
Monograph:
Goddard, M. (2008) Quality in and Equality of Access to Healthcare Services in England. Working Paper. CHE Research Paper . Centre for Health Economics, University of York , York, UK.

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Quality in and Equality of Access to Healthcare Services in England

CHE Research Paper 40

Quality in and Equality of Access to Healthcare Services in England

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August 2008

Background

CHE Discussion Papers (DPs) began publication in 1983 as a means of making current research material more widely available to health economists and other potential users. So as to speed up the dissemination process, papers were originally published by CHE and distributed by post to a worldwide readership.

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Acknowledgements

The following individuals provided detailed comments on relevant sections of the draft, for which I am extremely grateful:

Mr Mike Brown	Refugee Action
Mr Philip Hurst	Age Concern, England
Mr Andy Keefe	Refugee Council
Dr Vanessa Pinfold	Rethink
Ms Elizabeth McLennan	Help the Aged
Ms Emily Wooster	MIND

I am also grateful to Gillian Robinson for her assistance with the project, and also Kath Wright and Julie Glanville from the Centre for Reviews and Dissemination at the University of York for their assistance with the literature search. Finally, Anne Mason and Peter C Smith at the Centre for Health Economics provided valuable feedback.

The project was financed by the European Commission, Directorate General for Employment, Social Affairs and Equal Opportunities under the theme of Social Protection and Integration - Inclusion, Social Policy Aspects of Migration, Streamlining of Social Policies (Contract Number VC/2006/0209).

The summary report and copies of all the individual country reports can be found at: http://ec.europa.eu/employment_social/spsi/studies_en.htm#healthcare

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Acronyms

A&EAccident and Emergency
APMSAlternative providers of medical services
CABGCoronary artery bypass graft
CHDCoronary heart disease
COPDChronic obstructive pulmonary disease
CSIPCare Services Improvement Partnership
DoHDepartment of Health
GPGeneral Practitioner (i.e. medical doctor providing primary care)
HAZHealth Action Zones
HiMPHealth Improvement Programme
HOHome Office
MIMyocardial infarction
MINDNational Association for Mental Health
NHSNational Health Service
NICENational Institute for Health and Clinical Excellence
NSFNational Service Framework
ONSOffice for National Statistics
OPDMOffice of the Deputy Prime Minister
PCTPrimary Care Trust
PMSPrimary medical services
SEUSocial Exclusion Unit
UKUnited Kingdom of Great Britain and Northern Ireland
VHIVoluntary Health Insurance

1. Introduction

This "country report" for England is part of a larger, collaborative effort between eight European countries to document and analyse access to health care services. Key points from the country reports have been collated into an overall report for the European Commission, the funders of the project. The final version of the full report, summarising the results from all eight countries can be found at:

http://www.euro.centre.org/data/1215506214_37409.pdf

The purpose of this report is to identify and analyze barriers to access to health care services which are faced by vulnerable groups in society, and especially those most exposed to social exclusion. In addition, the report reviews the policy initiatives aimed at improving access and equity of access, highlighting the features that appear to be most promising in achieving these aims. This report addresses only the specific aims of the project brief and therefore does not cover the full range of issues related to access and quality.

The structure of the report follows the common template used by all countries. After identifying and discussing the research evidence on access barriers in section 2, the report addresses in Section 3 the specific situation of three vulnerable groups: (a) migrants, asylum seekers and illegal entrants; (b) older people and (c) people with mental health disorders. Section 4 presents a detailed case study on access to mainstream healthcare services by people with mental health problems.

1.1 Country profile

There are substantial differences in the organisation of health and social care between the four regions of the UK. This report focuses on England.

The UK has a mainly tax-funded system of public provision through the National Health Service (NHS) which provides the majority of health care services free at the point of delivery for residents. There are limited co-payments which are amongst the lowest in Europe. These include prescriptions for pharmaceuticals; dental care provided outside of the hospital sector; sight testing and corrective lenses. Certain groups (eg children, older people, those on low incomes or in receipt of benefits) are excluded from charges for these. Primary and secondary care is free for all residents.

In England, the commissioning of care to meet local needs is undertaken by Primary Care Trusts (PCTs). Provision of primary care services by GPs is organised in the community via the PCTs. Secondary and tertiary care is delivered through NHS Hospital Trusts or private providers. Ancillary services such as physiotherapy, occupational health, chiropody, etc are provided free in the community and in hospital.

The UK social security system provides a range of cash benefits designed to help people with costs incurred through meeting needs associated with age, illness and disability.

1.2 Promoting social inclusion through policy action at the system level

The UK government's strategic approach to social protection and social exclusion is to build a strong economy and a fair society with security and opportunity for all. Creating employment opportunities is a central part of the strategy, with support for those who cannot work. The key challenges identified for the UK (European Commission, 2006) are around the issues of: worklessness, childhood poverty, pensioners' retirement income and health inequalities. Targets are set for government departments to achieve progress in these areas and some progress has been made at national level (eg reduction of children in households where no-one is working; increasing rate of employment of lone parents).

These main areas have been supported by various initiatives, including two major ones, "Opportunity for All" which was launched in 1999 (Department of Work and Pensions, 1999) and the 2006 Green paper "A New Deal for Welfare: Empowering People to Work" (Department of Work and Pensions, 2006a). The main areas covered by the strategy are: (1) Eradication of child poverty; (2) Creation of employment opportunities for all – with a specific focus on some groups including older people,

people from ethnic minorities, the disabled and lone parents; (3) Meeting aspirations of people in later life; and (4) Improving communities. Each year progress on the Opportunity for All strategy is reported, focusing on how other national initiatives fit with the overall strategy and describing many of the initiatives taking place at local level across the country. The latest update report for 2006 (Department of Work and Pensions, 2006b) lists successes in a number of the above areas:

- Employment initiatives such as New Deal and Pathways to Work are mainstream policies that have helped people return to work after illness or provide support for those who have difficulty finding employment. Some initiatives have subsequently been tailored towards specific groups eg New Deal for Disabled People and specialist outreach employment services for ethnic minority groups, ex-offenders, drug users and refugees. These are supported by various financial packages which provide assistance for seeking work or improving skills and by income support of various kinds that ensure people are better off working than they would be on benefits. A Financial Inclusion Fund aims to help those without bank accounts and provide affordable credit.

  Evidence of progress highlighted in the report includes higher rates of job entries in areas with New Deal and Pathways to Work pilot schemes; a reduction in numbers of households without bank accounts and increased numbers of new savers.

  More work is planned which revolves mainly around changing the balance of financial support available to those who work and those who receive benefits, and extending programmes that have worked to additional client groups or rolling out local schemes nationwide.

- Promoting social inclusion for older people also involves work related initiatives, income support and pension reform, improving transport and tackling health inequalities (see later for discussion of the latter).

  Evidence of progress highlighted in the report mainly relates to enhanced take up rates of benefits by pensioners through targeted schemes and changes in the number of older people living in poverty.

  More work is planned including implementation of “A Sure Start to Later Life” which will extend to older people some of the principles of the “Sure Start” programme that was aimed at children and parents. Pilots are in place to test out mechanisms for integrating access to the full range of health and social care services in a seamless manner (Social Exclusion Unit, 2006).

- Policies aimed at children are the main focus of the latest update report and progress has been made towards reducing child poverty.

1.3 Quality in and equality of access to healthcare: summary of main findings

The remainder of the report examines the evidence on equity of access and barriers to access and also documents the nature of English policy initiatives aimed at addressing these access issues. Section 2 outlines the scope of the health basket and the degree of co-payments for health care services. Cost-sharing is not a major barrier in England due to universal coverage and a range of exemptions for the poorest groups. The exception is for groups whose entitlements to free care are restricted in some ways (eg asylum seekers).

Other barriers to access are identified and research evidence summarised. Overall, there is evidence that people living chaotic lives and those in disadvantaged circumstances – which describe all three of the groups covered in this report – face a number of barriers of various types on both the supply and demand side. Organisational barriers have potentially become more significant recently due to the proliferation of different types of services, governed by different health professions all of whom have their own idea of an “ideal user”. Navigation of an entry point into such services may therefore be more difficult for those from disadvantaged groups.

A great deal of policy effort has been targeted at addressing broad issues of social exclusion amongst disadvantaged groups generally and this encompasses older people, those with mental health disorders and people from ethnic minority groups. It would appear that the health care needs of asylum seekers and illegal entrants have received least attention. Whilst policy *has* been formulated for these groups, the government’s focus – particularly on illegal entrants - has largely been on circumscribing entitlements, which is not surprising given their focus on the need to ensure that NHS resources are used to the benefit of residents. This is a political issue and one which has to be framed within the broader objectives of the immigration policy of the UK. However, voluntary organisations have made substantial efforts in this area and the Department of Health aims to support access and guide people to appropriate health care services. A great deal of attention is currently paid to the health of children and younger people and policy has been directed at reducing inequalities in health between social groups. Whilst this does not address directly the needs of the groups considered in this report, it is perhaps a reasonable approach as the aim is to prevent the onset of cycles of deprivation and poor health which can arise in later life.

Policy initiatives are described in each section – both in terms of general initiatives to address access and also those targeted at each of the groups, which will be covered in more detail. Characteristics of what appear to be helpful initiatives are described in sections 2.10 and 3.4. A very broad observation is that increasing supply is probably less important than devising ways of supporting people in accessing existing services. Promising approaches to delivering on this include the development of processes of co-ordination, collaboration and integration that reduce the complexity of navigation through the system for disadvantaged groups.

2. Major barriers of access

A literature search for this report was carried out by the Centre for Reviews and Dissemination at the University of York. This consisted of electronic database searching, internet searching and citation searching. The general high level search was supplemented with more focused searches for the specific topics covered in the report (eg for each of the groups considered in depth). Details of the databases used and a brief outline of the search strategy are given in Appendix 1.

2.1 Introduction

As Mason and Smith (2005) point out, the English NHS is based on a statutory duty on the Secretary of State to provide services to meet ‘all reasonable requirements’. However, what is reasonable is a matter of judgement and strictly speaking this means that patients have no entitlement to specific services so the exercise of discretion is therefore at the heart of the statutory duties. In practice, little is specifically excluded and a plethora of regulations and managerial systems help to define: what is provided; national guidelines; decisions by the National Institute for Health and Clinical Excellence (NICE) and standards employed by regulators in their assessments of NHS performance. Along with case law, all contribute to what may be considered as ‘reasonable requirements’ for health care provision.

