EQUITY, POVERTY AND ACCESS: AN ENGLISH NHS PERSPECTIVE

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1. Scope

This report will focus on England but make reference to a Scottish review. A British National Health Service (NHS) does not exist as the devolved administrations of Northern Ireland, Scotland and Wales have key policy variations.

The report will focus on the role of General Practitioners (GPs) as they are seen as the gatekeepers of healthcare and will drive Practice Based Commissioning. Moreover, there are a number of workforce challenges facing the GP workforce.

2. Definitions

Equity – An impartial or fair act, decision, etc. (Collins Concise Dictionary)

Poverty – the condition of being extremely poor (Cambridge Dictionaries online - http://dictionary.cambridge.org/)

Accessibility of health care – A measure of the proportion of a population that reaches appropriate health services (World Health Organisation definition, http://who.int/en/)

3. Introduction

This report supports a larger piece of research into Equity, Poverty and Access for the International Medical Workforce Collaborative 2008 conference by providing a specific view from the United Kingdom, principally focusing on English healthcare. The report's findings show there is a north-south split on poverty, with the exception of London; in England most of the population live within close proximity of GPs and hospitals; however, there is an issue over appropriate access to healthcare and the impact this has on the health of the population. There are implications for the delivery and design of medical training due to equity, poverty and access issues.

4. Background

4.1. Policy framework

In 2000 the British Government published a 10 year plan for the English NHS, The NHS Plan the main objectives are shown in Box 1:

Box 1: Main Objectives of the NHS Plan (2000)

- Improve health, wellbeing and reduce health inequalities
- Improve quality, effectiveness and efficiency
- Increase choice and responsiveness
- Provide access to comprehensive services
- Achieve best value within available resources

In establishing a review of the progress made by the NHS in 2008 and implementing next steps of the NHS reforms the five objectives from box one were restated. The current health system in England has a number of levers available to support the next stage of reforms; the levers are shown in Box 2.

Box 2: Levers for Change in the English NHS (High Quality Care for All 2008)

- Payment By Results (PBR)
- Practice-based commissioning
- Strengthen commissioning through larger more strategic PCTs
- Foundation Trusts and non-NHS providers
- Access and choice

There remains the question over whether the workforce is available, with appropriate skills and capacity to lead the changes and deliver quality services. This will be a particular challenge as the population and the workforce are growing older, with a number of senior clinicians approaching retirement age.

These changes in the healthcare system require good information for clinicians, managers and the public. Currently there is a major programme of work to improve the availability of suitable information to support effective decision making. There is still work to be done before the programme is complete and the different elements of the healthcare information systems are linked together.

The existing continuation of health inequalities across England are due to a range of complex and linked issues, however, the current position indicates that the various health initiatives have not delivered the required improvements. The local NHS will have to work with Local Government and other agencies if the health of those in deprived areas is to be improved as the NHS cannot solve the problems independently.

4.2. High Quality Care for All: NHS Next Stage Review Final Report

"High Quality Care for All" is the result of the work led by Lord Professor Darzi to provide a vision for the English Health Care system for the next 10 years, building on the past eight years. It was published to coincide with the 60th anniversary of the NHS.

A cornerstone of the report is to strengthen the leadership provided by clinicians throughout the system. Each regional Strategic Health Authority also published their report to supplement the national report. A key priority for the reports is to develop services that are suitable for local populations and to address the existing health inequalities. The current documents are strategic and high level and therefore require subsequent development and implementation of detailed policies and service models which will require monitoring for improvements in health and a reduction in health inequalities.

There has been long term recognition of issues in terms of delivery of services in an equitable way, ensuring health for all. The document states "All too often, those living in poverty are poorest in health." Lord Darzi, states in the report "I set out plans to tackle inequalities in primary care by establishing over 100 new GP practices in the areas of the country with the fewest primary care clinicians and the greatest health needs – more often than not, these are our most deprived communities." The new practices will have to recruit experienced and skilled staff to ensure the delivery of quality care.

