative organisational structures including the development of dental access centres, personal dental services, and the updating and modernisation of existing practices. In order to maximise the utilisation of these services and structures the government has recognised the need to make increasing information available to people about these organisational arrangements. Increasing access to information will be achieved through the use of services such as NHS Direct (Department of Health, 2000f).

In terms of information and access to dental services, the type of information required by patients tends to reflect the functional and pragmatic views they have concerning their oral health. Additionally, the need for information reflects differing strategies for coping with adverse circumstances (Humphris, O’Neill and Field, 1993). People have typically been concerned with obtaining information that related to the personal characteristics of the dentist (quality of work, concern for patients and appearance), the price of treatment and the convenience of this treatment (office hours and waiting times) (Mangold et al., 1986).

Improving uptake

The evidence

Research has indicated that dental services accounted for 28% of the variance in the caries status of 5- and 12-year-olds in the UK in 1985, 43% in 1987 and 34% in 1989, whereas social factors such as the presence or not of fluoridated toothpaste accounted for 53%, 62% and 57% of the variance respectively (Nadanovsky and Sheiham, 1994). Further research has indicated that international comparisons also yield similar patterns, though comparisons at this level are subject to uncertainty because of missing data, differing diagnostic criteria and treatment patterns (Nadanovsky and Sheiham, 1995).

Few studies have looked at the evidence for methods of improving the uptake of dental services. In 1998 the government provided increased payment incentives to dental practices in deprived areas to increase the registration of children below the age of six. This research was based on a secondary data analysis at an area level and indicated no tangible increase in the uptake of services by children living in deprived areas. The results were therefore largely inconclusive and plagued by a number of methodological difficulties and concerns (Davies, 1999).

Other work looking at improving the utilisation of dental services has largely focused on comparative studies of different reminder systems aimed at reducing failed check-up appointments (Croucher, 1998; Reekie and Devlin, 1998; Reekie, Devlin and Worthington, 1997). This work, while indicating that the timeliness of information can improve uptake, does not help inform more recent developments with respect to
information technology and dental systems. In this instance dental research appears to be far behind current developments.

Other research concerning improvements in access has looked at the interface between integrated medical and dental services (Jones et al., 1999; Mason et al., 1994; Haughney et al., 1998). This type of work has been highlighted to be of importance in a recent regional research and development exercise into primary dental care. General dental practitioners have identified joint medical and dental registration and research into access to services by looking at ways in which registration at dental services could be encouraged in other localised settings such as pharmacies and general medical practices (Newton et al., 2000).

While access is an important issue, most data are currently collected from NHS dentistry and this in itself will become increasingly unrepresentative if the drift away from NHS dentistry continues. The nature of the relationship between private and NHS dentistry has not yet been adequately analysed, although there is evidence to indicate that this is an important issue to consider. For example, the 1998 Adult Dental Health Survey confirmed that many more people said their last course of dental treatment was provided by the private sector (18%, compared with 6% in 1988); this difference was even more marked in the south of England (24%, compared with 6% in 1988). These changes were noted most particularly in those from non-manual occupations (from 5% to 21%) and among those who reported attending for regular check-ups (from 4% to 19%) (Jones, Lamont and Haines, 1995).

There is therefore a need for research into the underlying dynamics of this shift, especially with respect to access. This last point is especially pertinent considering that increasing numbers of patients may be having to pay for their treatment by instalments (from 17% in 1988 to 29% in 1998). In addition, unsolicited comments (31% of the total sample) at the end of the Adult Dental Health Survey questionnaire most frequently referred to the costs of care (10%). Respondents were also concerned with a general drift away from NHS dentistry (7%) and difficulties in keeping or finding NHS dentistry (5%) (Jones, Lamont and Haines, 1995).

Currently, little is known about how people decide to attend for private dental treatment; there are few qualitative and quantitative data available on the processes involved in attending the dentist (Gibson et al., 2000). Indeed, perhaps the dentist has considerable influence to induce demand for private dental treatment (Calnan et al., 2000; Sintonen and Maljanen, 1995).

Further work of this nature should inspect what is said in dental services and the impacts this may have on the treatment decisions people make.

The only dimension?

It is a fundamental principle of our current vision of informing patients’ perspectives that uptake of services should not be the only outcome of
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access to health care resources. It is important to consider how integrated care and the use of health promotion resources can be used to improve outcomes in primary care settings and to develop community awareness. It is therefore encouraging to note that work is ongoing which is focused on assessing and integrating primary health care approaches to oral health promotion (Watt, 2000). Work is also currently aimed at systematically reviewing the evidence for the utility and effectiveness of oral health promotion (Kay, 2000) and at developing a unified community-based approach to oral health promotion (Lea, 2000; Blair and Possilpark, 2000; Whitehead, 2000; World Health Organization, 1986; Badura and Kickbusch, 1990). This includes work being conducted with respect to Asian communities (Williams, 2000).

The development of community consciousness by promoting health in initiatives such as the Health Action Zones and Sure Start schemes, which are aimed at promoting utilisation of dental and health care resources, need to be supported by further systematic research. For example, whole systems approaches to the promotion of a range of health and social issues entail the development of alternative modes of evaluation. Such initiatives would provide interesting challenges to researchers. It is important that access to health promotion resources (where this refers to health promotion with respect to both the environment and the individual) are considered a paramount concern with respect to the political and social dimension of access. Research relating to this important dimension of access should therefore be encouraged.

Particular attention should be placed on health promotion initiatives aimed at reducing inequalities by focusing on broader or integrated approaches.

Fairness in access for different groups

The most systematic and reliable sources of information on patterns of uptake and service utilisation in the UK are the Adult and Child Dental Health Surveys (Kelly et al., 2000; O'Brien, 1994). These surveys represent good sources of cross-sectional data on the nature of oral health in the UK. They are carried out every ten years and they date back to the late 1960s and early 1970s respectively.

In addition, up-to-date information on registration rates is readily available from the Dental Practice Board web site at http://www.dpb.nhs.uk/. Further localised information on the normative oral health needs of children in local areas is collected on a routine basis by the community dental service and can be obtained by writing to the various health authorities.

Attendance behaviour of UK adults

In 1998, 60% of adults in the UK reported attending the dentist for regular check-ups. A further 10% reported attending the dentist for an occasional check-up and 30% reporting that they only attended when
they were in pain (illness behaviour) (Kelly et al., 2000). It has generally been assumed that behaviour with respect to registration is a useful way of distinguishing whether a person's dental attendance pattern is indicative of health or illness behaviour. Attending for regular check-ups and maintaining registration is said to be a useful aid to continuing care and benefits the long-term oral health of patients (Department of Health, 2000f). Additionally, being registered with a dentist allows the patient ease of access to out-of-hours emergency dental treatment. It also follows that reported attendance for dental care appears to bear little resemblance to actual attendance leading to further methodological difficulties (Elderton, 1983).

Regular attendance patterns vary by:

- social class – 65% of adults in social classes I, II, and IIINM reported attending for a regular check-up versus 50% in social class V
- age – in 1998, 48% of 16–24-year-olds reported attending on a regular basis; this figure increased steadily with age so that 68% of 55–64 years olds reported attending the dentist on a regular basis, although for the 75+ age group regular attendance appears to drop to 60%.
- gender – following other health-related behaviours, women were much more likely to report attending for regular check-ups than men (66% of women, 52% of men)
- location – there are indications from the current adult dental health survey that location within the UK may also affect attendance patterns; for example, among those in unskilled manual occupations, 57% of dentate adults in Wales reported attending for regular dental check-ups compared with 34% of the same group in Northern Ireland; there are also indications that such differences can also be observed in England, where regional variations in the uptake of services abound – for example, it is generally believed that there is a north/south and centre/periphery divide in the utilisation of dental services.

