Section 2: health inequalities

Inequality in access to and uptake of health services

a single version of the truth

NHS Wiltshire Clinical Commissioning Group

Wiltshire Council Where everybody matters

Wiltshire Assembly Public Services Board

Related briefings in the JSA for Health and Wellbeing

Briefing	Section
Entire section	Health inequalities
Child mortality	Children and Young People
Health inequalities	Children and Young People
Men's health	Health promotion and preventative services
Screening	Health promotion and preventative services
Health trainers	Health promotion and preventative services
Deprivation	Resources

Outcome Frameworks Summary

The Public Health Outcomes Framework for England, 2013-2016[1] outlines the overarching vision for public health as "to improve and protect the nation's health and wellbeing, and improve the health of the poorest fastest". Each indicator domain has an objective that includes health inequalities:

Domain	Objective
1. Improving the wider determinants of health	Improvements against wider factors that affect health and wellbeing and *health inequalities*
2. Health improvement	People are helped to live healthy lifestyles, make healthy choices and reduce *health inequalities*
3. Health protection	The population's health is protected from major incidents and other threats, while reducing *health inequalities*
4. Healthcare public health and preventing premature mortality	Reduced numbers of people living with preventable ill health and people dying prematurely, while reducing the *gap between communities*.

Edition

Edition	Version no.	Changes/Comments
2012/13	1	N/A
2013/14	1	N/A

Executive summary

Access to healthcare services are one piece in the overall picture of health inequalities. Availability, quality, costs and information are all reasons for variation in access to healthcare. People living in rural areas and older people can have difficulty in accessing healthcare services.

The NHS must ensure that access to all services is equitable for different groups. As Wiltshire has a relatively older and more rural population, these aspects need to be considered in local access and uptake of health services. Local Health Needs Assessments should consider health services access and uptake to ensure that this potential source of inequalities is assessed and where required addressed.

Background

Health inequalities are variations in health between population groups resulting from a variety of societal and economic processes that are unequally distributed within or between populations. They are avoidable and unfair.

Access to healthcare services are one piece in the overall picture of health inequalities.[2]

How might health services affect inequalities?

- Access to care
  - Physical access (availability)
    - For example registration of patients with GP.
    - For example poorer facilities in more deprived communities.
  - Financial access
  - Cultural access
    - Knowledge and awareness of services

- Access through care
  - Navigating the health system
    - For example absence of interpreters.
  - Equal treatment according to wants / needs
    - For example differential referral depending on age, gender or ethnicity.

Adequate access is also linked to timeliness and the quality of services.

> "*Appropriate access to health care for a diverse population requires more than simply providing the service. Provision alone cannot ensure access to care for all people, regardless of their religion, culture, or ethnic background.*"[3]

Equal access to health care has been a central objective of the NHS since it began, inequalities in health care access still persist. The inverse care law, first described

by Julian Tudor Hart in 1971, states: “The availability of good medical care tends to vary inversely with the need for it in the population serve”

Equality of access requires that, for different communities[4]:

- Travel distance to facilities is equal.
- Transport and communication services are equal.
- Waiting times are equal.
- Patients are equally informed about the availability and effectiveness of treatments.
- Charges are equal (with equal ability to pay).

Treatment received (i.e. utilisation) is often used as a proxy marker for access. However, utilisation of health services may vary for many several reasons (such as perceptions of benefits or availability, availability of alternative therapies or services) and is an imperfect measure of access. Waiting times are another proxy marker for access.

For people living in rural areas, access to health services can be difficult due to distance to services and the time taken to travel to those services. Lack of public or private transport may mean that people living in rural areas do not use available services. Access to advice via the internet and telephone may be an advantage to people living in rural area. However older people are less likely to access to the internet.[5] In Wiltshire, in 2011, a large proportion of the population live in rural areas, with 47.5% classified as rural compared to 31.6% of South West or 17.6% of England.[6] The Rural Share of Deprivation in Wiltshire report in 2009 showed 8.2% of those living in rural areas were 6+km from a principle GP site.[7] Therefore, rurality has the potential to have a large impact upon access and uptake of health services.

In 2006, a joint report from the Healthcare Commission, Audit Commission and Commission for Social Care Inspection[8] identified the following as key areas for further action in improving the experiences of older people of public services:

- Tackling discrimination through ageist attitudes and an increased awareness of other diversity issues.

- Strengthening working in partnership between all the agencies that provide services for older people to ensure that they work together to improve the experiences of older people who use services.