High Quality Care for All sets out to strengthen the existing scrutiny of healthcare by local people, including local politicians. This should support making decisions that are appropriate and relevant to the local populations. There are many examples of where Primary Care Trusts consult with the local population over the proposed closures of services, including GP practices and other community services.

The supporting World Class Commissioning programme for Primary Care Trusts is defined as being "designed to raise ambitions for a new form of commissioning that will deliver better health and well-being for the local, improving health outcomes and reducing health inequalities – adding life to years and years to life."

High Quality Care for All is supported by a workforce document, A High Quality Workforce which sets out the future for the workforce and workforce planning across England. In addition the report responds to the recommendations within the report of Profession Sir John Tooke who led the independent inquiry into Modernising Medical Career which had produced a number of recommendations to improve medical education.

4.3. Workforce Planning in England

The Parliamentary Health Select Committee produced a report on English NHS workforce planning in 2007 which concluded there was a trend of boom and bust in the numbers of staff available due, in part, to the long term nature of training set against the relative short term funding arrangements of the NHS. It is worth noting that the Department of Health did not agree with this conclusion.

Traditionally workforce planning has been separate from service planning and public health issues with the recent publication in England of "A High Quality Workforce" this separation had been explicitly identified and a new system is being designed to strengthen these links. It was noted that the workforce planning system had been developed and had evolved through a number of NHS re-organisations and the current structure did not effectively replicate the overall healthcare system in England.

To date workforce planning has tended to focus on the absolute numbers of trainees required, or feasible within a system, as opposed to the absolute need of local populations. The numbers of medical trainees across England has generally been determined at national level, with other staff groups being managed at a more local level.

This has meant that variations in local health status have generally not been considered in workforce planning. In Yorkshire and the Humber the overall number of GP Trainees is determined by a national allocation, but where GP Trainees are located is driven by the capacity of GP practices to support the trainees. This has historically led to an imbalance of placements, with many trainees not placed in deprived areas where there are larger public health challenges. There have been a number of attempts to prioritise medical numbers, especially General Practitioners (GPs) based on the population distributions, but the limiting factor of quality placements remains an issue.

All too often workforce planning processes fail to look at the population being served, the traditional models within health care tend to take the existing workforce and base future plans based on expected income (financial return) or on the anticipated availability of key staff.

The recent advent of Foundation Trusts and the World Class Commissioning look to strengthen the consideration of the local population which will by necessity consider the relative health of the all sections of the population. It remains to be seen how this will impact on local workforce planning.

4.4. Poverty in England

Health inequalities are important and linked to poverty as Wilkinson (2005) states "whether we look at life expectancy or at the frequency of most causes of death and disability, health standards are highest among those nearest the top of the social ladder – whether measured by income, education, or occupation."

Poverty is not limited to urban or rural areas, but spans both. However, in rural areas the economical active rates (that is employment rates) tend to be lower due to fewer opportunities and increased transport issues, in terms of availability and cost.

A local PCT in Yorkshire and the Humber has reviewed its provision of education programmes due to problems of attendance from staff based in rural areas that could not physically get to the sessions.

GP services should be the first port of call for the majority of the population, however, this requires people to be registered with GPs and then to attend the GP practice at the appropriate time. There are a number of groups within the population who are not registered, or who do not access GP services as a matter of choice. In the mid 1990s in East Birmingham the local South Asian community surrounding a large Accident and Emergency (A&E) department tended to access A&E rather than the GP practice, even when the GP practice was accessible.

In comparison to the other countries covered in the International Medical Workforce Conference the issue of accessibility is not one of distance or time to travel to the GP practice, but one of appropriate understanding of the nature of the services available and actual access to a GP.

5. The Current Position

This section is focused on health inequalities within England and the the GP workforce in England and specifically Yorkshire and the Humber set against population statistics and incorporating policy developments highlighted in High Quality Care for All and A High Quality Workforce.