Aside from charges for a small number of services and items (see section 2.3), the main forms of rationing are by waiting list for some elective procedures (with maximum waiting times guarantees in place); national guidelines and decisions from NICE (which are sometimes recommendations rather than statutory requirements, except where they rule on the provision of effective treatments); local decisions by commissioners about the affordability of implementing NICE decisions (there is discretion leading to variation in provision of some treatments across the country) and local decisions on affordability of some procedures within available resources (eg extraction of wisdom teeth). These can all lead to some variation in availability of treatments between geographical areas. There is potential for people to be confused by, or unaware of, the degree of local variation but only a relatively small subset of care is affected so this may not be a major issue.

The provision of services for treatments where there is some local discretion creates much media attention eg eligibility for IVF treatment varies, with some areas restricting access more tightly according to age than others. The key is that where services are restricted locally in some way, this is normally done on the basis of clinical and cost-effectiveness (often for sub-groups) and not in terms of ability to pay or other patient characteristics that are unrelated to clinical effectiveness. Commissioners are not allowed to issue blanket bans as there must always be allowance for exceptions based on clinical need. This might make it difficult for people to determine their potential eligibility for some types of care until they progress through the health care system.

2.2 Population coverage for health care under public programmes

The mainly tax-funded National Health Service (NHS) is a universal service that covers all residents in the UK for free health care at the point of delivery. It is not possible to opt out from paying taxes. The health care system is based on allocation according to need and rationing is managed by mechanisms that mostly do not reflect ability to pay. Co-payments are in place for a small number of things which includes prescriptions (pharmaceuticals and some appliances), some dental care provided outside of hospital setting, sight testing and glasses. Certain groups (eg children, older people, those on low incomes or in receipt of benefits) are excluded from charges for these. There are some differences between regions of the UK (eg Wales has no prescription charges). Primary and secondary care is free for all residents. A small proportion of the UK population (about 11.5%-12%) have voluntary health insurance which is both complementary (dental insurance has become more popular as the availability of NHS providers has diminished) and supplementary, providing faster access, mainly to elective treatments for which there are waiting lists. There are also better amenities provided in private hospitals. Voluntary health insurance is sometimes provided as part of an employment package or is purchased individually by those who are willing and able to pay.

The full range of free NHS care is available to: those who have been living legally in the UK for more than 12 months; permanent residents; students who are in the UK for more than 6 months; asylum seekers or refugees who have made an application to remain in the UK (including those challenging the results of an application); people detained by immigration authorities and primary care for people from countries with reciprocal agreements. Those not eligible for the full NHS free treatment are: students on courses of less than 6 months; those who have not submitted an asylum or refugee application to the home office; those who have exhausted the appeals process for challenging a failed application for asylum and illegal entrants.

Since 2004, visitors from overseas are not entitled to the full range of free treatment and are required to pay for secondary care, as are all those mentioned in this second category. The second category are eligible for some free treatment – mainly related to emergency or “immediately necessary” care, although the interpretation of this is left to the medical profession. There is also free family planning, antenatal care, compulsory psychiatric treatment and treatment for some notifiable communicable diseases (not HIV/AIDS) for this group. For primary care services, proposals were made in 2004 for all these people to be excluded from free primary care services but at the time of writing this has not been taken forward and the GP has discretion on whether to treat people in these groups without charge.

2.2.1 People not covered by the public system

There are no legal or other distinctions in coverage of the NHS by personal characteristics. In practice, certain groups may find it more difficult than others to register with a GP and to access other care even if they are in principle entitled to it eg the homeless.

The situation for asylum seekers and refugees is detailed in section 3.1.3. There are no central records of how many people fall into the second category of people for whom only emergency care and “immediately necessary” care is available free of charge. The main changes in policy have reflected views on “health tourism” which have affected charging policies for non-emergency hospital care for overseas visitors, for people whose appeal rights are exhausted and illegal entrants.

2.3 The scope of the health basket

This section covers the scope of publicly funded services under each of the sub-headings and also details the level of co-payments where applicable. The latter is referred to again in section 2.4.

- *Health promotion, prevention and preventive health services (including screening)*

  All these services are available free to UK residents and the groups of people identified as having same rights as residents in section 2.2.

- *Home visit by general practitioner*

  GPs make decisions on home visits based on need and these are provided at no cost to the patients.

- *Home visits by other providers (allied health professions for older people with reduced mobility)*

  A range of domiciliary care is provided eg district nursing, health visitors – largely based around needs of particular groups such as older people and new mothers.

- *Medication (prescription drugs; limits of reimbursement)*

  A charge is made for prescriptions unless patients fall into one of the exempt groups. In Wales, charges have recently been abolished. The charge in England is fixed (£6.85) and there are 4 month and 12 month pre-payment options available to those for whom it would be cheaper to pay this way. Exempt groups in England include children under 16; those in full time education aged 16-19; people over 60; pregnant women or those who have given birth in last 12 months; war pensioners; people with certain special conditions and people and their partners who are in receipt of various benefits that indicate a low income. Overall, 50% of the population are entitled to free prescriptions and 85% of prescriptions are dispensed without charge.

- *Maternity services (pre- and post-natal up to age of six months of the child)*

  These are provided free to residents and all those with equivalent status.

- *Family planning and sexual health services (including oral contraceptives)*

  These are provided free to all people, including those who fall into the second category outlined in section 2.2.1.

- *Dental services (including dentures)*

  This is a complex area which has changed in recent years. In England, all those under 18 should receive free treatment. Those patients who are not entitled to free treatment pay for NHS treatment. Payment will fall into one of three charge bands depending on the type of treatment received. The minimum amount is £15.90 and the maximum amount was reduced in 2006 as part of a revision of the dental payment system and fell from £378 per course of treatment to its current level of £194. Exemptions are those aged under 18, those under 19 in full-time education, pregnant women and those who have given birth in last 12 months. Patients in receipt of various social security benefits or with a low income are entitled to partial or completely free treatment. The age limits are more generous in Wales in terms of having a higher lower age limit (25 years) and being free for those over 60.

  A growing number of people find it difficult to access dentists who will accept them for NHS treatment rather than treating them privately and this has been the subject of much debate. This is discussed further in section 2.4.

- *Physiotherapy (ambulatory/community provider)*

  The arrangements for providing services such as physiotherapy at home are largely made on a local basis subject to resource constraints and are then allocated according to need. GPs may refer patients for free physiotherapy but waiting lists in some areas mean that many choose to pay privately to be seen more quickly.

- *Wheelchairs, Zimmer frames*

  Provision of publicly funded wheelchairs are subject to the assessment of need. Vouchers are available in some parts of the country which allow people to top up the amount that an NHS wheelchair would cost and to purchase one privately. This allows the purchase of wheelchairs at a higher specification than the basic NHS model. This does raise some equity issues in terms of ability to pay for higher quality chairs.

  There is no single model for the assessment and provision of wheelchair services and a review of practice nationally revealed substantial variation in the resources available at local level to meet assessed needs (Care Services Improvement Partnership, 2006a) and a fundamental overhaul of services has since been initiated by the Department of Health.

- *Hearing aids, glasses*

  Sight tests are free for those receiving hospital eye services; people over 60; children; those in fulltime education aged 16-19; people on a low income; those at high risk of developing eye disease; blind people; partially sighted and those with complex conditions. Partial cost-sharing for glasses is available for those on low incomes, children and those aged up to19 still in full time education. NHS hearing aids are free.

- *Mental health counselling*

  The NHS provides free services to those in hospital and for community services on recommendation of the GP. Waiting lists mean that many people pay as waits can be many months or years.

  The main benefit of complementary voluntary health insurance (VHI) is faster access for elective procedures for which there are NHS waiting lists or high thresholds for getting onto waiting lists eg hip replacements, varicose vein surgery. Amenity levels are also higher in private sector. VHI are free to set their own benefit package and many have started to offer more health promotion and prevention activities such as cholesterol testing, cancer screening etc.

2.4 Cost-sharing requirements as barriers to access

The extent of cost-sharing in England is limited. Appendix 3 has details of the latest NHS Prescription Charges. As illustrated in section 2.3, exemptions on co-payments are based largely on income – either indirectly eg for children and pensioners, or directly eg people in receipt of income support benefits. Thus they provide some measure of protection for disadvantaged groups. Whilst there is some evidence that the demand for drugs is responsive to the price of prescriptions (summarised by Mossialos and Thomson 2003), the research is extremely dated and it would be difficult to draw conclusions for the current situation.

There does not appear to be a trend towards increased cost-sharing and indeed in some regions (eg Wales) it is being reduced. One exception is the restrictions on free care applied to those from overseas (see 2.2 above). This is considered further in section 3.1.3.

However, problems in accessing NHS dental treatment have led to discussion of the impact of high costs of private treatment. It is not possible within the confines of this paper to describe the full context of the debate but due to many complex historical changes in the way in which dentists were remunerated for providing NHS treatment and to several workforce issues, it has become more difficult for people to find a dentist willing to treat them as an NHS patient because dentists have shifted increasingly into private practice (Gibson, 2003). The latest round of payment reforms (April 2006) guarantees dentists a minimum income which, in conjunction with shifting the responsibilities for dental services to PCTs, was meant to address this problem of access (Oliver, 2006). However, there are still reports of problems in specific geographical areas. PCTs have a duty to find a dentist willing to treat NHS patients for people unable to access one for themselves, but some geographical areas are under-served which makes it necessary to travel long distances. This has resulted in higher use of private care and private dental insurance which may work against those unable to afford this as an alternative.

Substantial variation in the mechanisms of assessing needs for wheelchairs and the restricted funding often available locally has led to concerns about equity of access both in terms of the provision of NHS equipment, but also access to specialist advice and information for those who fund their own provision. This should be addressed to some degree in England by the review recently launched by the Department of Health (see 2.3).

2.5 Geographical barriers of access to health services

Geographical factors may inhibit the use of services by groups who experience difficulties in mobilizing the practical resources required to access distant services. People in vulnerable groups may lack the necessary social support to organise care for dependents if they need to travel to receive that care. Rates of car ownership are lower in more disadvantaged groups, making travel more difficult, especially out of hours when access to public transport is limited. Older people have identified concerns over safety as well as availability and cost of public transport as a barrier to access distant services (especially for rural populations) and primary care out of hours services (Foster *et al.*, 2001; Stark *et al.*, 1997). Mothers whose first language is not English report that journeys to treatment centres for their children are more difficult and they had larger families which made attendance more difficult (Carter and Bannon, 1997). More generally, living further away from a primary care centre, being a lone parent and having a larger family all appear to make accessing distant services more difficult because of the problems of arranging support and care (many studies are summarised in Goddard and Smith, 1998 and Dixon-Woods *et al.*, 2005).