Given these attendance patterns and the context of the current contract, it is a concern that significant numbers of people from lower socioeconomic groups are now being predisposed to receiving emergency and temporary dental treatment only. The trend away from NHS to private dentistry, while representing further differentiation in the way dentistry is provided, may however serve to further reduce access to NHS dentistry for lower socioeconomic groups.

In addition, groups such as older people have a low perceived need to access dental services and therefore uptake appears to be very low (Adams et al., 1997). One response has been to develop domiciliary dental services, which have subsequently required evaluation in relation to their effectiveness. A randomised controlled clinical trial is currently underway to evaluate one such service (Robinson, 2000), and further research and development is being conducted on the
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development of dental services specifically targeting people over 75 years old (Craven, 2000; Morse, 2000).

Issues of access in relation to specific groups

As data from the Adult Dental Health Survey indicates that those from lower socioeconomic groups and older adults appear to access dental services less readily, it is important to realise that the Survey is an extensive and comprehensive view of the ‘residential’ population of the UK and therefore there are specific groups that may be excluded by default (Gibbons et al., 2000; Robinson et al., 2000, Khan et al., 1998; Robinson, Gelbier and Gibbons, 1998).

Groups that should be considered for special attention include those in temporary accommodation or who are homeless and will not even have been included in this data set. There is a shortage of systematic data on the nature of access to and utilisation of dental services with respect to homeless people. For example, the process of oral health care for these people may indicate that access to and utilisation of dental services is one dimension of their re-integration into society. Vulnerable groups such as these have effectively been excluded, not only from mainstream services, but also from oral health services research. Some service development at the interface between these ‘outreach’ services and more mainstream oral health care services has taken place although further information and service development would be invaluable (Daly, 2000).

An important review of research into the nature of oral health for ethnic minority groups highlighted the need for further research and development into this important area (Bedi, 1995). The result was the commissioning of some systematic research, although further work was advised (Gibbons et al., 2000; Robinson et al., 2000, Khan et al., 1998; Robinson, Gelbier and Gibbons, 1998). Following from this, it is encouraging to note that the Department of Health has funded a project at the Transcultural Oral Health Centre at the Eastman Dental Institute to promote healthy diets and oral hygiene while also providing advice on how to encourage families to register with a dentist. The subsequent evaluation that forms part of this work will without doubt help inform knowledge in this area (BDA News, 2000).

Top priority should be given to studies that consider the role of dental services in re-integrating the socially excluded into mainstream services.

Financial barriers to access

As dental services are not free at the point of delivery it is not surprising to find that patients want to know more about what the dentist is going to do, why, and how much it is going to cost. Particular attention to these factors in the Adult Dental Health Survey indicates that these concerns appear to take a major jump between the ages of 16 and 34, when most people are beginning to experience restorative dental treatment for the first time. Additionally it has been reported
that more people are negotiating to pay for dental treatment over a period of time rather than at the point of delivery (Kelly et al., 2000).

Cost is one of the traditional barriers to dental treatment (Finch et al., 1989), although with the increasing importance of private dental treatment such a linear and singular view of costs may no longer be appropriate (Hancock, Calnan and Manley, 1999). For example, recent work has indicated that the time taken to get to the dental practice was more significant in determining attendance than the fee for item (fee for item had a small but significant effect, though) (Sintonen and Maljanen, 1995). The time taken to attend services will therefore have different regional impacts on utilisation, given that someone who lives in a rural area may expect to travel further to obtain treatment (Daniels, 2000). Nevertheless, the significance of the geographical spread of services must be highlighted.

Patients’ preferences in relation to the quality of NHS dental care have recently highlighted that access rather than cost is their major concern in relation to service quality. Additionally, the decreasing availability of NHS dental treatment is largely unacceptable (Calnan et al., 2000; Hancock, Calnan and Manley, 1999).

The cost of dental treatment impacts disproportionately on those who have the highest level of need (Kelly et al., 2000). Therefore it is important to account for differences between the direct and indirect costs associated with dental treatment and the effects that having a service that is free at the point of delivery may have on the choices patients make concerning their dental treatment. It may for example be easier for a dentist to persuade a patient to accept more complicated treatments when the treatment is free at the point of delivery. We know from UK data that patients who are exempt or remitted from dental charges tend to receive more expensive treatments. For example, in the period between April 1999 and March 2000 in England and Wales the average costs of treatment for those not receiving benefits was £34.78, whereas the average costs of treatment for those in receipt of benefits was £51.10 (Dental Practice Board, 2000a). Those in receipt of benefits tended to receive more complicated treatments such as crowns and bridges (Dental Practice Board, 2000b). It is therefore a matter of some debate whether these treatments represent differing levels of need or service-led demand.

Recent work indicates that in deciding to provide more private dental care dental practitioners appeared to be trading off conflicts of professional identity. They wanted to provide a service to the highest standards of care with the latest technology alongside preventive and caring delivery. The fee per item system did not encourage preventive dentistry and dentists seemed to feel that the fee for item system left them with ‘perverse incentives’. In short, it was felt that the NHS provided a piecemeal third-party system and that it made sense for dentists to attend to more than one ‘paymaster’. It is therefore important that we develop a better awareness of the supply side of the dental interaction (Calnan et al., 2000; Sintonen and Maljanen, 1995).
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This important work also indicates that another dimension to the increasing role of private dentistry might be that the profession has always maintained its distance from state control of its operations. Dentists in the early 1990s operated in a health care system that encouraged them to innovate and diversify. The move towards increasing provision of private treatment may well reflect this diversification. Therefore significant regional variations in basic underlying costs will lead to varying pressures on dentists to enter the private market. Personal and professional values may act as both constraints and pressures towards this tendency; these in turn will lead to major regional impacts on the accessibility of NHS dentistry (Calnan et al., 2000).

The differentiation of the oral health care system is further reflected in the increasing significance of the newly labelled ‘Professionals Complementary to Dentistry’ (PCDs). As yet there is no clear research dealing with the impacts these professions may have on access to dental services. Increasing numbers of large corporations (i.e. Boots) are becoming involved in the provision of dental treatment.
Organisational barriers to care

As NHS dentistry has become increasingly patchy and unreliable in some areas, access to emergency dental service provision in some circumstances can only be obtained after a drive of up to three hours (Daniels, 2000). The result has been the development of increasing numbers of centralised emergency dental services. To date there are very few systematic data on the use of emergency dental services, a recent survey demonstrating that over two-thirds of local authorities have no formal arrangements for emergency dental coverage on weekday nights (Anderson and Thomas, 2000). The current system may not be well integrated with primary dental care services, with patients being caught in a cycle of temporary treatments.

This situation is further complicated by the development of dental access centres and personal dental services which all reflect differing organisational arrangements for access and delivery of dental care. There is no systematic knowledge of how effective these new organisational arrangements are and additionally neither is there any indication of the impacts they may have on levels of access in their various different localities. Some work has indicated that formalised structures for direct access referrals to specialist day care can lead to improved levels of access and satisfaction on the part of dental practitioners (Joshi et al., 2000; Joshi, 1999).

There is also no evidence that such organisational arrangements will fit the patterns of access of people who do not normally attend current primary dental services. However, some work is underway which aims to look at how specific ethnic minority groups access and utilise secondary care in an inner London borough (Bedi, 2000).