There is a general assumption that there is an issue of access to services in rural areas and that poverty is restricted to urban areas, however, recent work by public health professionals in Primary Care Trusts shows that rural poverty and access issues in urban areas are real and in some wards significant issues. The detailed data within PCTs shows that aggregation of data hides problems within small localities which can be missed at the higher level.

A recent report on the GP workforce showed that there is a vicious circle of shortages of GPs, numbers of single handed practices, a lack of training places coupled with a potential retirement bulge working through the system. The availability of GPs to access on-going professional training has also been highlighted in reports such as Scotland's Training Pathways for GPs report (2007). The remit of the Scottish GP sub-group is to produce a curriculum for use by general practitioners in remote and rural practice, define the curriculum and its core competencies and specialties, models of achievement, workforce, recruitment and retention, as well as address sustainability.

A concern in Yorkshire and the Humber is the potential lack of trainees experiencing the delivery of services in areas of deprivation because of the problems stated above

and the subsequent impact on the recruitment of GPs as trainees often work in the areas where they trained. This will be a key issue for the new GP practices Lord Darzi states he is planning to introduce to the areas of most need.

The challenge for those responsible for placing student GPs and other professionals is to ensure that the quality of learning and training is not compromised for the sake of placing students in different geographical areas to gain a range of experiences.

The impact of living in rural England is not a significant issue in relative terms compared to US, Canada, Australia, however, localised travel issues do arise whereby certain populations appear to self impose restrictions on where they will travel to, the author has experienced this in relatively rural Lincolnshire and the urban area of the Black Country in the West Midlands. This adds to the complexity of service design and locating services that will be accessed by the local populations.

A further consideration for healthcare commissioners and service designers, given the current drive for choice for patients and users, is the ability of people to understand and assimilate data and then use it to make informed choices regarding their healthcare.