Historically there have been inequities in the supply of GPs across districts and a large amount of empirical research from the 1990s and early 2000s demonstrates a mismatch between the number of GPs in areas and “need” (measured simply by population or in more sophisticated ways), with deprived areas being under-served and affluent areas being over-served (eg Benzeval and Judge, 1996; Hippisley-Cox and Pringle, 2000; Gravelle and Sutton, 2001). Some recent studies find this to be a localized rather than a general problem, with London being the main problem area (Baker and Hann, 2001); or suggest that evidence is not as strong once methodological issues have been accounted for (Gulliford, 2002). Overall, most commentators would agree that there is some inequity in supply of GPs between deprived and less deprived areas. However, what is less clear is whether or how the variations in supply result in an inability of people from vulnerable groups to register with and visit a GP. There is little evidence on this issue and the relatively high consultation rates amongst disadvantaged groups may suggest that supply is not a prime issue affecting access to primary care services, at least as measured by utilisation rates.

Evidence that people are disadvantaged in terms of utilisation rates relative to “need” by the centralisation of services has been found in many studies (summarised in Dixon-Woods, 2005). The “distance-decay” relationship has been illustrated mainly in the context of specialist coronary care units, showing that those who live closer to such centres have higher rates of utilisation after adjustment for need. The impact of distance on utilisation of preventive services such as screening appears to be stronger than on curative treatments, especially where repeat treatments are required (Goddard and Smith, 1998; Haynes, 2003).

There is a patient transport system and a hospital travel costs scheme available to help those on low incomes to cover travel costs of accessing services but it has been noted that these are badly publicised and both professionals and patients are unsure of eligibility criteria (Office of the Deputy Prime Minister, 2003). Accessibility Planning is part of the government’s plan to help people from disadvantaged groups to access services and employment. Local transport authorities have to involve the NHS and local authorities in formulating plans to enhance accessibility and a variety of indicators and sources of information have been suggested. Funding has been available for enhancing transport to health services and for other schemes, such as mobile health units. Whilst evaluations suggest some success in terms of improving access, there does not appear to be any systematic analysis of whether this has had a differential impact on vulnerable groups.

As mentioned in section 2.1, the National Institute for Health and Clinical Excellence (NICE) plays a role in making decisions on the provision of treatments deemed to be effective. Where NICE assesses a health technology to be effective, there is a statutory duty on PCTs to provide funding for it and this has helped to standardise the availability of some treatments across the country (http://www.nice.org.uk). In other circumstances (e.g. public health interventions), NICE issues guidance which may be taken up and implemented unevenly across the country.

The issue of geographical access is complex because the quality of care provided in centralised services may be higher than if they were more evenly dispersed, as illustrated by empirical evidence on the volume-quality link for some specialties. Thus, improving access to central services may be a more sensible policy response than providing localized services in some contexts.

In primary care where local access is more important, developments nationally in Personal Medical Services (PMS) have provided incentives and funding to increase the supply of primary care services in “under-served” geographical areas (which tend to be deprived areas). These are also targeted at better provision for specific disadvantaged groups and this is discussed further in the next section.

2.6 Organisational barriers

In England, a number of policy initiatives have centred around the re-organisation of services to enhance overall access. These include NHS Walk-in centres (usually not 24 hours) where people can receive care without being registered with a GP in the area and without the need for an appointment; NHS Direct, a nurse-led 24 hour telephone advice and consultation service; and arrangements for out of hours primary care provision which is increasingly provided by specialist groups of GP co-operatives who contract with PCTs to provide such services.

In principle, NHS Direct can improve access to help for groups of the population who have difficulty accessing primary care. Evaluations of the impact of NHS Direct have tended to focus on the volume and nature of enquiries and whether it has been a substitute for or complement to, other types of care, rather than on the impact on access or equity of access. Munro *et al.*(2000) found no obvious impact of this service on demand for A&E services, out of hours or ambulance services combined. However, there appeared to be an effect on halting the increase in use of GP co-operatives. Older people appear to be less likely to use NHS Direct than younger people (George, 2002; Cooper *et al.*, 2005), which may be related to preference of older people to see their GP (Ullah, 2003). An analysis of awareness of the service amongst patients arriving at A&E who had not contacted NHS Direct, suggested older patients, those from ethnic minorities and those from less affluent postcode areas were less aware of the existence of NHS Direct, suggesting that target populations have not been reached by publicity (McInerney *et al*., 2000). A postal survey asking about use of and awareness of NHS Direct found that use was significantly lower amongst poorer socio-economic groups and those with communication difficulties (hearing and language problems) (Knowles *et al*., 2006). Ecological studies that analyse call rates suggest that calls about adults were generally higher in more deprived areas (Burt *et al*., 2003; Cooper *et al*., 2005) but this may not be evenly distributed by age as calls about children appear to be lower in the most severely deprived areas (Cooper *et al.,* 2005).

Out of hours primary care centres run by GP co-operatives could in principle improve access but also often require patients to travel some distance at times when public transport is unavailable, therefore making access more difficult for those without a car, without social support (such as lone mothers) and without sufficient funds to pay for taxis (Shipman *et al*., 2001).

A systematic review of the evidence on several types of re-organisation of services to improve access supported the evidence outlined above and provided further commentary on Walk-In centres (Chapman *et al*., 2004). Whilst they were well-used and produced high levels of patient satisfaction, they attract mainly white middle-class patients, although they do also serve younger men who tend to access primary care less often.

A more wide-ranging attempt at improving access in areas traditionally under-served by primary care is the change in contractual arrangements that allowed the development of Personal Medical Services (PMS) to target the needs of local areas plus the more recent development of Alternative Providers of Medical Care (APMS) aimed at encouraging suppliers into the primary care market to meet specific needs and expand supply in under-served areas. Whilst there is some evidence to suggest progress has been made in targeting older people and more deprived areas (Chapman *et al*., 2004) and whilst OPDM has tried to publicise PMS to vulnerable groups such as the homeless, there is little evidence on the effectiveness in terms of addressing inequity of access.

Perversely, the increase in organisational forms aimed at improving overall access, including NHS Direct and NHS Walk-In centres may increase the problems of matching perceived health needs to the appropriate health service. Different professionals are often involved in each sector with their own expectations of what is an “appropriate” use of the service and this may make it difficult for people in disadvantaged groups to know how to negotiate their pathway through them. Thus services that require a lot of “work” on the part of the patient to access them are less “permeable” than others and this might explain the higher use of Accident and Emergency services amongst disadvantaged groups compared with other groups, as this is a permeable service that is relatively straightforward to access (Dixon-Woods *et al*., 2005). The variety of new forms of service, each using their own terminology and each with a different definition of “appropriate” access that may not be easily distinguishable to some groups, may make the services less permeable than initially hoped.

2.6.1 Waiting lists

Waiting lists have been a major feature of English health policy over many years. The current targets are 13 weeks for first outpatient appointment and 6 months for first inpatient appointment, both from the time of GP referral. These apply to non-urgent care only. These have been reduced substantially since 2002 and evidence comparing England and Wales (which did not consistently have targets) suggests that targets with financial penalties attached have helped achieve reductions in waiting times (Hauck and Street, 2007). There are other “recommendations” for maximum waiting times for certain types of care – for example, the National Cancer Plan contains a number of different waiting times for aspects of cancer care eg maximum one month wait from an urgent referral for suspected cancer to the start of treatment. Some of these are the cause of controversy as commentators argue that manipulating referrals in order to meet arbitrary waiting times targets may crowd out care for more seriously ill patients.

There has been a long history of research looking at the influences of prioritisation of patients on waiting lists. Surgical and administrative factors are usually cited as important influences. Reasons for treating particular patients are very varied including provision of a good case mix for teaching junior doctors, ensuring a balanced list and ease with which a patient can be contacted. Pell *et al.*

(2000) found that after adjusting for age, sex and type of operation, socio-economically deprived people were less likely to have their operation for CHD classified as urgent when compared with those from higher socio-economic groups. They were reported to wait on average an extra three weeks for surgery as a result of this. Hacker and Stanistreet (2004) analysed by multivariate regression, the waiting times between placement on list and receipt of surgery in two specialities. In ophthalmology, women, those aged over 70 and those from a deprived area were found to wait significantly longer for surgery than their comparison groups. Age had the biggest effect. In orthopaedics, similar trends were noted but did not reach statistical significance. No patterns appeared in relation to ethnicity but sample sizes were small.

However, one might now argue that the overwhelming focus on waiting times as a determinant of order of treatment for patients means that much of the control has shifted away from doctors as the pressure is now to achieve targets. There are two main implications of this shift: (a) there may still be administrative features that influence the degree to which people are seen sooner rather than later so very mobile populations or those with no permanent address may be dropped from a list after repeated attempts to contact them have failed; and (b) what is probably more important now, is the process by which people get onto the waiting list in the first place. The latter is heavily influenced by the social construction of professionals' views on suitability of people for treatment and there is a large body of literature suggesting that those from vulnerable groups, including older, socio-economically disadvantaged and people from ethnic minorities may be viewed as less good candidates than those from more advantaged groups (Goddard and Smith, 2001; Dixon-Woods *et al.*, 2005). This is discussed further in section 2.7.

2.7 Supply-side responsiveness

2.7.1 Culturally appropriate services, including language and translation services

This issue has been discussed most widely in relation to gender and people from ethnic minorities.

(1) Gender

Research suggests that the gender of the practitioner can affect people's willingness to use services. This includes cervical cancer screening where attendance rates are higher in practices with female practitioners (Majeed *et al.*, 1994; Bentham *et al.*., 1995), although care must be taken not to attribute causal relationships from statistical associations. Men have also indicated a preference for male practitioners for some procedures and problems (Cameron and Bernardes, 1998).

There is a broader issue of the importance of "gender-sensitive" care which requires practitioners to recognize where gender-related issues are relevant and to attend to the needs of the individual within this context rather than to approach men and women in different ways as a matter of routine. Research suggests that providers' inability to respond to health problems in a sensitive manner can affect service use. Some examples include the need for an understanding and friendly attitude by staff involved in emergency contraception rather than staff focused on risks that women had taken; ability to deal with embarrassment and stigma for women using sexual health services; privacy in a hospital's A&E department for women seeking help for domestic violence and anonymity for young men seeking counselling for mental health disorders (summarised in Dixon-Woods, 2005).

(2) Ethnicity

Perceptions of cultural sensitivity of services has been reported as an important influence on both entering into the health care system and maintaining contact. Barriers to help-seeking include perception of language difficulties, lack of awareness about beliefs and values and lack of translation facilities. Dixon-Woods *et al.* summarises 14 studies that report such perceptions amongst people from ethnic minority groups. However, there are mixed views about "ethnic matching" as a means of promoting access. For instance Asian women have expressed concern about being seen by Asian male doctors because of social status issues and confidentiality concerns, rather than gender issues (Chapple, 2001).