Of the new service developments, dental access centres may well have a positive impact on access, given that time taken to attend dental services was said to be a greater determinant of service utilisation than cost per item (Sintonen and Maljanen, 1995). Additionally, these services do not put the onus on patients to maintain a pattern of access that may not be acceptable to them. However, the pace of developments over the last few years has been phenomenal, occurring alongside background developments in the profession with the increasing importance of specialist registration. The differentiation of dentistry into specialist fields will have direct implications on access to secondary care. As yet there appears to be little systematic research concerning changes in geographical service distribution. Areas such as orthodontics and oral surgery have been characterised by poor access to specialist advice. As a result, a number of innovative studies developing and evaluating teleconferencing and expert systems for the delivery of consultant and orthodontic advice to remote primary dental services have been developed (Steed, 2000; Stephens, 2000).
Conclusions

In conclusion, therefore, it is important to see access to dental services in the context of water fluoridation and the current general dental services contract. The current dental contract encourages the maintenance of temporary registration which subsequently becomes an end in itself and may have had the unintended consequence of predisposing some groups of patients to receiving emergency care only. The reasons for this should be the subject of further discussion and perhaps research.

In addition to this, dentists have been changing their working patterns so that they are now providing significantly more private dental treatment. This drift is said to have had significant opportunity costs for the provision of NHS dental services. Additionally, the drift away from NHS dentistry means that current methods for measuring access will become increasingly unreliable. Work is underway into the working patterns of dentists and there have been a number of developments looking at the shortage of NHS dentists in some areas.

The government has responded in a number of innovative ways by developing new organisational arrangements. These arrangements are being assessed, although more work may need to be done. In particular, the effectiveness of NHS Direct needs to be assessed alongside other methods for improving information provision and uptake of services. In relation to health promotion it is imperative that the current volume of work being undertaken should be supplemented with other work looking at specific health promotion initiatives which are aimed at reducing inequalities.

There has been a significant historical pattern of unequal access to dental services. In particular, there is a lack of information about the concerns and needs of vulnerable groups, in particular the homeless. It is therefore important that this significant imbalance be addressed.
Section 11  Concluding remarks

There has recently been a shift in the main focus of policy from issues of efficiency towards a concern with fairness and addressing the concerns of consumers. This shift makes research into ‘access to health care’ particularly relevant. This brief review of access to health care shows that there is a complex range of pathways and barriers through which patients may access care. Individual sections of this report contain specific research recommendations which are brought together in the Executive Summary. This scoping exercise has also drawn attention to wider issues and potential conflicts regarding the goal of increased access to care and equity and efficiency of services.

**Centralised versus decentralised planning of services**

Traditionally services were planned centrally with an aim of providing universal equity. This was followed by a decentralised market-based system, which inevitably led to disparities in service provision across health authorities and general practice populations, and inequity of access to services. Recent initiatives aimed at reorganising health services have given considerable emphasis to locally based needs and priorities. Primary care trusts have been charged with the task of arranging services tailored to local needs. Similarly, Health Action Zones and Health Improvement Programmes have encouraged local solutions to local problems. It is not possible to have equity of access across the population if we allow local preferences to determine the types of services provided locally. The tension lies between a centrally planned system, with equity of access and universal standardised service provision, and a local needs and priority-based system which inevitably leads to local variations in services. The policy issue is therefore to find an appropriate balance.

**Geographical concentration or local provision**

Similar issues have been raised in recent debates concerning the relation between organisation and quality of services. Some evidence has shown that people who are treated at national or regional centres of excellence may achieve better outcomes than those treated by local services. This is particularly true for patients who need specialist services. Centralised services may provide greater efficiency through improved quality of care and potential economies of scale, but centralised services may be less easily accessible, thus increasing costs to patients. However, the barriers to uptake of centralised services may vary for different groups of patients, especially those living in rural areas. This tension between competing objectives needs to be resolved by designing services that will optimise access to care while at the same time maintaining quality and ensuring the best possible treatment outcomes.
It may be argued that the population’s and patients’ preferences should inform the way these tensions are resolved. However, it will be critical to assess the preferences of different groups and to consider how these preferences should be elicited. Methodological work is also needed to consider broader measurement issues relating to access, including not just patients’ preferences, but also the measurement of access costs and other barriers to care. Work is also needed to provide standard measures of appropriateness of access for use in different conditions.

Studies are needed to distinguish the effects of access to care, from other factors affecting utilisation and outcomes. As we noted in an earlier section, evaluations of new services present their own difficulties, especially in the timing and design of evaluations. Finally, the results from cost-effectiveness analyses need to be viewed in the context of concerns for equity in service provision, utilisation and outcome.

A consistent theme running through this review has been a concern with ensuring that health care resources are mobilised to meet the needs of different groups in the population. Thus ‘access’, whether it is defined in terms of health service availability, health service utilisation, or health care outcomes, is very much concerned with equity. Not only may equity may be defined in several ways, but different groups have different priorities and values. A primary objective for researchers is to make explicit the consequences of different choices in the provision of health care in order to inform policy decisions.
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Craven, R. 2000. *Facilitating Best Practice in Oral Care for Older Adults in Residential Homes*, NRR Project: N0500063563. NHS Executive North West


Daly, B. 2000. *Strengthening the Interface between Outreach and Mainstream Dental Services*, NRR Project: N0116069375. Lambeth, Southwark and Lewisham Health Authority


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*Contemporary Britain: A Case Study of the South Thames Region.*
London: Division of Dental Public Health and Oral Health Services Research, Guy's King's and St Thomas's Dental Institute

Gibney, D., Murphy, A.W., Barton, D., Byrne, C., Smith, M., Bury, G. *et al.* 1999. Randomised controlled trial of general practitioner versus usual medical care in a suburban accident and emergency department using an informal triage system. *British Journal Of General Practice* 49:43–4


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Kipping, R., Meredith, P., McLeod, H. and Ham, C. 2000. Booking Patients for Hospital Care: A Progress Report, second interim report from the evaluation of the national booked admissions programme. Birmingham: Health Services Management Centre


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Morse, A. 2000. *Developing Dental Services for People over 75 - A Collaborative approach*, NRR Project: N0026062279. NHS R & D Southwest


Murphy, A.W. 1998a. 'Inappropriate' attenders at accident and emergency departments: definition, incidence and reasons for attendance. *Family Practice* 15:23–32

Murphy, A.W. 1998b. 'Inappropriate' attenders at accident and emergency departments II: health service responses. *Family Practice* 15:33–7


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Rogers, A., Flowers, J. and Pencheon, D. 1999. Improving access needs a whole systems approach. And will be important in averting crises in the millennium winter. British Medical Journal 319:866–7


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Warden, J. 1995. 4.5 million miss outpatient appointments. *British Medical Journal* 310:1158

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## Appendices

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Sample letter/e-mail sent to researchers, managers of research, consumer associations, professional organisations, community health councils, NHS trusts, regional and district health authorities and boards. Sentences in the second and third paragraph were tailored according to the individual organisation or recipient.

Dear ......................

Access to Health Care in the UK

The NHS R&D Service Delivery and Organisation (SDO) Programme has commissioned a three-month scoping exercise in 'Access to Health Care'. The aim of the project is to evaluate future research needs in this area. The term is understood to include both service availability, and the processes leading to service utilisation. The scope of the work is broad including all client groups and conditions, and different levels of care including primary, community and hospital services, as well as intermediate forms of care. Key issues, among others, might include:

• definition and measurement of access
• factors affecting access (patterns of health care, patient characteristics, type of condition, funding and prioritisation issues etc.)
• different models of service provision
• relative priorities of different groups (service users, health professionals, managers etc.).