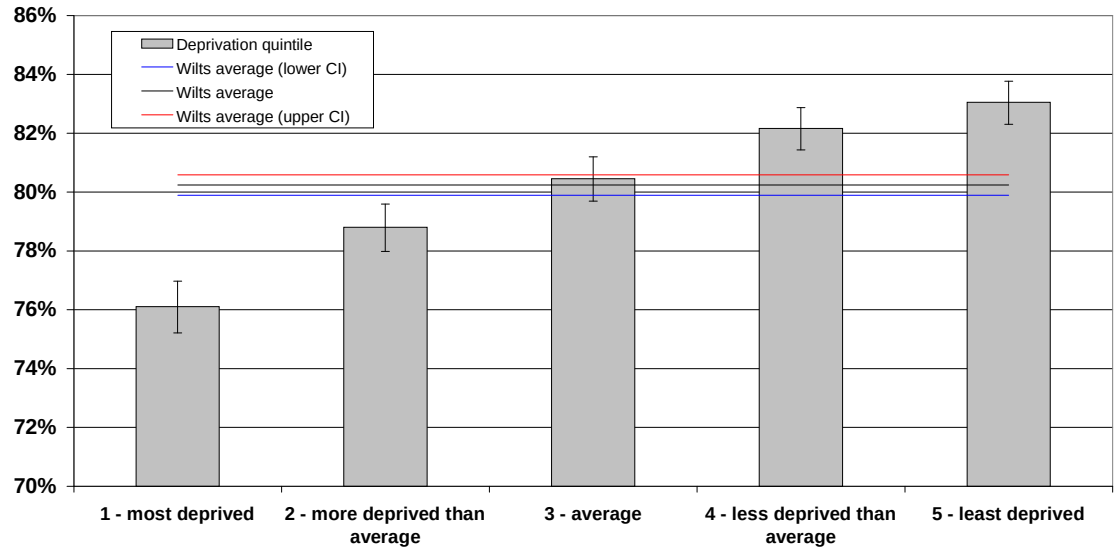
The report identified deep-rooted negative cultural attitudes to ageing in local public services, especially those for mental health.

In Wiltshire, in 2012, it is estimated that 18.9% of the population is aged 65 or over, which is higher than the England estimate of 16.9%[9]. This means that a higher percentage of the population has the potential to benefit from services which do not discriminate by age and improvements in the experience of older people using services.

Wiltshire example – does this need updating?

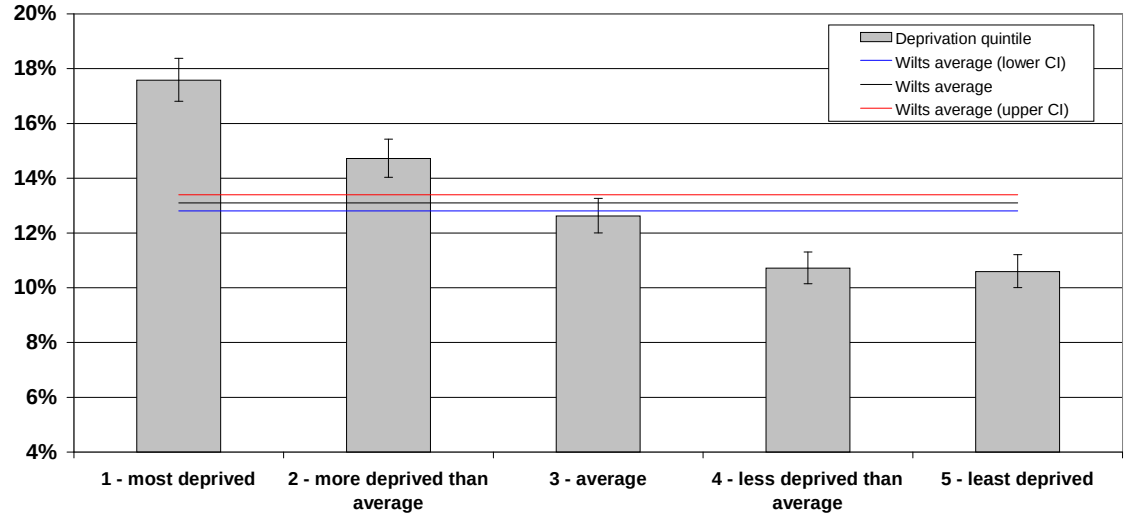
The percentage of completed screens for breast cancer in the most deprived two quintiles is statistically significantly lower than the Wiltshire average and the percentage of completed screens in the least deprived two quintiles is statistically significantly higher than the Wiltshire average (Figure 1). Additionally the percentages of patients not attending (and not opting out) are statistically significantly higher in the most deprived quintiles (Figure 2).

Figure 1: Percentage of complete breast cancer screens by deprivation quintile.