Studies report lack of interpreting services, especially when accessing out of hours care as a barrier (eg. Green *et al.*, 2002). However, provision of translation services per se will not necessarily address all barriers as additional problems such as fear of confidentiality have been identified. There is growing interest in the use of Link Workers which some see as going beyond provision of language services and addressing advocacy and co-ordination issues, but little evaluation exists especially in terms of facilitation of access.

Surveys have revealed lack of knowledge amongst health service staff about religious and cultural beliefs and practices of minority groups, but there is increasing evidence that this problem is recognised and is being addressed (eg. McLean *et al.*, 2003 report that patients feel there has been a reduction in institutional racism).

There is an interaction between gender and ethnicity as it is often reported that women in some minority groups find it especially important to see a female doctor but this cannot always be assumed as some research suggests there is no difference between different ethnic groups and it is an issue of gender, not ethnicity (eg. Rashid and Jagger, 1992).

2.7.2 Staff attitudes

There is a huge literature discussing how inequities in access may stem from the way in which health care professionals treat some groups systematically less favourably than others. Dixon-Woods *et al.* uses a concept of “candidacy” to describe the process whereby access to care is negotiated between patient and professional. One important element of this process is the way in which people are categorized by staff in terms of how interesting, serious or deserving their problem is and how it matches their idea of how resources should be allocated and thus the entitlement of patients to care. Whilst these influences are less marked where serious and obvious health conditions exist, they are far more likely to emerge where there is diagnostic uncertainty or an element of elective care.

Whilst professionals may state that the main influence on their referral decisions are technical and are linked to their views on how well patients will do if they receive the treatment, this can indirectly disadvantage some groups who, as a result of poorer social circumstances, experience a greater tendency to co-morbidities or “bad” habits such as smoking and overeating, or who lack social support networks for after-care, that may technically reduce the effectiveness of treatment. As Dixon-Woods notes “professional perceptions of the cultural and health capital required to convert a unit of health provision into a given unit of health gain may function as barriers to health care” (Dixon-Woods *et al.*, 2005, p.112). Similarly, there is evidence to suggest that some GPs are more likely to refer the economically active and those with dependents (Goddard and Smith, 1998).

Moreover, even apparently “technical” judgements may be socially and morally constructed and commentators have noted that one of the key determinants of a group being “vulnerable” is that language creates a culture giving ordinary people “permission” to think the unthinkable eg early days of AIDS/HIV and now similar language is used about the “deservingness” of asylum seekers to access services (Spanswick, 2003). There is some evidence that people of ethnic minority groups perceive themselves as being stereotyped negatively, but observational studies are far less common. Bowler (1993) reported midwives’ views of Asian women being characterised as rude, unintelligent and “over-users” and “abusers” of the midwife service, but this study is now very dated. A tendency amongst older GPs to assume all people from ethnic minorities have close knit families and prefer to receive family care has also been reported (Katbamna *et al.*, 2002).

The greatest volume of research in this area has focused on mental health because of the related issues of control, stigma and discrimination. Much of this is in the context of explaining the higher rates of compulsory admission to hospital for mental health amongst some groups, especially Afro-Caribbean males. The “medicalisation of racism” argument has been widely discussed in the literature (Atkinson *et al.*, 2001, provides a summary of evidence) and there is evidence to suggest that members of this group are far more likely to be diagnosed with schizophrenia and sectioned under the Mental Health Act or kept in locked wards, than their white counterparts. Much of this can be explained by the interpretation of behaviour by professionals and the categorisation of patients according to racial and cultural characteristics rather than medical ones (McLean *et al.*, 2003).

Research on “age-ism” is less extensive, although surveys suggest that some older people perceive this to be the case in the NHS. Some commentators have noted that rather than direct discrimination, some diagnoses may be more difficult to make in older people where many co-morbidities exist (eg.

depression – Crawford *et al*., 1998). Issues of technical candidacy relate mainly to whether professionals sometimes believe that older people may not benefit as much from certain treatments when in fact evidence may suggest there is little difference in expected outcomes. This has been suggested in some areas (eg prescription of statins) but evidence is difficult to collect as many clinical trials exclude older people from their studies.

2.8 Health literacy, voice and health beliefs

2.8.1 Health beliefs/management

A very useful way of viewing the way in which some groups perceive their health care needs is outlined by Dixon-Woods *et al*. (2005), who suggest that differences between groups in consultation behaviour and management of symptoms can be explained by whether health is managed as a series of minor and major crises rather than treating disease as requiring maintenance and prevention. People from more disadvantaged social groups tend to judge their need for treatment as event based. Thus they will often require a specific event to occur before they think it is legitimate to seek help. This also explains the lower uptake of preventive services and lack of responses to invitations for screening, immunisation etc as they are more likely to wait until there is a specific problem to report. There is also an issue about whether people feel they are entitled to ask for help and this can be linked to social class and whether people have a history of high use of services and fear being classed as “over-users”.

Sociological work has shown how people in disadvantaged conditions lack a positive concept of health and perhaps a more fatalistic attitude which makes them less inclined to take preventive action. However, other evidence suggests that people from lower socio-economic groups often self-manage less than higher social groups and are less confident about handling symptoms especially for children, thus consulting GPs more than other groups. Richards *et al*. (2002) suggest that people from deprived areas are unwilling to consult GPs about some illnesses as they perceive they will be blamed for their “risky” behaviour.

The very marked inverse relationship between need and utilisation in preventive care may be explained by these different concepts of health in addition to other practical issues of access.
The picture for ethnic groups is similar to that for disadvantaged groups in general although research has focused especially on the role of help-seeking behaviour amongst ethnic groups. The area is very complex and there is a danger of over-simplifying given the restrictions on space. They are considered in more detail in section 3.1.

2.8.2 Voice

There is evidence to suggest that by virtue of their education, articulacy and general self-confidence, the better off may be better at explaining their problems and persuading GPs that their condition requires treatment or a referral for further investigation (Dixon *et al*., 2007). In general research confirms that people from lower social groups are les active in consultations, less assertive and ask fewer questions (Cooper and Roter, 2003). Professionals have noted that their response to patients is in part influenced by the level of understanding they gain from the accounts given by patients and if these are poorly expressed, the likelihood of referral is reduced. Midwives’ attempts to address inequalities have been shown to be influenced by their perception of womens’ expectations which means that those seen as knowledgeable (likely to be middle class) received more resources (Hart and Lockey, 2002).

2.9 Interlinkages and overarching policy initiatives

To some degree, policies to tackle social exclusion all reflect a concern with the access of vulnerable groups to employment, education and community participation as well as to health and social care. In terms of health, the focus is on narrowing health inequalities - improving access is therefore just one strand in achieving this policy goal. It is difficult to assess whether “sufficient” attention is given to access as a tool for reducing health inequalities because the relative effectiveness of different approaches to tackling inequalities is not known. Policy on social exclusion, health inequalities, and on access is discussed below.

The need for a cross-governmental department approach to tackling social exclusion, and indeed the need to engage with the voluntary sector and private sectors, has been recognised to some degree by the appointment of a Minister for Social Exclusion and an associated Social Exclusion Taskforce. The Social Exclusion Action Plan was launched in September 2006 (Cabinet Office, 2006) and re-iterates the commitment to addressing the needs of the most disadvantaged groups. This stresses the need to tackle problems at an early stage, thus focusing substantially on childhood and early years, including parenting support. Priorities in the adult group include those living “chaotic lives” and those with multiple needs who find it difficult to access support (eg those with mental health disorders, young offenders). Funding is available for pilot schemes to build on innovative approaches in a more systematic way. The report details plans to build on previously successful schemes such as those aimed at facilitating employment opportunities for people with mental health disorders (eg Individual Placement and Support Scheme). Other programmes, such as “Supporting People”, aim to offer housing related support to vulnerable groups in order to develop and sustain capacity to live independently (Office of the Deputy Prime Minister, 2004a). This involves tackling problems associated with housing and providing intensive housing-related support with the aim of improving quality of life for groups such as older people, those with mental health disorders, homeless, people with alcohol drug problems, those with a sensory or physical disability, etc. Overall, the focus appears to be mainly on addressing problems of childhood and the early years. As there is evidence that it is necessary to avoid a life-cycle of social exclusion, this may be an appropriate focus. There is a commitment to monitoring progress towards goals.

In terms of health inequalities, one important goal is in relation to infant mortality across social groups where there is a national target for 2010 to reduce health inequalities by 10% as measured by life expectancy at birth and infant mortality. Particular focus is given to geographical areas with the worst health and deprivation indicators. The latest data shows a mixed picture in terms of progress, with many of the indicators underlying these targets showing no change because they are long-term goals (Health Inequalities Unit, DoH, 2006). Some show progress in terms of moving in the direction required to narrow the inequality gap (eg child poverty), whilst others show a widening of the gap between the worst and best, despite improvements overall (eg life expectancy).

Policy to tackle health inequalities has a long and complex history but was consolidated in the NHS Plan (Dept. of Health, 2000). Health Improvement Programmes (HiMPs) were introduced at that time with a focus on collaboration between health authorities, local authorities and other local organisations towards strategy for local health improvement. Health Action Zones (HAZs) started in the late 1990s and were specifically aimed at developing strategies to tackle inequalities through local partnership working and community involvement. There is a huge amount of evaluation of HAZs, but most assessment focused on the processes involved rather than the outcomes on health which were not directly observable (Sassi, 2005). There appears to be a consensus that whilst they were very useful in raising awareness of health inequality issues locally, their overall impact on inequalities was not substantial (Bauld *et al.*, 2005; Judge and Bauld, 2006). This is attributed by some to the fact that local level small-scale projects could not be expected to make an impact on issues with incredibly complex causes, although the counter-argument is that local initiatives are required in order to implement and adapt to national policy efforts.

“Tackling Health Inequalities: A Programme for Action” (Dept. of Health, 2003b) set out the detailed policy to be adopted for achieving the targets set nationally and is organised around four themes: (i) supporting families, mothers and children; (ii) engaging communities and individuals; (iii) preventing illness and providing effective treatments, and (iv) addressing the underlying social determinants of health. Each theme contains some reference to issues of access. The document highlights the links between specific health policies and those that are initiated outside the Department of Health but play a key role in social support eg employment and education policies. There is clear recognition that policies originating in different sectors need to be integrated if the over-arching goals are to be reached.

