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Payne, Rebecca; MacIver, Ellen; Clarke, Aileen

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Do new models of primary care risk exacerbating existing inequity?

Rebecca Payne, Ellen MacIver and Aileen Clarke

There have been major changes in modalities of both access and provision in general practice.[1] Delivery of general practice is unrecognisable compared with several years ago. General practice is experiencing the repercussions of the COVID-19 pandemic, increased digitalisation of services, implementation of primary care additional service roles through the Additional Roles Reimbursement Scheme (ARRS), austerity cuts, and continued challenges in staff recruitment and retention. In response, practices have sought to address these challenges with ever-changing, increasingly complex access routes, software platforms, and reorganisation of services.

Achieving safe, quality care for those already disadvantaged remains harder than ever.[2] We argue that new (largely remote) models are exacerbating the already felt inequalities in access and quality of care.

New models of primary care prioritise access for those who are digitally literate, able to navigate complex online systems or apps, are verbally competent, or well supported. Simply increasing the digitalisation, without addressing these issues, risks exacerbating inequalities.[3] The impact of increasing digitalisation on the most vulnerable such as those living in poverty, people with learning disabilities or neurodiversity, those with poor literacy skills or poor English, and isolated older adults has been under-recognised, with insufficient mitigations put in place.

Navigating and 'gaming' the system

In the context of austerity, life expectancy and healthcare provision has worsened for the most vulnerable.[4,5] The Dhalgren–Whitehead 'rainbow model' of health determinants[6] revolutionised understanding of the determinants of health, incorporating the importance of societal and policy factors, alongside provision of health care. Yet, in keeping with the inverse care law, inequities in the quality and safety of patient care are continuing to grow.[1]

Improving access but for who and how?

Recent research highlights a worrying trend of digital exacerbation of inequalities.[7] Educated and health literate patients are often able to successfully navigate access systems.[8] Those without such skills, those disadvantaged via social isolation, literacy (both digital and normal), income, and disability, struggle to gain access[9] and are more likely to end up with inappropriate Emergency Department attendances[1] — a setting unable to deal with their long-term healthcare needs. Where patients need to text pictures to the surgery, or fill in webforms, phone data are quickly eaten up. There is a real, and underappreciated, barrier to access.[10]

Once access to services has been gained, care can involve a complicated back-and-forth — sending photos via text, filling in webforms, and having the wherewithal to present a succinct and comprehensive story on the telephone.[8] Poor health literacy can lead to an understating of symptoms on webforms, which then enters the patient record unchallenged.[8] Cultural barriers, communication difficulties, and illness can make presenting a true and accurate picture more difficult. Patients struggling to deal with these complexities may have symptoms underplayed, or be labelled aggressive as they become frustrated. Receiving a phone call back from a triaging doctor isn't always feasible because of work, family commitments, or poor rural infrastructure. Such systems mean patients need to make complex judgements in order to avoid being excluded from health care.

Spotting the hidden signs

Many consultations are now delivered via asynchronous communication or via telephone. The inherent limitations of remote consultations can mean it's harder to gain a full picture and the context behind a patient's presentation. A malnourished patient or a hungry child in the surgery can prompt referral to appropriate services. On a telephone call, without these visual cues it may be harder to pick up on and signpost to help. Limits with remote consultations in recognising those at risk of domestic abuse and safeguarding have been highlighted.[11]

Fragmentation of care

Attempts in England to provide easier access to services for patients such as via urgent care centres, the Pharmacy First scheme, and providing services at regional rather than practice level have fragmented care delivery and divorced ongoing health needs from the presenting complaint.[12] Comprehensive, coordinated, and continuous care is replaced by a transactional and single-problem-oriented approach with patients often signposted back to the surgery they couldn't access in the first place, when other needs are identified. Other needs slip under the radar because of problems of access or quality of healthcare delivery. Where a service is set up for single-problem care, there are rarely reminders to go for screening, or support for long-term condition monitoring. One problem, sorted, done, out the door, and on to the next. This couldn't be further from Starfield's core values of continuous, comprehensive, coordinated, and accessible primary care[13] — this is more like factory medicine. Relational knowledge is lost.