The scoping exercise is being carried out by a group of us in the Department of Public Health Sciences at King’s College London. In addition to literature searches we are also contacting health managers, health authorities and trusts, health-related organisations and academic centres to ask if they would like to make any comments from their particular area of knowledge in the following areas:

• recent relevant research studies, including reviews and grey literature
• research in progress
• key issues for future research in this field.

We would be grateful for your views, particularly with regard to your hospital (organisation/department)’s work in this area. These would be used to inform our final report which will be completed by January 2001. We understand that the report will be used to inform commissioning decisions at the SDO programme.

We cannot guarantee that all suggestions will be included in our report, nor that suggestions will be attributed to individuals. However, we will try to include an acknowledgement of all respondents in our final report.

Please accept our apologies if you receive this message by more than one route.

Thank you for your assistance.
### Appendix 2  Summary of respondents

<table>
<thead>
<tr>
<th>Type of organisation</th>
<th>Number contacted</th>
<th>Number of replies*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health authorities (generally addressed to Directors of Public Health)</td>
<td>41</td>
<td>11</td>
</tr>
<tr>
<td>NHS trusts</td>
<td>39</td>
<td>3</td>
</tr>
<tr>
<td>Community Health Councils</td>
<td>17</td>
<td>2</td>
</tr>
<tr>
<td>Academic departments of public health and associated institutes, university research centres and other research institutes, including named individuals known to have worked on aspects of access</td>
<td>58</td>
<td>32</td>
</tr>
<tr>
<td>Condition-specific patient organisations, funds and charities</td>
<td>52</td>
<td>10</td>
</tr>
<tr>
<td>Other general user organisations, funds and bodies</td>
<td>20</td>
<td>5</td>
</tr>
<tr>
<td>Professional organisations, associations and bodies</td>
<td>54</td>
<td>19</td>
</tr>
<tr>
<td>NHS Executive regional researchers</td>
<td>10</td>
<td>3</td>
</tr>
<tr>
<td>Dentists</td>
<td>50 +</td>
<td>15</td>
</tr>
<tr>
<td>Mailbases</td>
<td>**</td>
<td>**</td>
</tr>
<tr>
<td>Other</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total (excluding mailbases)</strong></td>
<td><strong>345 +</strong></td>
<td><strong>101 +</strong></td>
</tr>
</tbody>
</table>

*  As at 23 February 2001

** The Public Health list gave 1204 separate addresses and the Health Service Research list 370 in November 2000; however, the exact number of individuals is not known, because many have more than one address and some are on both lists. Some cross-posting between mailbases and other categories occurred. Responses from the mailbases have been included in the most appropriate category.

A response rate has not been calculated because replies were only expected if the recipients of letters had specific information or comments to contribute to the debate on access to care. In addition, many of the Public Health list respondents were not based in the UK.
Owing to the short time frame for the scoping exercise, it was not possible to incorporate all of the comments and references received into the final report, or to follow up all of the recommended contacts. Below is a summary of some of the main comments and issues raised by respondents, together with references to documents sent to us, where relevant.

We would like to thank all who have taken the time and effort to contribute to this debate and apologise for any omissions.