Under “supporting families”, policies include the expansion of Sure Start; provision of day-care places; policies to improve school attendance and improving access for young parents to antenatal and postnatal care. Under “engaging communities”, policies include: involvement of older people in setting policy direction; improving falls prevention services to older people; reducing numbers of homeless people and improving access to crisis mental health services. Under “preventing illness and providing effective treatment”, policies include: reduction of smoking through extension of cessation and support services; expansion of national fruit scheme; improving access to rural services by increasing mobile units and one-stop primary care centres; extending access to primary care through walk-in centres; extension of breast cancer screening to the 65-74 year old group; increasing influenza uptake rate in older groups and reducing waiting times. Under the "determinants of health" section, policies include: improvements in housing, expansion of training and skills programmes, special programmes to help disabled people return to work and local transport plans. There are 12 national headline indicators that are monitored with respect to these issues.

In terms of access to health care services and quality standards, one of the major national developments has been the creation of National Service Frameworks (NSF) that set out targets, policies and resources to be used – usually in relation to client groups (eg the NSF for older people, children) or disease groups (eg CHD, diabetes). The NSFs (and associated policies such as the NHS Cancer Plan) usually document the approaches to be taken to address inequities of access and include targets. See sections 3.2 and 3.3 for more details of the NSF for older people and for people with mental health disorders. Progress with NSFs is monitored and reported upon and thus it is possible to track progress in achieving improved access to quality care.

In terms of the specific groups considered in this document, older people are targeted through a number of other social support and health policies. These include programmes to help improve the employment opportunities for older people and those with disabilities, such as targeted support programmes like New Deal for Disabled People which has helped 75,000 people into jobs and Age Partnership Group's Be-Ready campaign that encourages age diversity amongst employers. Pension arrangements for older people and disabled people have also received a great deal of attention.

Many other health related initiatives are targeted at the young, especially nutrition and exercise based initiatives in schools. Homelessness strategies such as the Homeless Strategy for England has reduced the number of households becoming homeless which, insofar as it targets disadvantaged groups generally, may improve the situation for minority ethnic groups, asylum seekers, migrants and those with mental health disorders. Minority ethnic groups are targeted in terms of reducing barriers of access to employment (there are national targets for improvements in employment rates which are being met) and the promotion of community cohesion in local areas.

There is variation in the speed and scope of policy on social exclusion and compared with the efforts made in some groups (eg children), the efforts in others are somewhat less substantial. Commentators have highlighted inequalities between ethnic groups as one such example. Some would also argue that policies in certain areas have worked directly against social inclusion in the terms applied to other groups – for example, asylum seekers - and conclude that "the inclusion agenda has, literally, had borders" (Hills and Stewart 2005, p.344).

2.10 Conclusions

Sustained policy attention has been given to health inequalities generally (including aspects of access) and to social exclusion issues. These have been at the centre of policy for a number of years and a large amount of effort and funding has been targeted accordingly. There has been an emphasis on the importance of working across government departments and many initiatives have sought to facilitate joint approaches to tackling key policy issues. This has been largely successful although there are some areas in which contradictory approaches may have been taken (eg policy on asylum seekers versus social inclusion policy). Policy towards social inclusion in England rests heavily on improving opportunities for employment in all groups, especially vulnerable groups, and improvements in creating such opportunities have been demonstrated for many groups.

Exworthy *et al.* (2003) analyse government policy to tackle inequalities up until early 2002, and classified polices into several "domains", including those aimed at the life course and early childhood (eg Sure Start, tackling child poverty); area based initiatives that focus on disadvantaged communities (eg HAZs); redistributive polices (eg pensions, tax credits); health reforms; and joined up working. Area based initiatives are particularly common in terms of tackling social exclusion but may be short-lived (depending on special grants and funded initiatives) and difficult to integrate into the mainstream. Other initiatives are long-term (appropriately) and it is difficult to say much about progress in reaching targets in the short-term. Also, many targets work in the same direction as general trends were already moving and there is an important distinction to be made between overall improvements and improvements in equity.

There is not a lot of evidence about "what works" – the most recent Social Exclusion Action Plan (Cabinet Office, 2006) aims to address sharing of current best practice and setting up of pilot studies with subsequent roll-out of best practice. Well-established programmes such as Sure Start that have worked for some groups are being rolled out as pilot schemes to other groups although longer-term evaluation of this apparently successful programme has shown that the impact may be less that initially thought, especially amongst the most deprived groups (Belsky, 2006). Reviewing progress made by the Labour government in promoting equality, commentators have noted that poverty and social exclusion have been taken very seriously by the government since 1997 (Hills and Stewart, 2005). Also, there has been recognition of the multi-faceted and inter-linked nature of problems with policies targeted both at improving the current situation (eg through income support and better current services) and also on tackling the long-term drivers of disadvantage with a major focus on improving life chances for children. However, some targets are very long-term (eg reduction on health inequalities) and whilst population health is improving, not all the indicators of inequality are moving in the desired direction.

There are many, very varied small-scale project initiatives in England which are generally either not evaluated at all or are evaluated at a very basic descriptive level. Many government documents contain examples that are called "good practice" but usually without supporting evidence. It is impossible to collate and summarise all such details and these would by themselves be uninformative. Indeed, the "Closing the Gap" project was unable to list any good practice examples for England (EuroHealthNet, 2007). Specific initiatives around the 3 groups considered in more detail in this report, are discussed later in the relevant sections. Aside from the larger initiatives (often employment based) mentioned in section 2.9 and also earlier in this section, my interpretation of the available information leads me to suggest the following are likely to be key features of promising policy initiatives in England:

- A national context: although many initiatives need to be tailored towards local circumstances in order to be successful, they are likely to have a greater impact across the board if they are part of a larger scale initiative that is clearly thought out and provides a framework within which local schemes can be developed and assessed.

- A pilot phase: piloting or experimentation of initiatives seems useful and policies that have worked in one sector can be adapted for other sectors or locations.

- Financial incentives: many initiatives have focused on providing extra funding for providers to develop new services or to re-organise services. Similarly, initiatives at the level of the individual health professional (eg expansion of physical health screening for those with mental health disorders) are more powerful when accompanied by financial incentives for additional effort.

- Co-ordination: as illustrated elsewhere in this report, a major barrier to access for many vulnerable groups is the difficulty in negotiating entry points to services – whether this is due to language or cultural barriers or to the complexity of the organisation of services. Many policy initiatives therefore focus on providing extra help in co-ordinating services, streamlining care, providing advice and support on eligibility, or ensuring a single point of assessment rather than multiple assessments.

The potential impact on equity of access of recent national developments to expand choice of provider is a matter of some controversy. The ability and motivation to make informed choices is likely to vary systematically with socio-demographic variables such as education and age and may not be easy for those in disadvantaged groups and those with specific illnesses such as mental health disorders. Such policies may therefore exacerbate the inequities of access that already exist although some argue that rather than dispensing with the policy, there is a need to enhance participation through the provision of support for those less well able to make such choices for themselves (eg. Dixon and Le Grand, 2006). However, others note that choice, working in combination with the new payment mechanisms that will reward financially the providers who attract more patients and penalise those who are not popular choices, creates a danger of loss of quality of services in some areas, leaving those who live in such areas forced to travel to distant providers.

3. Improving quality of and access to health care for people at risk of poverty or social exclusion

This section considers the evidence on access for the three vulnerable groups identified in the project brief: migrants and asylum seekers, older people and those with mental health disorders. Details of policy initiatives for these groups are also outlined. Section 4 describes in more detail the situation for those with mental health disorders.

3.1 Migrants, asylum seekers and illegal entrants

3.1.1 Background

Migrants – first or subsequent generation - who have residency status are entitled to the same access to health care as any permanent resident of the UK. The definition of terminology is not straightforward but most of the literature relevant to equity of access issues refers to *minority ethnic groups*, usually with no distinction made between migrants and those born in the UK. The barriers to access faced by ethnic minority groups have been discussed in the previous section and the most common observation relating to recency of migration status is that over time, there may be an amelioration of some of the problems faced by ethnic minority groups as they develop support systems, overcome language barriers and adapt to their environment. The exception to this is the body of research that has focused on asylum seekers and refugees specifically which is discussed later in this section.

There is also usually very little distinction made in research on utilisation and access in terms of differences within ethnic minority groups – for example, in terms of age. The most common observation is that some of the problems faced by older people in these groups (such as literacy and competency in negotiating bureaucracy) may not be as acute for youngest generations.

The “newness” of migrant status has however been addressed specifically in the context of asylum seekers and refugees. Refugees are people outside their own country who are unable to return as a result of fear of persecution. If the Home Office accepts a person as a refugee, this is reviewed after five years. Asylum seekers are in the process of applying for refugee status or are appealing a former decision, although many research papers use the terms interchangeably. Applicants whose appeal rights are exhausted (also sometimes called “failed” asylum seekers) may gather fresh evidence to support their claim but became “illegal entrants” if the Home Office has given removal directions.

The estimated number of people arriving to live in the UK for at least a year was 565,000 in 2005 (National Statistics, 2006). This continues a trend of high in-migration to the UK that began in the late 1990s, but does not include short-term migration. The biggest increase in 2005 was amongst Polish citizens.

In 2006/07 in the UK, 22,750 asylum applications were received, which represents a drop of 10% from the previous year (National Statistics, 2007). Of the initial decisions made between April 2005 and April 2006, 12% were granted asylum. 10% were granted humanitarian protection or discretionary leave; and 78% were refused. Between 20% and 30% of Home Office decisions to refuse asylum are overturned on appeal.

3.1.2 Ethnic minority groups

Much of the research evidence on equity of access related to ethnic minorities is difficult to interpret because of interactions with social deprivation. Ecological research that links utilisation rates to the socio-economic characteristics of geographical areas will pick up utilisation by people from ethnic minority groups as there is a tendency for such communities to be located within areas of relative deprivation. Similarly, studies that set out to analyse the link between ethnicity and utilisation of services will often fail to control for socio-economic differences which would often dominate any differences picked up by ethnicity variables (Goddard and Smith 1998). Establishing whether observed variations in utilisation rates between white and ethnic minority groups is an indication of inequity, is also subject to methodological difficulties because there are higher rates of morbidity in ethnic minority groups for some conditions and lower rates for others. The way in which studies adjust for need is therefore of key importance. There are also problems associated with the classification of ethnic group and there is a concentration in the literature on particular groups (eg there is little research on East European and Jewish groups compared with people from South Asia and Afro-Caribbean communities).