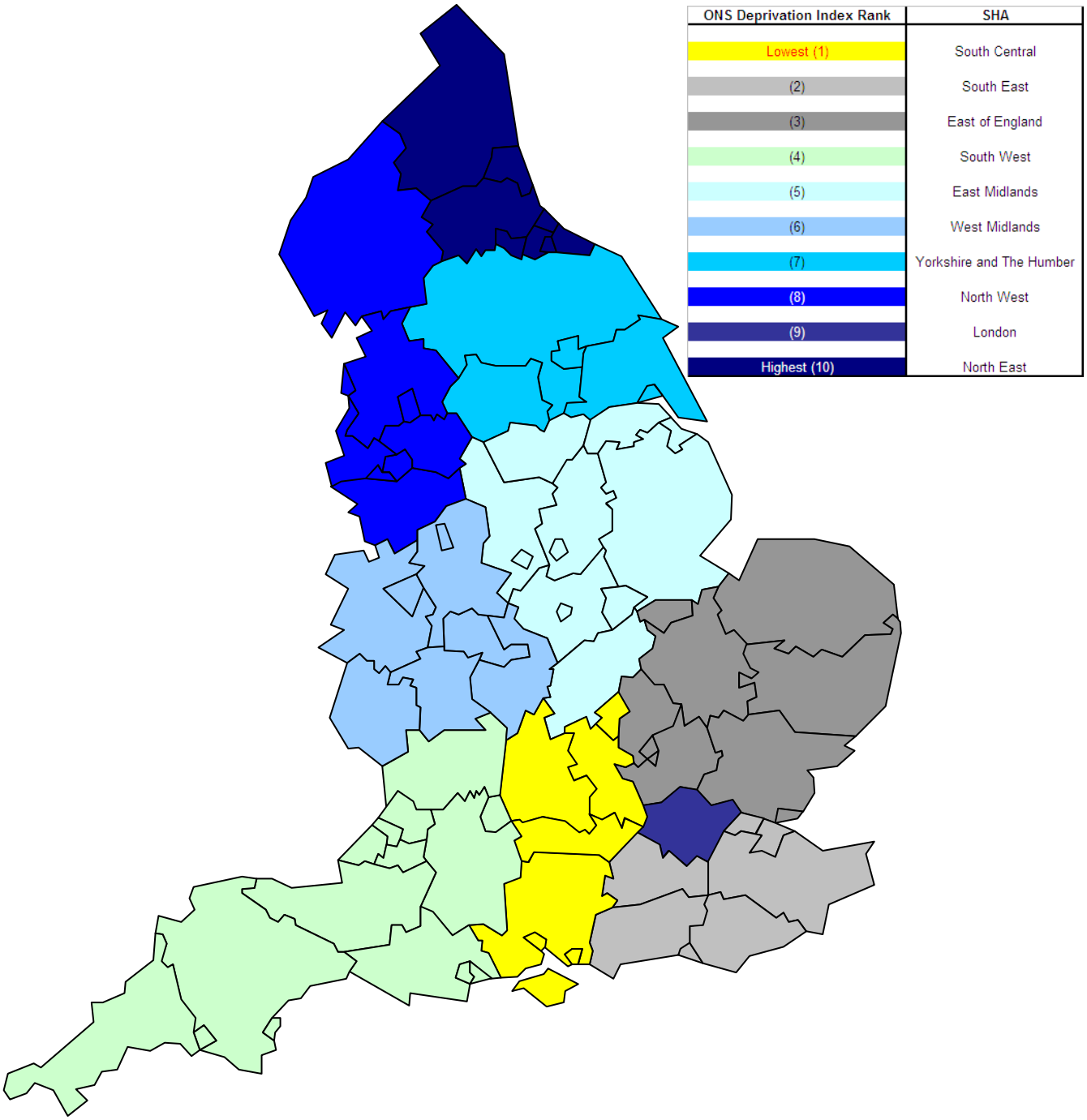
Literacy and numeracy skills are lacking, the recent Leitch report (2006) on skills identified the relatively poor basic education standards of the UK meant that the UK was lagging behind international competitors. Yorkshire and the Humber has some of the worst education attainment rates within England, although the gap is now closing, there are still concerns, especially for those where English is not their first language. There is a need to consider the best way to make use of interpreters and advocates to support effective healthcare and provision of choice if all people are to have equal access to choice.

Within Yorkshire and the Humber Health Ambition report the staying healthy care pathway group called for a 10% shift in health investment into prevention and support for lifestyle changes. While the Strategic Health Authority supports the ambition to turn the spotlight onto prevention, with a significant shift in investment, it is clear further work is needed to understand exactly how such a shift might be planned, implemented and measured. In the first instance, the SHA would like to measure progress on output indicators such as life expectancy and health inequalities (Healthy Ambitions).

5.1. Indices of Poverty

The Office of National Statistics (ONS) produced the data for indices of poverty as at the first of January 2007. From the data the average deprivation score has been used and ranked. The ONS averages have been derived from local concentration of poverty, income scales, employment scales and an index of multiple deprivation points. Figure one shows graphically the ranked distribution of poverty within the 10 Strategic Health Authorities (SHA) in England. The positive direction of poverty is northerly, with the exception of London. South Central has less than two-thirds (62%) the national average, whereas the North East has over a third (34%) more than the national average. Comparing the least and most affluent SHAs, the least affluent SHA has over twice the rate (217%) of the most affluent SHA. These figures need to be monitored over time to assess changes and need to be linked to health needs. It is the role of the Public Health Observatories (PHO) to develop this greater understanding for healthcare professionals.