Source: NHS Wiltshire Screening Unit and Index of Multiple Deprivation, 2007.

Figure 2: Percentage of patients not attending and not opting out of breast cancer screening by deprivation quintile.



Source: NHS Wiltshire Screening Unit and Index of Multiple Deprivation, 2007.

National research

National research is important as it may give us indication of areas in Wiltshire where there may be inequalities in access or uptake. However local Health Needs Assessments for individual conditions and services will highlight in more detail inequalities in access and uptake, or where further research is required.

Some examples of possible inequalities of access from research:

- Screening uptake for colorectal cancer is worse in deprived areas.[10,11]
- Ethnic minority women, single mothers, and those with an earlier age at completing education access maternity services late, have poorer outcomes, and report poorer experiences across some – though not all – dimensions of maternity care.[12]
- People from black and minority ethnic community groups have been found to be poorly served by mental health advocacy.[13]
- Vaccination uptake in the over 74 years of age has been shown to be worse in areas of deprivation.[14]
- Education and income effect waiting times for elective surgery, with those in the most deprived groups waiting longer for surgery.[15]
- Inequalities in access to specialist palliative care.[16]

However there are also a number of studies that show no inequality of access to a range of health care services for those in different groups.

Resources

Tackling inequalities in general practice:
http://www.kingsfund.org.uk/projects/gp-inquiry/health-inequalities

Fair Society, Healthy Lives - The Marmot Review:
http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review/fair-society-healthy-lives-full-report

Rural Wiltshire: Rural Facilities Survey 2012 and an Overview. 2010:
http://www.intelligencenetwork.org.uk/community/
(under 'Rural Communities and Services')

The Rural Share of Deprivation in Wiltshire. 2009:
http://www.intelligencenetwork.org.uk/community/
(under 'Deprivation' and 'Rural Deprivation')

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[1] Healthy Lives, Healthy People: Improving outcomes and supporting transparency, Department of Health, January 2012 https://www.gov.uk/government/publications/healthy-lives-healthy-people-improving-outcomes-and-supporting-transparency
[2] House of Commons Health Committee. Health Inequalities, third report of session 2008-09. http://www.publications.parliament.uk/pa/cm200809/cmselect/cmhealth/286/286.pdf
[3] Szczepura A. Access to health care for ethnic minority populations. *Postgrad Med J* 2005;81:141–147.
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[5] DEFRA. Rural Service review. 2004. http://archive.defra.gov.uk/rural/documents/policy/services/rural_services_review.pdf
[6] KS101EW, 2011 Census, ONS. https://www.gov.uk/government/publications/2011-census-rural-analysis-a-guide-to-nomis & http://www.nomisweb.co.uk/
[7] The Rural Share of Deprivation in Wiltshire. 2009. http://www.intelligencenetwork.org.uk/community/ ('under Deprivation')
[8] Commission for Healthcare Audit and Inspection. Living well in later life. A review of progress against the National Service Framework for Older People. 2006. http://www.audit-commission.gov.uk/SiteCollectionDocuments/AuditCommissionReports/NationalStudies/HCC_olderPeopleREP.pdf
[9] 2012 mid-year estimates, ONS. http://www.ons.gov.uk/ons/rel/pop-estimate/population-estimates-for-uk--england-and-wales--scotland-and-northern-ireland/mid-2011-and-mid-2012/index.html
[10] Power E, Miles A, von Wagner C, Robb K and Wardle J. Uptake of colorectal cancer screening: system, provider and individual factors and strategies to improve participation. Future Oncology. 2009: 5(9); 1371-88.
[11] McCaffery K, Wardle J, Nadel M and Atkin W. Socioeconomic variation in participation in colorectal cancer screening. *J Med Screen*. 2002:9(3);104-108.
[12] Raleigh, Hussey, Seccombe and Hallt. Ethnic and social inequalities in women's experience of maternity care in England: results of a national survey. J R Soc Med. 2010:103(5); 188-98.
[13] Newbigging K, McKeown M (2007). 'Mental health advocacy with black and minority ethnic communities: conceptual and ethical implications'. *Current Opinion in Psychiatry* 20 (6): 588–93.
[14] Mangtani P, Breeze E, Kovats S, Ng ES, Roberts JA, Fletcher A (2005). 'Inequalities in influenza vaccine uptake among people aged over 74 years in Britain'. *Preventive Medicine* 41 (2): 545–553.
[15] Laudicalla M, Siciliani L and Cookson R. Waiting time and socioeconomic status: evidence from England. Social Science and Medicine. 2012: 74(9); 1331-41.
[16] Payne M. Inequalities, end-of-life care and social work. Progress in Palliative Care. 2010:18(4); 221-7.