Summarising a large body of evidence from numerous sources, the following conclusions can be drawn about the variations in utilisation that cannot easily be explained by differences in need:

- After adjusting for need, there appears to be higher rates of consultation in primary care amongst some ethnic minority groups than amongst similar white groups (S Asians, Pakistani Indian, Bangladeshi origin); and lower rates in some groups, such as the Chinese. Patterns are not always consistent between genders.
- Utilisation of specialist outpatient and inpatient care appears lower amongst ethnic minority groups than equivalent white groups but this is not consistent across gender, age or specialism and many studies have poor methodologies. Most research has been done in cardiac services where the focus has been on lower rates of surgical procedures such as revascularisation and angioplasty amongst some groups (S Asian).
- Research on uptake of preventive care is equivocal.
- Most research effort has been in the area of mental health disorders where there is a generally consistent picture of greater than expected rates of diagnosis and compulsory forms of psychiatric treatment amongst black patients than amongst their white counter-parts.

Barriers to access

The evidence relating to barriers to access has largely been covered in section 2.8 earlier and has much in common with those faced by socially disadvantaged people from all ethnicities. To summarise the evidence, the explanations on which the research evidence is most robust revolve around aspects of help-seeking behaviour. However it is too simplistic to attribute these only to lay beliefs and cultural differences. There is a variable pattern between groups and between diseases in terms of the tendency to seek help. Thus for example, in a study of reasons for inpatient admission for asthma, South Asians talked about their illness in passive terms and were more likely to be admitted than white people. In contrast pregnant Chinese women had low attendance at antenatal care because they did not view pregnancy as a health problem and obtaining confirmation of pregnancy was not a high priority for them (Chan *et al.*, 2000). It is however, especially the case that cultural beliefs and perceptions of stigma influence help-seeking behaviour for mental health disorders and there is a large volume of literature on this.

Other influences on help-seeking behaviour are also important. These relate to the difficulties of mobilising the resources necessary to access care which (in common with barriers faced by socially disadvantaged groups in general) include lack of easily accessible information about what is available and difficulties in organising the social and practical support necessary to facilitate attendance for treatment, especially out of hours or where services are distant. These are overlaid with specific problems related to the challenges faced by those who do not speak English. So for example, organising a bus journey to a distant provider may be difficult for anyone from disadvantaged circumstances because of the cost of arranging care for dependents, especially if they are a lone parent. Reluctance to use family and children as interpreters and fear or lack of confidentiality means even if translation is available it may not be taken up.

Reluctance of people from ethnic minority groups to use services that they perceive as being unwelcoming and culturally inappropriate is important and section 2.8 summarised research on the role of health professionals in negotiating access to care.

A recent study of the experiences of migrants from Central and East Europe to England revealed a widespread lack of knowledge about the health care system amongst migrants on their arrival (Spencer *et al.,* 2007). Only a third reported knowing how to register with a GP and only a fifth said they knew how the health system worked. Knowledge varied with fluency in English with the most fluent reporting the highest level of receipt of information about GP and other health care services.

However, it is not clear that lack of knowledge was a barrier to accessing subsequent health care, because despite low levels of use, respondents indicated this was because they did not require care.

As indicated in 3.1.1, it is not common for studies to distinguish between first generation and established migrants when undertaking research about access by people from minority access groups. A few studies have looked at this in detail, for example, Livingston *et al*. (2002) reported on a study of use of health and social services by immigrant elders in London and found the same levels of use of health care as amongst older UK born people, but higher use of social care services by African and Caribbean peoples. The remaining literature distinguishes ethnic minority groups generally from recent migrants who are asylum seekers or refugees. This is discussed below.

3.1.3 Asylum seekers and refugees

(a) Health needs of asylum seekers and refugees

There is a large body of evidence that outlines the specific health problems often experienced by those seeking asylum in the UK. However, not all of their health problems are necessarily linked to refugee status but overlap with those associated with deprivation and ethnicity. There is a consensus that specific problems experienced by asylum seekers include: physical after-effects of war, torture and journey to the UK; mental health disorders, either following trauma of war or torture or as a result of coping with a new culture and loss of their home (Bardsley and Storkey, 2000; Burnett and Peel, 2001a and 2001b). The mental health needs of asylum seekers and refugees has received particular attention with research suggesting very high rates of symptoms in such groups although symptoms of distress are not always signs of mental health disorders. Refugees may be at higher risk of communicable diseases after arrival in the UK, potentially because of poor housing and accommodation. These problems can worsen after arrival in the UK and some studies suggest a steady decline (quoted in Kralji and Barriball, 2004).

The mobility of populations after arrival creates other problems with health care treatment. The dispersal of asylum seekers with HIV may lead to increased medical and psychosocial problems for the people affected as well as an uncertain impact on the spread of HIV/AIDS (Creighton *et al*., 2004). Enforced dispersal of non-indigenous peoples to areas with little previous ethnic diversity can stigmatise. People are sometimes dispersed without adequate supply of drugs and without case notes which may make treatment difficult (Yoganathan, 2004).

(b) Legal and financial barriers to access

Full access to free NHS care is available to: those who have been accepted by the Home Office as a refugee; those who have made an application for asylum and are awaiting a decision; those who are appealing against a decision; or have been detained by the immigration authorities in detention centres and those given leave to remain in special circumstances. This applies to the applicant and all their dependents. Access includes the right to register with a GP for primary care and to receive free care in hospitals. Asylum seekers may also apply for a certificate that gives them free NHS prescriptions, NHS dental care, NHS sight tests and glasses. Also they can have free transport to and from a hospital at which they are receiving treatment from a consultant. Asylum seeker status may last for several years. Since April 2003, asylum seekers who are not given refugee status may be granted Humanitarian Protection or Discretionary Leave for up to three years after which their situation must be reviewed.

Asylum seekers who have no means of supporting themselves can claim additional support from the Home Office in the form of accommodation (the location of which they cannot choose) and cash support (100% of the income support level for dependents under the age of 18 and 70% of the income support level for adults, with additional payments for mothers and babies). The children of asylum seekers have the same right to education as residents. They are barred from employment unless they have been waiting for more than 12 months for an initial decision on their application.

Those who have been in the country for more than three days but have not yet submitted an application for asylum, those who have exhausted the appeals process following a failed application and those who have entered the country illegally (and have no documents), are *not* eligible for generally free NHS care (if they are over 18), although they are eligible for free NHS care in certain circumstances. The circumstances are: “emergency or immediately necessary” care (primary or secondary); treatment of sexually transmitted diseases (except HIV); treatment of specific communicable diseases on public health grounds (eg TB); family planning, compulsory psychiatric services and services provided in an A&E department. Some people whose appeal rights are exhausted may pursue further legal challenges even at the end of official processes, for instance where their circumstances have changed or where the Home Office failed to follow their own procedures.

Since 2004, all secondary care for the latter group has been subject to a charge unless deemed by a health care worker to be “immediately necessary”. These are the same rules that are applied to visitors and reflected the attempt to address “medical tourism”. In 2004, proposals were also made to withdraw access to free primary care services unless also immediately necessary or life-threatening but at present this has not been enforced and GPs can use their discretion to add people whose appeal rights are exhausted and illegal entrants to their lists (Hargreaves, 2005).

In principle, all other support finishes when an asylum seeker has exhausted all appeals. However, in some circumstances they may be eligible for short term support from the Home Office if it is shown that they are trying to return home but cannot do so because of circumstances beyond their control. In such cases, “section 4” support is available in terms of accommodation and some financial support but this is not an open-ended commitment. The Asylum and Immigration Act makes provision for the withdrawal of all support from asylum seekers and their families if they do not take steps to leave. This has been the subject of much controversy (and challenges under the European Convention on Human Rights) and subsequent reviews of policy have reduced the numbers ineligible for support. The current government approach is to say that they hope to facilitate assisted departure through improvements in the process rather than using this mechanism.

“Section 4” support is also available to those making further representations to the Home Office. It consists of basic accommodation and £35 per week in supermarket vouchers. All applicants must demonstrate their destitution and their eligibility under one of the criteria (e.g. unfit to travel; further representations under consideration).

The different eligibility criteria for free NHS services between those whose appeal rights are exhausted and successful asylum seekers (refugees) creates different barriers to access as the latter group have legal entitlement to access which may or may not be difficult to achieve in practice, whereas the former have much more limited access in principle as well as in practice. Clearly, one of the main barriers to access by those who have been declared ineligible for free NHS services (illegal entrants and those who have exhausted all appeals against failed asylum applications) is cost. An in-depth interview study of destitute asylum seekers in south east England (Dumper *et al.*, 2006) reported that almost all felt their physical and mental health had deteriorated since arrival in the UK and a majority said they felt depressed or suffered symptoms such as stress and sleeplessness. Many were distressed at having to rely on charitable services but could not see how to avoid this if they were not allowed to work and had lost National Asylum Support Service (NASS) support. Half were receiving some help for mental health disorders but the majority felt that being destitute made access more difficult and there was high awareness of not being eligible for NHS primary care services and GPs were using discretion about what constituted emergency or necessary care. Many were afraid of not being able to afford medications or being challenged by the doctor.

Some parts of the medical profession have been very critical of the policy to deny free care to these groups. Three main issues have been discussed. First, there are practical difficulties in establishing legal status of those who present for care and also whether the care required fits the criteria of being “immediately necessary”, meaning that treatment is free (Feldman, 2006). There may be insufficient resources to undertake this task and research suggest that many professionals are unclear about the administrative and legal regulations themselves and the process may damage doctor-patient relationships (Hull and Boomla, 2006). Second, some doctors feel that denying free access to people who need treatment conflicts with their sense of professional and moral duties as a member of the medical profession. There has been extensive debate in the medical press about whether the denial of treatment clashes with the core principles of a universal service based on need (Hall, 2006; Romero-Ortuno, 2004). Third, it is often the important but non-urgent conditions that pose a dilemma if the patient cannot afford to pay, eg childhood immunisations or diabetes care. These all need management to prevent future serious illness. A charitable organisation report found evidence that some asylum seekers were not able to afford treatment for such conditions (Kelley and Stevenson, 2006). Charges for HIV/AIDs treatments are particularly controversial with commentators pointing out the often debilitated state of patients from whom payment is then meant to be recovered (O'Farrell *et al.*, 2004).