<table>
<thead>
<tr>
<th>Name</th>
<th>Organisation</th>
<th>Key points and references</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alaszewski, Andy</td>
<td>University of Hull</td>
<td>I have recently got interested in the geographical aspects of access and the balance between services and provision. While problems of access in inner city (cultural and limited service provision) and rural area (pockets of deprivation, lack of services, poor transport), we have recently done a case study of coastal deprivation which while it figures in DETR stats is not well recognised. Plus articles.</td>
</tr>
<tr>
<td>Alexander, Malcolm</td>
<td>Association of CHCs</td>
<td>There are a number of areas where access to appropriate care is severely restricted or information about health care not readily available. Firstly, many local people who fail to get appropriate care because they are refugees or asylum seekers, whose knowledge of public services is likely to be vague and because of this, and sometimes because of language problems, fail to receive care of the right type at a clinically appropriate time and find it difficult to given informed consent for treatment. The demand for passports by some health practitioners is also a great problem, especially as the Home Office often retains the patient’s passport, causing anxiety and fear at the point of NHS access. Secondly, women suffering from fibroids who live locally and are often black, frequently complain that they are treated unsympathetically by doctors, given little information about their prognosis, and scant information about treatment choices. They often complain about unnecessary surgery including hysterectomy. Access to appropriate, empowering and clinically expert services are often demanded by women that we meet. Thirdly, men who are living in poverty fail to access primary and secondary care at appropriate levels and consequently suffer a great deal of unnecessary morbidity. Men frequently explain during discussions with the CHC their avoidance of primary care and the dire consequences they have suffered. The national statistics on gender, morbidity and mortality would seem to support our observations.</td>
</tr>
<tr>
<td>Name</td>
<td>Organisation</td>
<td>Key points and references</td>
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<tr>
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<tr>
<td>Lastly, many black people report to the CHC that they experience racism in the NHS and consequently avoid services. Although there are many black users in the most contained parts of the service, access to appropriate primary and secondary preventative care is poor and diminishing because resources are being targeted at the most dependent patients. Black users often feel alienated from services and bunched together as black, Afro-Caribbean or African without any regard to their ethnicity, origin or language or experiences before coming to the UK.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anderson, Robert</td>
<td>University of Cardiff</td>
<td>Access to dental care in the UK is virtually 19th century compared to general medical care, and the fundamental problem – the registration system, patient co-payments and fee-for-service – has been judiciously avoided as a subject for serious research for too long.</td>
</tr>
<tr>
<td>Purcell, Bernadette</td>
<td>University College Hospital</td>
<td>Suggest look at some of the CSAG publications including recent one on epilepsy.</td>
</tr>
<tr>
<td>Braterman, Geoff</td>
<td>British Homeopathic Association</td>
<td>Access to NHS homoeopathy is variable, often depending on individual GPs or health authority agreements. Difficulties in obtaining accurate data. Research is needed on how the NHS reforms have affected access. Plus see below.</td>
</tr>
<tr>
<td>Bywaters, Paul</td>
<td>Coventry University</td>
<td>Complementary medicine and barriers to access. Factors affecting access: the scope feels as though it could be wider than you suggest, e.g. there may be barriers to access which are prior to the patterns of service provision such as income/transport or negative experience of doctors at immigration. Another dimension to this is patient choice. People often do not choose to access health care when they could. We need to understand more about those choices and how a health care service should relate to them.</td>
</tr>
<tr>
<td>Capewell, Simon and Goodacre, Steve</td>
<td>Liverpool University</td>
<td>Emergency patients with chest pain represent a large and important client group for SDO attention on the basis of: requiring different levels of care including primary, community and hospital services; demonstrating worrying variations in access; models of provision; service availability and service utilisation; along with conflicting priorities of different groups.</td>
</tr>
<tr>
<td>Clipson, Caroline</td>
<td>SCOPE</td>
<td>Awaiting full reply.</td>
</tr>
</tbody>
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<thead>
<tr>
<th>Name</th>
<th>Organisation</th>
<th>Key points and references</th>
</tr>
</thead>
<tbody>
<tr>
<td>Craig, Georgina</td>
<td>National Pharmaceutical Association</td>
<td>We are working closely with NHS Direct in Essex to explore referral to pharmacy from this service, thus reducing the number of referrals to GP within 72 hours and giving people quicker access to advice. We are also working with the walk-in centre team at NHSE on the pharmacy/WIC interface and are keen to explore how the principles of WICs and the access they provide to NHS consultations could be provided from a community pharmacy. This is a concept we would like to see piloted (pharmacies as NHS WICs) in the next few years.</td>
</tr>
<tr>
<td>Currie, Graham</td>
<td>Marie Curie Research Institute</td>
<td>Awaiting full reply.</td>
</tr>
<tr>
<td>Dalziel, Katherine</td>
<td>British Association of Dermatologists</td>
<td>Problems with few consultants and long waits to access service. A number of new models of care are emerging, but as yet little critical assessment in terms of quality or impact on waiting times. Key issues for future research include: assessment of current models of service being developed; the impact of improved dermatological education for health care workers; impact of 2-week waits, cancer; guidelines on general dermatological services; access to appropriate care for elderly and ethnic minority groups; appropriate prioritisation of patients with inflammatory dermatoses; impact of NICE referral protocols. Research in progress: large randomised trial of consultation versus store and forward telemedicine (at Sheffield). Plus 12 reports, see below.</td>
</tr>
<tr>
<td>Dhillon, Charnjit</td>
<td>Royal College of Obstetricians and Gynaecologists</td>
<td>Sent a list of their current clinical guidelines. In addition their Clinical Effectiveness Support Unit is currently undertaking a National Sentinel Audit of Caesarean Section. The recent published reports related to quality issues include: Clinical Governance, Good Medical Practice WP Report on Continuing Professional Development, discussion document on Revalidation.</td>
</tr>
<tr>
<td>Doyle, Yvonne</td>
<td>Merton, Sutton and Wandsworth Health Authority</td>
<td>Key issues for future research: the correlation between good and poor access and health/morbidity outcomes measured at other levels, e.g. overall mortality, avoidable deaths, cardiac mortality, major cancers – the two-week wait rules. How do the national primary care collaborative initiatives around diverting unnecessary demand on secondary care improve morbidity for those deemed to be in true need? Does current work on care pathways – for example a number of such pathways for stroke, chronic obstructive airways disease involving primary and secondary care, and the use of community therapists and nurses – actually give equal or better access to effective health care? Not aware of any current research locally on access.</td>
</tr>
<tr>
<td>Name</td>
<td>Organisation</td>
<td>Key points and references</td>
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</tr>
<tr>
<td>Edwards, Nigel</td>
<td>NHS Confederation</td>
<td>Key points: What do commissioners need to know to organise health services? How to prioritise services and how people route themselves through the system, and what prevents them using it? In particular, why do British delay so long in presentation for cancer services: is it patient behaviour, gatekeeping or organisation of services, especially for specialist services? Importance of distance and travel times, and the debate about centralisation of services, especially access to paediatric and maternity services. Trade-off between quality and access, e.g. in terms of quick emergency access: when is it better to treat at scene or 'scope and run' to nearest specialist centre, possibly bypassing nearer sites where care may not be so good. The importance of engaging the public in these debates, in ways that they can understand (e.g. may be access versus equity from a policy point of view, but more likely to be access versus quality from individual perspective). Also the need to look at trade-offs between cost of making small improvements in outcome versus cost of access for many.</td>
</tr>
<tr>
<td>Edwards, Wendy</td>
<td>The Stroke Association</td>
<td>Please see comments in RCP report.</td>
</tr>
<tr>
<td>Ehrich, Kathryn</td>
<td>Brunel University</td>
<td>Study on 'inappropriateness' of demand for out-of-hours primary care for children under five, and experiences of previous scoping exercises.</td>
</tr>
<tr>
<td>Enderby, Pam</td>
<td>University of Sheffield</td>
<td>References to various pieces of work that have examined access to speech and language therapy services.</td>
</tr>
<tr>
<td>Frankel, Stephen</td>
<td>University of Bristol</td>
<td>Number of studies conducted here concern assumptions about the relationship between health service capacity, health care needs and levels of demand. The issues are summarised in our <em>BMJ</em> paper of 1 July 2000.</td>
</tr>
<tr>
<td>George, Steve</td>
<td>University of Southampton</td>
<td>Out-of-hours primary care review plus references.</td>
</tr>
<tr>
<td>Goldberg, David</td>
<td>The Royal College of Psychiatrists</td>
<td>No relevant research in this area at the moment. Previous collaboration with the Institute of Psychiatry.</td>
</tr>
<tr>
<td>Gracethorne, C.S.</td>
<td>University of Brighton Health and Social Policy Research Centre</td>
<td>We are currently conducting some research on workforce planning in health and social care organisations. Of interest would be any information or references concerning the priorities of different groups (service users, health professionals, managers etc.) in relation to workforce planning. This might relate to issues such as these different groups’ involvement in ‘workforce planning’ systems or views/involvement etc. re workforce development, i.e recruitment, training etc.</td>
</tr>
<tr>
<td>Name</td>
<td>Organisation</td>
<td>Key points and references</td>
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</tr>
<tr>
<td>Gravelle, Hugh</td>
<td>University of York</td>
<td>The key to understanding how access affects use of services and outcomes is the availability of panel data on individuals (socioeconomic characteristics, utilisation, health status) and the characteristics of the services available to them (so we also need information locating both the individuals – postcodes – and the services. Panel data are required to properly identify the effects of access and to disentangle it from other factors affecting utilisation and outcomes. Single cross-sections are not adequate. Plus see below.</td>
</tr>
<tr>
<td>Guite, Hilary</td>
<td>Bromley Health Authority</td>
<td>In areas where there is a very broad base of prevalence from which primary care clinicians need to decide who to refer (e.g. asthma, depression), there is a concern that initiatives in primary care, ostensibly to improve management within primary care and reduce referrals, may in fact have the opposite effect. This could operate by raising awareness and rates of diagnosis of these conditions (only about 50% of people with depression are recognised in primary care). In Bromley the primary care mental health facilitator has been working with practices to improve management of depression. She has emphasised the management within the primary care setting more than increasing recognition. We are currently looking at the relationship between her input into practices and their trends in referral rates to the specialist mental health services. The NSF for mental health requires the development of protocols between primary and secondary care for conditions such as depression, anxiety, schizophrenia etc. These protocols will include guidance about referral to secondary services. The impact of these protocols on referral rates is not clear.</td>
</tr>
<tr>
<td>Harris, Avril</td>
<td>Royal College of Physicians of Edinburgh</td>
<td>One of the key issues for future research is to adopt a whole-system approach, i.e. viewing the issues as a whole across the primary–secondary care divide. The differential provision across this divide varies considerably from region to region and can affect access and utilisation in both sectors. ‘Intermediate’ care will require careful definition from the outset as the term has been applied to hugely different types of care. Somehow, the provision, access, utilisation and costs issues need to be linked to measures of clinical quality and outcomes. Work is needed in the area of equity of access, which cannot be simply equated to local availability, though the latter may be crucial to securing improved utilisation to meet clinical need and to improve outcomes, e.g. in areas characterised by multiple socioeconomic deprivation or a high level of ethnicity within the local population. Future research needs to reflect patient focus, but it also needs to demonstrate how this can be realistically reconciled with resource constraints and often conflicting professional views.</td>
</tr>
<tr>
<td>Name</td>
<td>Organisation</td>
<td>Key points and references</td>
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</tr>
<tr>
<td>Harris, John</td>
<td>British Institute of Learning Disabilities</td>
<td>Key issues for future research on access to health care for people with a learning disability: impact of training staff and carers on access to health care; the impact of PCGs and PCTs on access to health care; meeting the health care needs of older people with a learning disability; health care for people with dementia or mental illness; problems in delivering health care to people with high support needs (including a consideration of medication, administered by non-medical staff); access to healthcare for people who challenge services. Obstacles to effective access: eligibility criteria; charging policies; professional expectations and boundaries. Professional training – GPs and specialists. Transport is often a major obstacle to access. Communication: signs; availability of accessible written information; how professionals talk to people with a learning disability. Access for people with multiple conditions each of which might require highly specialised care.</td>
</tr>
<tr>
<td>Haynes, Robin</td>
<td>University of East Anglia</td>
<td>Importance of travel time and cost. Disadvantages of current resource allocation formula in rural areas. Problems of measuring geographical access; few studies control for need. Accessibility Of Primary Health Care Services In East Anglia, Research Report Number 9 (2000) by Andrew Lovett, Robin Haynes, Gisela Sunnenberg and Susan Gale. School of Health Policy and Practice and others cited in report.</td>
</tr>
<tr>
<td>Hoare, Colette</td>
<td>National Eczema Society</td>
<td>Currently involved in a project investigating the needs of people with eczema and their carers (in collaboration with the College of Health). Plus references.</td>
</tr>
<tr>
<td>Hudson, Ruth</td>
<td>Community Practitioners and Health Visitors Association</td>
<td>There are many practical examples where we have increased access to primary and secondary care services for specific groups of people, e.g. through developing services based on the needs of homeless people, travellers and minority ethnic communities and for people with specific conditions such as coronary heart disease and asthma. There are also examples where access to mainstream services has been improved through considering the needs of the local population and adapting services accordingly (e.g. health visiting, out-of-hours services). There is a need for good-quality research to explore whether and how community practitioners can improve access to health care so that lessons can be learned, good practice disseminated and services improved where necessary. There is also an issue concerning the merits of 'universal versus targeted' services and the impact of this on access. Need access to the service? what is the optimum balance or combination between universal and targeted services to ensure that all sectors of the population have access to appropriate services?</td>
</tr>
</tbody>
</table>
## Access to Health Care