Figure 1: ONS Deprivation Index Average Rank within the 10 SHAs in England



Source: http://www.neighbourhood.statistics.gov.uk/

5.2. Patient Travel Times

Patient travel time is vital in access for health care. The longer the trip takes, the more inconvenient (and perhaps costly) it is, and the more likely a patient may be not able or willing to take the time to maintain health trips that can be significant in their day to day health. Previous research has shown a gradient where people further away from a hospital are less likely to visit; however, the reasons for this gradient have not been researched. The 10 SHAs and PHO were contacted for any completed up-to-date patient research into travel times but they had no information. Data had been found from the Department for Transport (DfT) with their research into core access indicators. This data has been used but please note the data is from

2005. The data conglomerates all types of transport, from cycling to rail and so these averages may not be reflective in all situations all the time.

Figure two shows patient travel time to GP surgeries. The population is split into households with one or more cars, and households with no cars. The weighted average was 95% living within 30 minutes of a GP surgery, and over 99% within 60 minutes. This is not to say they are registered at the surgery, rather they live within the time to travel. Figure three shows patient travel time to hospitals. The weighted average was 37% living within 30 minutes of a hospital, and 83% within 60 minutes. 17% had to travel over 60 minutes to get to a hospital.

Figure four shows the average number of GPs and hospitals accessible for English residents (outside of London). For the average Local Super Output Area there are 28 GP surgeries and one hospital within 30 minutes. With London being the second highest deprived SHA area it would be useful for this data, but one might consider with the greater concentration and more expansive transport system in place the average might lower. This though would need to be countered with the greater congestion and lower average travelling speed in the capital. London SHA had no data on this and so would need to be investigated further for a clear picture.

Figure 2: Patient Travel Times to GP Surgeries in England in 2005

	Within 30 mins		Within 60 mins		Over 60 mins	
	No	%	No	%	No	%
Households	16,898,495	94.5	17,786,308	99.5	89,378	0.5
0 Car Households	4,277,733	96	4,432,420	99.5	22,273	0.5

Source: http://www.dft.gov.uk/pgr/statistics/datatablespublications/ltp/coreaccessindicators2005

Figure 3: Patient Travel Times to Hospitals in England in 2005

	Within 30 mins		Within 60 mins		Over 60 mins	
	No	%	No	%	No	%
Households	6,326,212	35.4	14,583,988	81.6	3,288,546	18.4
0 Car Households	1,986,761	44.6	3,863,664	86.7	592,696	13.3

Source: http://www.dft.gov.uk/pgr/statistics/datatablespublications/ltp/coreaccessindicators2005

Figure 4: Average Number of Hospitals and GPs Accessible for English Residents (outside London)

	30 minutes	60 minutes
Hospitals	0.90	4.35
	15 minutes	30 minutes
GPs	7.09	27.86

Source:
http://www.dft.gov.uk/pgr/statistics/datatablespublications/ltp/coreaccessindicators2005

This data needs to be updated and if possible made more reflective of the actual situation, as many people may not be registered at their nearest GP for a variety of reasons. The impact of choice of location of care may also mean people will not travel to their nearest hospital for their care.

Access has improved over recent years with the service on target to achieve the 18 week target from referral to treatment by the end of 2008 in England. However, there are concerns over the sustainability of service delivery. Also there remains a question over access to GP services for all members of the population. There are a number of hard to reach groups which PCTs need to ensure can access appropriate health care in an appropriate setting.

There is a need to work with communities to support their needs to ensure services are sensitive to their needs and that they understand how to access the best healthcare. Often healthcare is accessed later than other communities when the conditions have worsened, or services are accessed inappropriately, such as attending Accident and Emergency when it would have been more appropriate to attend a GP practice at an earlier time.

5.3. Workforce Planning

Another approach to workforce planning is to consider a zero based approach, which traditionally starts with the business plan and builds up to a required profile of the workforce, however, this approach can still miss the needs of the population if they are excluded from the business planning process.

A population based model for workforce planning has been developed by Organisational Development Services, a management consultancy firm, the population centric ™ model is a six step model which initially focuses on building the workforce demand from the population's needs. This approach, alongside improved information on the public health, can support provider organisations and PCTs plan better services to reflect the needs for equity, poverty and access.