(c) Other barriers to access

Even amongst those who are legally entitled to free NHS care, significant barriers have been reported consistently in the literature. These are very similar barriers to those described elsewhere in this report for disadvantaged groups and for people from ethnic minority groups generally. However, there are also some additional specific issues. Summarising the literature on access problems, Feldman cites the familiar problems with registering with GPs, lack of language support, inadequate services for specific chronic illnesses and for mental health disorders (Feldman, 2006). This is reported widely (eg (Norredam *et al.*, 2006; Burnett and Peel, 2001b). A study in north west England looked at the HIV treatment and care provided by the NHS and NGOs over a three year period and compared non-asylum seekers with asylum seekers' use. Use of specialised hospital services by HIV positive asylum seekers differed very little between groups but asylum seekers relied more on NGO provision (Cook *et al.*, 2006) even though they were eligible for free NHS treatment. A study of HIV/AIDS services for asylum seekers revealed equal satisfaction levels with services between residents and asylum seekers but revealed unmet needs amongst patients relating to specialist services for torture victims (Allan and Clarke, 2005) . Research has suggested that people often feel stigmatised by healthcare screening processes and can be reluctant to seek help (Burnett and Peel, 2001a). A case study in Liverpool looked at the variety of ways in which asylum seekers can register for primary care services and found all had problems eg no language stated on notification letters, no prior warning of arrival and lack of information on health status (Ghebrehewet *et al.*, 2002). There may be some additional barriers such as fear of revealing status when seeking treatment and fear that being seen as having a mental health problem will reduce the chances of a favourable asylum decision.

A major problem for these groups is the lack of knowledge about entitlement and the interaction between their health problems and significant problems related to housing. Accommodation in segregated centres exacerbates this as they tend to be cut off from important sources of support. For example, there are refugee community support and specialist lawyers in London but very few elsewhere. Concern has been expressed about access to health care by those being detained for long periods and there have been reports by charities suggesting that basic health care treatment was not being provided and the health of those being held is deteriorating (Cutler, 2005).

Meeting the needs of these groups is even more problematic, as it is likely they are unevenly distributed (Barsdley and Storkey, 2000). Tens of thousands of people whose appeal rights are exhausted are estimated to be in the UK and it can take years for them to be repatriated. Estimates are that 75-85% of asylum seekers and refugees live in London and the majority of the rest live in other cities. The Immigration and Asylum Act 1999 gave the government power to disperse existing and new asylum seekers around the country in order to relieve pressure on service providers, but this may also have implications for the isolation felt by these groups and access to specialist services that have developed in areas of high concentration of asylum seekers.

(d) Health care services and policies to address needs of asylum seekers and refugees

The developments in primary care aimed at providing financial incentives for enhancing services to meet the special needs of particular areas have included some developments in relation to serving large immigrant and refugee populations. The Dept. of Health (2003b) have issued guidance for providers, including a resource pack to aid development of services plus case studies and outlines of good practice, focusing on requirements for multi-agency working. Quite a lot of experience is building up, especially in London and other cities and dispersal areas where new types of primary care services have been developed.

Feldman (2006) summarises several reports and papers that outline good clinical and organisational practice as well as numerous guidelines and standards against which services for asylum seekers can be measured. Examples of these services in primary care are summarised in three main categories following a review of the literature and of reports from service providers across the country:

(1) “Gateway services” aimed at facilitation of access: examples include nurse-led outreach teams that provide treatment in hospitals and health centres and liaise with mainstream services to get asylum seekers registered with GPs. They use hand held notes to facilitate continuity of care. In Barnet, a dedicated clinic within a walk-in centre offers full health checks for asylum seekers with access to interpreters; Health Support Teams and PCTs have outreach teams to new arrivals. In 2003, over 70% of unregistered patients seen by the HSTs were registered on discharge from the team. A specialist health visitor is employed in some areas to work with refugees and asylum seekers to facilitate registration with GPs and dentists. A survey of the information published by 16 PCTs in London suggested that some are providing excellent information regarding interpretation and translation facilities (Kralj and Barriball, 2004). In Lambeth, a service run jointly by the PCT and a mental health trust provide a service to register all newly arrived clients and to facilitate their access to GP, screening and specialist mental health care (Refugee Council, personal communication).

(2) “Core” services – means of comprehensive provision either through dedicated practices or specialist additions or more commonly, in mainstream practices with no specialist provision. For the latter, there is often no language and translation service and reports have suggested culturally inappropriate care may be delivered. Dedicated practices may serve a local population of asylum seekers at particular accommodation centres or hostels. Many also serve other groups such as the homeless. In dispersal areas, such practices usually maintain strong links with housing providers and well established links with social care services such as child care and baby clinics. Dedicated practices may become redundant if asylum seekers are dispersed or numbers fall. Alternatives include enhanced services where practices receive incentives to fully register and improve provision for refugees and asylum seekers.

(3) “Ancillary” Services - essential support services that are required to meet the extra needs of refugees and asylum seekers such as health teams for asylum seekers and homeless, link workers and advocacy, interpretation and translation, health promotion, services for survivors of torture and violence and mechanisms to transfer from dedicated to mainstream services. These may be further divided into:

(a) facilitating communication and information – numerous reports stress the need for community involvement by refugee teams and making links with community organisations can be a way of accessing interpreters, advocates and link workers. Feldman (2006) notes that failure to use interpreters has been reported as one, if not, the largest barrier to accessing services. Cross agency collaboration can reduce the costs of provision and audits of what is available are important for planning new services. Some PCTs administer the interpreting service themselves which DoH recommends in terms of sensitive consultations. Allowing extra time for consultations is necessary or pre-GP consultations with nurses and interpreters can allow identification of problems in advance. Some services work with link workers who provide advocacy and can also be a useful source of information for developments in the community and can increase awareness of services and health promotion activities. Written information is often provided in many languages – the Health for Asylum Seekers and Refugees Portal provides electronic multilingual resources such as translated appointment cards and has links to other agencies and resources. The Audit Commission has recommended more use and local adaptation of centrally produced information.

(b) Training of health workers which has been an important need identified by many studies, in terms of working with interpreters, cultural issues and also understanding of the legal system. Commentators have noted that poor training can affect not just the recipients of care but also creates feelings of inadequacy and frustration amongst staff.

(c) Mental health services for survivors of torture and violence. Mental health disorders feature prominently in most reports on health needs of asylum seekers and refugees both in terms of frequency of it as a health problem and difficulty in getting suitable treatment. Although commentators note that not all mental distress experienced by asylum seekers amount to a mental health problem, there is widespread agreement of a shortage of services to meet needs. The Scrutiny Report on Access to Primary Care in London suggests that PCTs would have to triple their allocation to meet needs adequately (Greater London Authority, 2003). There are very few specialist services for these groups – some trauma services include torture victims in their remit but these may exclude asylum seekers with more general mental health disorders. Partnership initiatives that also deal with social and counselling services can be appropriate. There are some guidelines on the treatment of post-traumatic stress disorder (eg NICE guideline).

Evaluations of specific initiatives have highlighted important general lessons. For example, a lot of mental health care can be provided informally – by provision of space for people to talk together with others or help with very practical things such as housing or ability to make culturally appropriate food. It might not be necessary to label services as mental health services. An example is the LINKS project in Hastings (Dumper *et al.*, 2006) which is a drop-in centre that provides a comfortable environment and where people can access advice and support services under one roof – employment, housing, health, family, debt, clothing, education. A whole range of voluntary and statuary partners are involved, and the PCT facilitates the service. A very small-scale qualitative evaluation of an inner-city Health Access Team aimed at improving access of asylum seekers and refugees into mainstream services found that recipients were receiving very specialised help and advice on their complex health needs but also valued the informal social interactions that promote mental well being and social support (Cartledge, 2006). Overall, although there are several small scale evaluations of services, there is little systematic review of the effectiveness of these to enable PCTs to plan new services.

There is also a large range of NGOs involved in the provision of care for these groups but it is not without controversy. For example, involvement may be limited because they lack access to special funding to make their services available to new groups and there may be a feeling that they draw on already stretched formal and informal resources in communities of high need, or resentment by indigenous users. Some are also inaccessible to many asylum seekers they are organised around eligibility such as being in receipt of housing benefit. Some organisations target refugees and asylum seekers specifically, whilst others such as “Project London” run by Medecins Du Monde, aim to meet the needs of several groups (vulnerable migrants, homeless, sex workers) and focus particularly on those groups excluded from free NHS care such as people whose appeal rights are exhausted or those with no documents (McColl *et al.*, 2006).

A similar debate arises about services for asylum seekers and refugees as for services for ethnic minority groups generally – should they be provided separately or integrated into mainstream services? Arguments for the former tend to focus on the very specific needs of asylum seekers and the need for specialist skills and knowledge amongst practitioners. Also, it may not be possible in areas of high demand such as London and other cities, to provide sufficient services to meet demand without creating dedicated services. It can be argued that even if integration is the ultimate aim, there may be an interim need for special services at least for some time. The danger with this approach is increasing marginalisation and stigmatisation of an already socially excluded group. Some commentators have argued that the development of UK policy over time reflects attempts at increasing marginalisation of asylum seekers – from income support to vouchers (now disbanded), from provision of local authority housing to segregated accommodation, from opportunity to support themselves through paid work to exclusion from employment ((Burchardt, 2005). There is concern that such policies are at odds with other policies emanating from the same government departments aimed at creating an inclusive and tolerant environment. For some services what is essential is providing the link between the relevant groups and the services that already exist in the mainstream sector, but specialise in relevant care eg clinics specialising in female genital mutilation exist in two London hospitals. There are calls for basic and postgraduate training for doctors and nurses to include issues of ethnic diversity and exchange programmes for health professionals in the UK and less developed countries to promote understanding (Khan and Ghosh, 2005).

The government’s health policy is to provide a broad spectrum of services but in practice provision reflects concerns with costs and public health and may also be influenced by a desire not to appear “soft” on asylum seekers.

3.2 Older people with functional limitations

3.2.1 Background

Most research on equity and access amongst older people does not distinguish their functional status in precise terms. Thus almost all of the evidence cited here relates to older people as a generic group, although where age is cited (eg over 65 or over 75), this is reported. Older people in the UK are not a minority group – the ageing population means those over 65 out-number those under 16.

Methodological issues with many studies arise because one would expect the health status of older people to be lower than that of younger people and hence there may be generally higher use of health services which arise particularly in the final year of life. The difficulty is in adjusting for "need" when comparing patterns of utilisation in order to judge whether the higher use adequately reflects greater need or whether problems of poor access and under-use exist. Many studies also use age and sex as controls as they are known to affect utilisation, rather than studying these factors specifically. There are also likely to be interactions with gender and ethnicity. Measurement of social class is also difficult in older people, due to limitations in the definitions used in classifying social class.