<table>
<thead>
<tr>
<th>Name</th>
<th>Organisation</th>
<th>Key points and references</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jenner, David</td>
<td>South Derby Health Authority</td>
<td>I would like to see the R &amp; D programme focusing on equity, i.e. relationships between access to health care and need, e.g. project within the ESRC Health Variations Research Programme. Plus a review of the various NHS Resource Allocation Formulæ, the York formulæ and underpinning work asking the question ‘do these formulæ really distribute NHS resources according to need – and is access to health care equitable as a result?’</td>
</tr>
<tr>
<td>Jessop, Edmund</td>
<td>West Surrey Health Authority</td>
<td>Have investigated travel times and admission rates to local hospitals.</td>
</tr>
<tr>
<td>Johnson, Alan</td>
<td>BAO-HNS</td>
<td>Action on ENT project, to follow up.</td>
</tr>
<tr>
<td>Kidd, Judith</td>
<td>Ataxia Association</td>
<td>A similar survey is being carried out by the Neurological Alliance.</td>
</tr>
<tr>
<td>Lattimer, Val</td>
<td>University of Southampton Health Care Research Unit</td>
<td>Primary medical care outside normal working hours: review of research since 1994 by V. Lattimer and S. George, November 2000.</td>
</tr>
<tr>
<td>Law, James</td>
<td>City University</td>
<td>Had a pilot project on access for disabled groups for the London region last year and will be going for another in the coming year.</td>
</tr>
<tr>
<td>Luckock, Sandra</td>
<td>Mencap</td>
<td>Awaiting full reply.</td>
</tr>
<tr>
<td>McColl, Elaine</td>
<td>University of Newcastle Upon Tyne</td>
<td>Key issues that came out of our research were in relation to access to: emergency services (in areas remote from hospital A &amp; E departments, such services have to be provided by GPs); out-of-hours care; balance of home visits vs. surgery consultations suggests that the rural/urban dimension may be another major factor affecting access, in addition to those you list, plus references.</td>
</tr>
<tr>
<td>McCombie, Claire</td>
<td>DoH, London Region</td>
<td>The London Organisation and Management Group identified access for ethnic minority groups, and the managing demand as key areas.</td>
</tr>
<tr>
<td>Masterton, Philip</td>
<td>Royal College of Physicians</td>
<td>See <a href="http://www.rcplondon.ac.uk">http://www.rcplondon.ac.uk</a> for access to various reports and publications produced by the College in recent times.</td>
</tr>
<tr>
<td>Name</td>
<td>Organisation</td>
<td>Key points and references</td>
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</tr>
<tr>
<td>Meadowcroft, Robert</td>
<td>Parkinson’s Disease Society</td>
<td>Key issues: importance of early and accurate diagnosis; informed and positive giving of diagnosis; need for national framework for neurological conditions; access to consultants with interest and expertise in Parkinson’s disease; access to residential care when needed; support and advice on employment and finance, for carers, and at the palliative stage; understanding and knowledge by health and social care professionals. Research is needed into effectiveness of different interventions, needs of carers, training of professionals, and coping with symptoms.</td>
</tr>
<tr>
<td>Moon, Graham, Prof. Mohan and others</td>
<td>Institute for the Geography of Health, University of Portsmouth</td>
<td>We are interested in the relationship between deprivation and various measures of distance to health care opportunity (time, cost, kilometres etc.). These interests are underpinned by technologies such as geographical information systems and statistical/mathematical models of varying sophistication. We regard this sort of work as having considerable future policy importance through: (a) its concern with excluded populations, and (b) the rapidly changing ‘landscape’ of health care provision.</td>
</tr>
<tr>
<td>Morgan, Carol</td>
<td>Muscular Dystrophy Group of Great Britain and Northern Ireland</td>
<td>Need for research into: (a) the difference in the respective standards of care, information and support (and their satisfaction with these services) provided to people with rare conditions at specialist and general clinics (b) the difference to the health and well-being of people with long-term degenerative conditions who are seen regularly and those who are discharged because ‘there is nothing we can do for you’.</td>
</tr>
<tr>
<td>Morris, Joanne</td>
<td>Newham General Hospital</td>
<td>Involved in a number of studies, see below. Access to particular health services/areas by ethnic minorities is of great concern to the trust and there are many local community groups that could be used to explore this.</td>
</tr>
<tr>
<td>Nattrass, Dorothy</td>
<td>British Polio Fellowship</td>
<td>Need for access to well-fitting callipers. Need for recognition of post-polio syndrome. Leaflet: The Late Effects of Polio – An introduction to difficulties experienced by many polio-affected people Leaflet: The Long-Term Medical Conditions Alliance – The living with long-term illness (Lill) project The Late Effects of Polio (Post Polio Syndrome). A selection of articles. The British Polio Fellowship.</td>
</tr>
<tr>
<td>Name</td>
<td>Organisation</td>
<td>Key points and references</td>
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</tr>
<tr>
<td>Parry, Gareth</td>
<td>University of Sheffield</td>
<td>Neonatal and maternity services: there are currently intense discussions on the configuration and centralisation of neonatal care services in the UK. Neonatal services by their nature have to fit within a framework comprising of maternity and paediatric services. If neonatal services are reconfigured, then maybe maternity services should also be, or vice versa. Recent work has been contradictory in identifying whether there is any clinical advantage to centralising neonatal services in the UK. We have recently been working on the (NHS Executive funded) UK Neonatal Staffing Study, which aimed to compare the clinical and cost-effectiveness of alternative organisational characteristics in neonatal intensive care units.</td>
</tr>
<tr>
<td>Pearce, Jayne</td>
<td>Association of Medical Secretaries, Practice Managers, Administrators and Receptionists</td>
<td>The Institute of Directors Health Provision Policy Group is to look at alternative ways of providing health services in the UK.</td>
</tr>
<tr>
<td>Pollock, Allyson</td>
<td>University College London</td>
<td>There are major and very serious issues around access to health care for nursing home and residential care residents and now the new intermediate care sector. The large group in private institutional settings is very vulnerable indeed, partly because their care is first a private responsibility until too poor to pay and then a local authority responsibility. The National Plan will simply make things much worse. Plus references.</td>
</tr>
<tr>
<td>Rayner, Claire</td>
<td>The Patients Association</td>
<td>Key areas are access to care for people with mental health problems and for older adults.</td>
</tr>
<tr>
<td>Robson, Dorothy</td>
<td>Equal Opportunities Commission</td>
<td>Men unhappy about inequalities in provision of services between men and women, e.g. cervical screening for women, but no provision for prostate screening, more money for breast cancer research than prostate cancer, well woman clinics but no (or few) well man clinics, women-only sessions run by some organisations. Other issues include: not being able to see a doctor of the same sex on request; reimbursements to GPs for condoms for women but not men; denial to some of gender reassignment and other reconstruction surgery.</td>
</tr>
<tr>
<td>Rogers, Anne</td>
<td>University of Manchester</td>
<td>Access to pharmacy and other care work at NPCRDC, references and articles, included in report.</td>
</tr>
<tr>
<td>Rowe, Rachel</td>
<td>NPEU, University of Oxford</td>
<td>Currently involved in three-year study looking at inequalities in access to maternity care.</td>
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<tr>
<td>Name</td>
<td>Organisation</td>
<td>Key points and references</td>
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<tr>
<td>Ryan, Stephen</td>
<td>Association of Optometrists</td>
<td>Audit and satisfaction surveys have shown that patients prefer to receive services in local, easily accessed settings rather than travel to remote secondary sites. Key issues for future research: integration of primary one-stop centres into existing primary care structures; implications of patients moving between optometrists when developing co-management schemes (e.g. diabetic retinopathy screening). Role of IT in facilitating care across service sectors and professional boundaries. Importance of letting patient’s own views be at the heart of any definition of access. Access to early diagnosis of medical conditions in diabetic retinopathy. Influence of location on uptake of screening.</td>
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<tr>
<td>Salisbury, Chris</td>
<td>University of Bristol</td>
<td>GPs’ out-of-hours availability (reference).</td>
</tr>
<tr>
<td>Savage, Jan</td>
<td>Royal College of Nursing</td>
<td>Models of service provision: NHS Direct seems to have enormous implications in a range of areas, especially perhaps in terms of the use of decision-support software and referral systems. Funding issues. Access or associated issues are not always amenable to measurement, and it is time that there was more encouragement of qualitative approaches, or mixed research approaches. There is much to be gained by widening the scope to facilitate the insights and approaches associated with other perspectives, such as those of consumers, or those of PAMs. Access to health care may appear good according to certain established criteria, but is limited once ‘softer’ issues are taken into account such as gender (the continuing practice of using mixed wards, and reluctance to accept admission because of the compromise of privacy or dignity).</td>
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<tr>
<td>Shackman, Gene</td>
<td>New York, USA</td>
<td>Information on walk-in clinics in USA, plus article.</td>
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<td>Shakespeare, Ruth</td>
<td>Southampton Health Authority</td>
<td>The needs of prisoners and those in police custody.</td>
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<td>Shalley, Martin</td>
<td>Birmingham Heartlands &amp; Solihull NHS Trust</td>
<td>Letter, to follow.</td>
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<tr>
<td>Sherriff, Robert</td>
<td>Buckinghamshire Health Authority</td>
<td>Intermediate Care: A review of the literature by Dr Somen Banerjee, November 2000. Buckinghamshire Health Authority.</td>
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<tr>
<td>Shields, Noreen</td>
<td>Glasgow Health Board</td>
<td>Geographic inequalities in access to maternity care: maternity care is a good example where geographical access related to rationalisation of hospitals is very topical and has been a key factor in strategic development, but historically strategy implications of the tension between equity and increased facilities for socially excluded groups have been given little attention.</td>
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<tr>
<td>Soljak, Michael</td>
<td>Ealing, Hammersmith and Hounslow Health Authority</td>
<td>Recent work identifying problems of access around ethnicity and elders. Also see HoLB web site.</td>
</tr>
<tr>
<td>Stanforth, Helen</td>
<td>The College of Optometrists</td>
<td>Proposing to commission research into optometric referral outcomes, plus report: <em>Primary Eye Care Services</em>. 1999. The College of Optometrists.</td>
</tr>
<tr>
<td>Stansfield, Jois</td>
<td>Queen Margaret University College</td>
<td>CLEFNET is a project within our department with the main aim of widening access to forms of specialist therapy.</td>
</tr>
<tr>
<td>Temple, Mark</td>
<td>Bro Taf Health Authority (Cardiff)</td>
<td>Location and inaccessibility. Problems of measuring ‘access’. Instead we should attempt to measure inaccessibility. If we use this method, then some of the geographical marketing work from the USA becomes of relevance. When the siting of secondary and primary care then is considered, the best solution is the one that minimises inaccessibility within budget rather than the single site that maximises access. This approach has the potential to address inequity in a way that the converse does not.</td>
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<tr>
<td>Vanclay, Lonica</td>
<td>Family Welfare Association</td>
<td>Key points: The value of universal settings especially GP practices and schools as a non-stigmatising and non-threatening base for people to feel comfortable about approaching services. The need for flexible non-bureaucratic and speedy responses from agencies to encourage access. A voluntary organisation as service provider being seen by people as ‘not the authorities’ and enhancing access. Responding appropriately to different needs and situations in differing ethnic and cultural groups, e.g. our Family Support Service in Tower Hamlets undertakes a lot of home-based work as many women feel uneasy about going out to services, and we then accompany people and facilitate their access to other services. Language is so important – but still a problem to find services with staff who speak languages, interpreters, and information in other languages, and it is expensive to use Language Line.</td>
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### Key points and references