Interfaces

Interfaces with secondary care also create challenges for the most disadvantaged. How does quicker out-of-area treatment work when the hospital isn't on a local bus route, and you have no other transport? Attempts to cleanse waiting lists by requesting that patients confirm appointments fail to accommodate the needs of those with poor literacy, chaotic lifestyles, or frequent changes of address. New evidence from the King's Fund estimates that people in the most deprived areas are twice as likely to experience a wait of more than a year for elective care compared with those in the least deprived areas.[14] Thus changes to the delivery of health care are compounding preexisting inequalities.

What can we do?

Fundamentally, the worsening of existing health inequalities reflects the worsening inequalities within society. This is exacerbated by an individualistic ideology at the heart of the UK's former conservative government,[15] the neglect of public health services,[16] and the underfunding of the NHS.[17] This particularly affects primary care services. Failure to invest in appropriately trained staff compounds the effects of detrimental governmental policies in welfare benefits, housing, and education; all target the most vulnerable of society.

We need to start by addressing the poverty in which so many UK citizens spend their lives. We then need to review and reform the funding and fragmentation of the NHS. Deprived practices require proper funding that considers differential health needs.[18] The fragmentation of healthcare delivery needs to be reappraised and evaluated with the trade-offs formally enunciated and acknowledged. IT systems need to support information exchange, so no matter what setting a patient appears in, key information about health and social circumstances is available, and where additional follow-up is required, it can be organised. When new initiatives such as the option for out-of-area treatment are introduced, a comprehensive equality impact assessment should be performed, with mitigations put in place to avoid further disadvantage to the vulnerable.

Within the new models of primary care, we need to address barriers at the level of the individual practice. The UK Equality Act 2010 requires all services to make reasonable adjustments to ensure equitable access for people with disabilities.[19] Vulnerable patients need to be identified, flagged on medical records viewable across all providers and software platforms, and provided with extra understanding and support. When they turn up in the 'wrong place', struggles accessing the system need to be acknowledged and recognised, and attempts made to either provide care, or not just signpost, but support them into more appropriate services. Investment in improved digital telephony is welcomed; however, reducing digital exclusion needs to be at the forefront of system changes or disadvantaged groups risk becoming further marginalised and unable to access quality care. Engaged tones are irritating for patients, but being placed in a queue can quickly burn through telephone credit on pay-as-you-go devices. Recommendations to reduce digital exclusion such as those recommended by the Health Foundation[1] need to be applied on both a system-wide and individual practice level.

The current state of health inequalities in the UK cannot be fixed through health care alone. However, the new models of primary care are currently failing to provide equitable, quality care. Increasing digital expansion is welcomed, but failing to prioritise digital inclusion is putting the cart before the horse. The spectrum of inequity in health care throughout the UK needs to be urgently addressed or we risk leaving the most vulnerable of society behind. Fix the inequalities and improved health outcomes are likely to follow.

Rebecca Payne,
(ORCID: 0000-0002-8954-7584), In-Practice Fellow, Nuffield Department of Primary Health Care Sciences, University of Oxford, Oxford.

Ellen MacIver,
(ORCID: 0000-0003-2483-9858), In-Practice Fellow, Nuffield Department of Primary Health Care Sciences, University of Oxford, Oxford.

Aileen Clarke,
(ORCID: 0000-0001-8299-3146), Professor Emeritus, Nuffield Department of Primary Health Care Sciences, University of Oxford, Oxford.

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CORRESPONDENCE
Rebecca Payne
Nuffield Department of Primary Health Care Sciences, Radcliffe Primary Care Building, Radcliffe Observatory Quarter, Woodstock Road, Oxford OX2 6GG, UK.
Email: **rebecca.payne@phc.ox.ac.uk**

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