6. Implications for the Medical Workforce

The implications for the medical workforce and healthcare in general are that the health needs of patients and service users need to be assessed at a local level and services need to be designed with the public in mind. Also there is a need for the design of training to keep pace with the design of services to ensure that students are exposed to the variety of service provision.

In England there is not the pressure that Scotland and other international countries have in terms of the distance to travel to access healthcare. However the data indicates that there are wide variations in health status and that equity, poverty and access are big, difficult issues for the NHS in England.

The Modernising Medical Careers inquiry report recommends the extension of the GP training to five years. This will provide an opportunity for wider experience to be gained by trainees, however, this also adds pressure on the trainers to provide

suitable placements across the core and specialist elements of their training. The quality of training is of greater importance that its location.

The recommendations from the Scottish remote and rural training pathways group for GPs to support GP training in the rural areas are shown in box 3. This review is comprehensive and provides recommendations on the curriculum required for GP trainees.

Box 3 Recommendations from Scottish remote and rural training pathways group

1. Remote general practice should be considered in the governance frameworks and training structures as a GP with a Special Interest.

2. The GP Rural Fellowship model with joint funding between CHP and NES for 1-year posts has been a success. It should continue to follow on after the GP Specialist Training and nMRCGP.

3. The GP Rural Fellowship for remote practice should follow the competences developed by the GP Rural Training Pathways Group and published on the NES E-library.

4. The new educational framework for GPST under Modernising Medical Careers requires competency assessments to be developed for the Rural Fellowship in a similar manner to GPST to match the new remote training competences.

5. The GP Rural Fellowship requires a certificate of satisfactory completion. It is proposed that a tripartite panel including RCGP Scotland, NHS Education for Scotland and the employing Community Health Partnership establishes the framework for the certificate to be issued.

6. The NES GP Director for Education responsible for the Rural Fellowship should be responsible for ensuring the remote competences are kept up to date and formally reviewed every three years.

7. All GP rural training pathways and accreditation mechanisms must maintain flexibility to allow established urban GPs to move to remote or rural locations at a later point in their career. It is recommended that a three-month orientation and the allocation of an established remote GP as peer mentor be considered best practice. Community Health Partnerships should fund training gaps identified during the orientation process such as BASICS courses or similar.

8. The sustainability of established remote general practice teams requires the rural proofing of educational policy within the RCGP, NES and clinical governance arrangements within CHPs.

9. This group has not considered the training requirements for GPs working in community hospitals or in support of consultants in Rural General Hospitals and this work needs to be followed through by new groups tasked with such a remit.

10. Rural GP academic teaching and research capacity requires funding and commitment from Universities and funding agencies to develop the evidence base for rural health policy and rural education.

11. This group recommends the establishment of a standing GP Rural Training Pathways Group.

The rural areas of England should consider whether the recommendations from the Scottish group could and should be applied locally, within the new framework recommended in the Tooke report. As a minimum joint learning opportunities should be explored by the people leading GP training.

Within the new model of workforce planning with England there will be greater transparency and scrutiny by organisations and clinicians. The scrutiny will take place at PCT and SHA level, as well as the national picture. The aim will be to ensure the plans for the future training numbers and design of training will meet the needs of the future workforce and those of patients and users of services. A key requirement of the scrutiny should be to support the narrowing of health inequalities gaps and to address equality, poverty and access issues.

7. Conclusions

Health inequalities are a complex and long standing problem which health policy can aim to improve the healthcare of all, however, healthcare systems cannot solve the problems alone.

The detailed policy changes within the English healthcare system that will follow the publication of High Quality Care for All need to ensure that they recognise the local nature of equity, poverty and access.

The redesign of medical and dental education need to ensure students are exposed to services within deprived areas, whilst not diluting the quality of the education.

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