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<td>Key issues for future research include:</td>
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<td>or prevent organisations from making their</td>
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<td>services more accessible – and sustaining the</td>
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<td>momentum and effort needed to constantly</td>
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<td>attend to this issue; lots of consultations with</td>
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<td>and treat people with respect, and this would</td>
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<td>certainly encourage people to use services</td>
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<td>respond in such a way? No doubt funding may</td>
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<td>Whole Family Support from Primary Care.</td>
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<td>Wheeler, Ben</td>
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<td>services (references).</td>
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<td>Winfield, Gill</td>
<td>Association for Spina Bifida and Hydrocephalus</td>
<td>Need for access</td>
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<td>and Russell, Andrew</td>
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<td>Wittenberg, Raphael</td>
<td>London School of Economics</td>
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<td>Wittington, Zoe</td>
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<td>Woodhouse, John</td>
<td>County Durham and Darlington Health Authority</td>
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<td>approach, by Carolyn</td>
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<td>Lester, Sara Hayes,</td>
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<td>Susan Griffiths,</td>
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<td>Gwendolyn Lowe and</td>
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<td>Sharon Hopkins. 1999.</td>
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<td>Public Health Medicine</td>
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<td>Region, discussion</td>
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<td>paper. 1 November 2000.</td>
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<th>Name</th>
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<th>Key points and references</th>
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<tbody>
<tr>
<td>Wrigley, Hannah</td>
<td>University of Southampton</td>
<td>Access seems at the moment to be a poorly defined and poorly researched concept in health care terms, with the majority of empirical studies we have identified using very crude measurements and many textbooks not covering the question at all. We are currently trying to develop a standard geographical measure for integrating public and private transport information, having already used GIS to produce 'postcode to GP' and 'postcode to hospital' accessibility estimates for private car access in our study region. Plus references.</td>
</tr>
</tbody>
</table>

In addition we received comments and contributions to the debate on access to dental health from: Stuart Boulton, John Boyles, Blanaid Daly, Janice Fiske, Professor Stanley Gelbier, Professor D. Gibbons, Linda Hillman, Professor Michael A. Lennon, Chris Leopold, Tim Newton, Nigel Nuttall, Derek Richards, Peter G. Robinson, Andy Sprod, and Geoff Taylor.
Details of reports mentioned above

British Association of Dermatologists references and articles

All Party Parliamentary Group on Skin. March 1997. An Investigation into the Adequacy of Service Provision and Treatments for Patients with Skin Diseases in the UK. London


Access to Health Care


Report of the Working Party on Dermatological Inpatient Services

British Homeopathic Association reports and articles


Faculty of Homeopathy. September 2000. Opportunities for Homeopathy within the new NHS. *Opportunities for Homeopathy in the New NHS*, Edition 3


NHS Confederation. *Complementary Medicine in the NHS. Managing the Issues*

Sharples, F. and van Haselen, R. *Patients’ Perspective on Using a Complementary Medicine Approach to their Health: A Survey at The Royal London Homoeopathic Hospital NHS Trust*


British Homoeopathic Library, Glasgow. 13 Abstracts

*Complementary Medicine*. Information pack for primary care groups. June 2000

*Complementary Medicine, Primary Care and The New NHS: Applying the Evidence*. Conference report

Hugh Gravelle: Distribution of GPs

The following (references) look at trends over time in the distribution of GPs across FHSAs and calculate inequality indices. There was little overall change in the need-adjusted inequality indices between 1974 and 1995. I have also recently supervised an MSc student who looked at the trend in the inequality in the geographical distribution of pharmacies in England from 1974 to 1999. We found that there was an initial increase in inequality up to about 1985 but thereafter inequality declined noticeably. The decline coincided with the introduction of controls on pharmacy location, though there were also changes to
Access to Health Care

pharmacy remuneration at the same time, so the controls may not be the reason for the reversal in the trend.

Shows that distance has a marked effect on the rate of admissions for cataract surgery from practices in NYHA (a 10% increase in distance reduces admission rates by about 3.5%, after allowing for other factors).

Initial analysis of data from samples of practice patients in 60 practices shows that there are significant income-related inequalities in health over the whole sample, and at individual practice level. Looks at the practice characteristics associated with practice-level inequality scores. We are extending this work to look at income-related inequalities in consultations, patient satisfaction and patient perceptions of practice accessibility.

Newham General Hospital research areas

1 Effect of using health advocates on the doctor–patient consultation time.

2 The effectiveness of doctors’ consultations and the amount of information the patient retains. The researcher wishes to investigate a novel method of improving the understanding of the patient and the amount of information they retain.

3 Factors that effect the speed at which patients access health care when they have symptoms of cancer, in particular the effect of having had a close relative with cancer.

4 Improving communication through training staff or reviewing. The staff training involves aspects of communication skills, and would also cover aspects of equality of access, e.g. communication with deaf people, blind people, non-English speakers, wheelchair users.

5 Improving communication through improving written literature for patients. Improving literature involves covering alternative formats of written information such as translations, Big Print and audiotapes, all of which promote equality of access through the information available.

6 We are trying to improve access to the Trust for people with a hearing impairment; we have just introduced a minicom phone into the switchboard (for use by deaf and hard-of-hearing people) and are about to get a second one on to our appointment helpline. This work is a result of consultations with a focus group for deaf patients.

7 Other surveys concerning access are often carried out, such as an inpatient post-discharge survey of evidence that some non-English
Access to Health Care

speaking patients may not achieve access to health advocates for language support.
Acknowledgements

Many people have contributed to this report. We would like to thank all who took the time and effort to respond to our request for information, including the following:

University of Brighton: C.S. Gracethorne
University of Bristol: Ben Wheeler, Chris Salisbury and Steven Frankel
Brunel University: Kathryn Ehrich
University of Cardiff: Robert Anderson
City University: James Law
Coventry University: Paul Bywaters
University of East Anglia: Robin Haynes
University of Hull: Andy Alaszewski
King’s College London: Irene Higgins and Jonathan Koffman
Liverpool University: Simon Capewell and Steve Goodacre
London School of Economics: Raphael Wittenberg
University of Newcastle upon Tyne: Elaine McColl and Julie Morris
University of Oxford: Rachel Rowe
University of Portsmouth: Graham Moon
Queen Margaret University College: Jois Stansfield
University of Sheffield: Gareth Parry, Anne Rogers and Pam Enderby
University of Southampton: Hannah Wrigley, Val Lattimer, John Gabbay and Steve George
University College London: Allyson Pollock
University of York: Hugh Gravelle and Maria Goddard

Martin Shalley, Birmingham Heartlands & Solihull NHS Trust
Mark Temple, Bro Taf Health Authority
Hilary Guite, Bromley Health Authority
Robert Sherriff, Buckinghamshire Health Authority
John Woodhouse, County Durham and Darlington Health Authority
Michael Soljak, Ealing, Hammersmith & Hounslow Health Authority
Bobbie Jacobson, East London and City Health Authority
Jean Jones, Maidstone & Malling Community Health Council
Yvonne Doyle, Merton, Sutton and Wandsworth Health Authority
Joanne Morris, Newham General Hospital
Ruth Shakespeare, Southampton Health Authority
David Jenner, South Derby Health Authority
Edmund Jessop, West Surrey Health Authority
Bernadette Purcell, University College London Hospital

Alan Glanz and Christine McGuire, Department of Health,
Gene Shackman, New York State Public Health Service
Claire McCombie, NHS Executive, London
We received comments and contributions to the debate on access to dental health from:

Stuart Boulton, John Boyles, Blanaid Daly, Janice Fiske, Professor Stanley Gelbier, Professor D. Gibbons, Linda Hillman, Professor Michael A Lennon, Chris Leopold, Tim Newton, Nigel Nuttall, Derek Richards, Peter G. Robinson, Andy Sprod, and Geoff Taylor.
This document was published by the National Coordinating Centre for the Service Delivery and Organisation (NCCSDO) research programme, managed by the London School of Hygiene & Tropical Medicine.

The management of the Service Delivery and Organisation (SDO) programme has now transferred to the National Institute for Health Research Evaluations, Trials and Studies Coordinating Centre (NETSCC) based at the University of Southampton. Prior to April 2009, NETSCC had no involvement in the commissioning or production of this document and therefore we may not be able to comment on the background or technical detail of this document. Should you have any queries please contact sdo@southampton.ac.uk.
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