3.2.2 Use of health and social care services

In terms of primary care services, older people are high users of GP services compared with younger people (Dept. of Health and ONS, 2002). There is a positive association with perceived health status, suggesting a link between consultation rates and "need". Lower rates in some particular groups eg women aged 80+ have been reported (Dept. of Health and ONS, 2002) but before concluding that those represent unmet need, it is possible they are using other services – for example, home visits by GPs are higher in older groups (although very low overall) suggesting a substitute effect; or they are in better health eg older non-consulters were actually in better health with lower levels of disability than consulters (Ebrahim *et al*., 1984). Most attention has been paid to dementia and depression, with some studies reporting lower than expected levels of consultation for depression in those aged over 65, especially men (Shah *et al*., 2001) and a mismatch between rates of GP consultation and presence of dementia (Nelson *et al*., 2002). Even amongst those who do consult, there are low levels of diagnosis and subsequent low levels of treatment, when compared to younger groups.

Most research has focused on the use of specialist services by older people. Treatment for CHD (revascularization and reperfusion) appears to be biased against women even after taking the lower mortality rate of woman into account (Goddard and Smith, 1998). However, this may be an age rather than gender bias because women with myocardial infarction (MI) tend to be older than men. The chances of being admitted to hospital following MI fall with age and those in the oldest age groups (85+) are very unlikely to receive investigations and revascularization compared with younger groups. However, over time, rates of revascularisation have been increasing faster in older groups than in younger groups so this pattern may alter. Prevention of cardiovascular diseases has been seen as a low priority in this group (summarised by Goddard and Smith, 1998). Surgical interventions and further tests are lower in older age groups with ischemic heart disease (Majeed and Cook, 1996). A recent study of self-assessed need for, and receipt of, hip and knee replacement surgery in those aged over 60 reported greater levels of need amongst females than males without a corresponding increase in receipt of services (Steel *et al*., 2006). Older people may find it difficult to access new or specialist services that are in short supply and Dixon-Woods *et al*.(2005) reports on studies that find lower use of community specialist palliative care amongst older age groups and that doctors are less likely to refer older men with sexual dysfunction to specialist services. There may be an interaction of age with distance for specialist services which tend to be provided at central settings e.g. renal services, with older people living far away tending to "under-use" services (Haynes, 2003). There are also potential interactions with ethnicity although studies have produced conflicting results (summarised by Dixon-Woods, 2005).

3.2.3 Barriers to access

In common with the discussion in section 2.5, older people who are in disadvantaged circumstances may find it difficult to organise the practical resources required for attending treatment due to poor mobility, lack of availability of public transport and inability to use it and the cost of such transport, even where available. This may also explain why there is an interaction between age and distance for some specialist services. However, this may either be due to the patient's reluctance to travel or doctors assuming that they would be reluctant to do so. Research investigating different methods of health assessment for the 75+ age group found the highest uptake to be for postal questionnaire, suggesting that travelling was a barrier to uptake (Smeeth *et al*., 2001).

Glendinning *et al*. (2002) plus other qualitative research has provided evidence of the complexity of the boundaries between different parts of the health care service, but especially between health and social care, as presenting barriers that older people find difficult to negotiate. Older people have a preference for seeing practitioners with whom they are familiar.

The help-seeking behaviour of older people may also be influenced by their expectations of health status as they get older. Walters *et al*. (2001) found that help was sought for less than a quarter of older people's needs because they were resigned to their situation and had low expectations of the value of contacting their doctor. There is also some research to suggest that interpretation of symptoms as being due to old age may hide symptoms of psychiatric disturbance. Even where help is sought, the existence of many co-morbidities may make it difficult for older people to get across their problems in the consultation setting and they also tend to report physical symptoms more readily than psychological or mood problems (summarised by Dixon-Woods, 2005). There is evidence that older people and their informal carers try hard to maintain their identity as being healthy and fit despite having health problems, "managing" their health accordingly (Tanner, 2003). They often also place great emphasis on their responsibilities in relation to health care interactions (only wanting to consult if "really" necessary), rather than on their rights. This means that even if offers of help are made, they may be declined. A small interview study of cardiac rehabilitation care found that some older people did not want to disrupt their routine by attending rehabilitation services so ruled themselves out (Tod *et al*., 2002). Sociological research has shed light on the difference between perceptions of "care" which suggest dependence; and "help" which suggest support to continue to feel in charge (summarised by Tanner, 2003).

The other major influence on access relates to the views and perceptions of health care practitioners. The existence of "age-ism" has been asserted by many commentators and has been expressed by many older people in surveys of their views of NHS treatment. Recent evidence is summarised by Fairhead and Rothwell (2006), and experience in cardiology by Harries *et al.* 2007. What is more useful to study is the basis on which decisions are made about the "candidacy" for treatment of older people. Doctors may mistakenly believe that some groups may not benefit as much as others and the presence of many co-morbidities amongst older people may be one factor that reduces their chances of being referred for surgery. However, there is often little evidence that older people fare less well from certain interventions eg use of statins for older age groups, so findings of lower use amongst older groups may be a signal of inequity (Reid *et al*., 2002). One of the difficulties in providing evidence of effectiveness of interventions in older groups is their exclusion from many clinical trial protocols. A review of qualitative studies on stroke care concluded that health professionals often relied on how "motivated" they felt patients to be when assessing them for rehabilitation and stroke services – this may be mediated by age but also depended on other things such as attitudes of family members (Mold *et al*., 2003).

As seen earlier there is not a great deal of evidence in the research literature on differential access to health care by older women. However, it is the case that this group is very socially disadvantaged in terms of income. Persistent poverty is concentrated amongst older women with the proportion experiencing poverty being three times that of the whole population (Evandrou and Falkingham, 2005).

One group whose access is not well-studied is residents of residential and nursing homes, who are mainly older people. Dixon-Woods *et al*. summarised the evidence and suggests that there are indications that these groups may receive lower quality care because of the way in which their access to GP services is handled within the care homes. A recent Help the Aged study found 21% of care homes had no regular visits from a GP (Owen and National Care Homes Research and Development Forum, 2006). Negotiations over the new GP contract failed to address this issue with the result that a wide range of arrangements exist across the country, with no overall strategy for ensuring good access. Reports suggest that some care homes pay for the services of GPs for their residents, despite them being entitled to free access (Glendinning *et al.,* 2002). Poor quality of primary care for this group is also an issue (Fahey *et al* 2003; Bowman *et al.,* 2001). Access to other health services such as chiropody, dental care, speech and language therapy and physiotherapy, as well as medicines management may also be poorer for those in residential care when compared to those in the community (Help The Aged, Age Concern, personal communication).

3.2.4 Policies to address access

Benefits in kind have increased under the Labour government, although it is a matter of controversy whether these are sufficient to tackle the social exclusion of older people identified in their 1999 "Opportunity for All" policy document (Dept. of Work and Pensions, 1999). The latter addressed pension policy which is not considered further here. Health and social care related benefits include free eye tests and prescriptions for those aged 60 or over.

Perhaps the most significant policy development in terms of addressing quality and access to health care services has been the National Service Framework (NSF) for older people introduced in 2001 (Dept. of Health, 2001). NSFs generally are targeted at reducing variations in service provision and increasing quality and the NSF for older people sets out a 10 year programme for service improvement. Under-pinning the NSF for older people were a number of reviews and reports that suggested large geographical variations in expenditure on services targeted at older people (eg old age psychiatry services), possibly low levels of investment in services overall, plus lack of information and support for users and carers. The NSF covers a mixture of general principles that should govern care for older people, approaches to the organisation of care, plus specific guidance for care of some conditions. The NSF sets out models of care to be followed, the standards and principles that are to be met and is accompanied by an annual increase in funding in order to facilitate implementation. However, it is important to note that unlike the Mental Health NSF, this is not a targeted pot of money but has to be found from the overall increase in funding. The NSF requires the health and social care and voluntary sectors to work together in order to achieve the aims of the NSF.

The areas covered as standards in the NSF are: general hospital care, stroke, falls, mental health, intermediate care, health promotion, person centred care and tackling age discrimination. Those elements of the NSF that are based on providing service models for care (eg stroke, falls,) have been praised, whilst others such as providing person centred care or addressing age-ism are less clear and focused. The NSF has introduced many specific interventions and examples of good practice are available on-line. However, evidence about effectiveness is anecdotal and it is probably too early to detect whether significant changes have been made by the NSF and how they impact on access and equity. A review of progress by the Department of Health in 2003, suggested that attitudes to age-ism were changing. It also reported that over the two year period since the NSF was published, breast cancer surgery increased amongst those aged over 85 (13%) and CABG increased in all older age groups but by most amongst those aged over 85 (Dept. of Health, 2003a) as well as increases in cataract surgery and hip replacements. However, as such operations are also likely to have increased in other groups, this alone is not evidence of better access. A review of falls in older people in 2005 suggested progress had been made by about half the providers who had developed integrated falls services and that reductions in falls had been reported as a result of this (Dalley, 2005). An in-depth independent review of progress with the NSF in 2005 found good evidence that explicit discrimination in access to services had been addressed in all areas aside from mental health services (see section below for more detail), although age-ism in terms of staff attitudes still existed (Commission for Healthcare and Audit Inspection, 2006).They found that 76% of NHS Trusts had assessed their criteria for eligibility to services as being in line with the standards set out in the NSF.

A major element of the NSF is the Single Assessment Process which aims to provide a person-centred, thorough assessment of health and social care needs as a single process. This is a substantial improvement over subjecting older people to several different assessments which are exhausting and confusing. However, it has been criticized for being limited to meeting needs only in terms of the local authority's remit for provision. It is not clear how/if needs that fall outside this remit will be met. In addition, there have been some concerns about the professional expertise required at the assessment stages and whether it will be possible for them to go beyond the superficial needs assessment that may previously have been undertaken (Tanner, 2003).

The LinkAge Plus pilot programme (Dept of Work and Pensions initiative) and the Partnerships for Older People (Dept of Health initiative) extend the principles of joined-up working to improve access to the full range of health, social care and other services that older people require.

In preventive care there are two initiatives aimed exclusively or mainly at older people. The first is health checks for those aged over 75. These were introduced to general practice almost 15 years ago with financial incentives attached for GPs to offer them to a high proportion of older people on their lists. However, the evidence base for this was lacking and although implementation has been patchy, there is no evidence than those not coming forward are in worse health (Jagger *et al.*, 1996). The financial incentives have subsequently been removed. Those aged over 65 are entitled to annual vaccinations against influenza but take up is around 70%. Research suggests this may be due to a mixture of beliefs about the side effects, older people not considering themselves as ill and also wishing to exert control over their own health (summarised by Dixon-Woods *et al.*, 2005).

Informal carers have a vitally important role to play in the care of older people (as well as for other groups) and provide the majority of physical and practical support. Indeed, in the UK it is estimated that there are 5.2 million carers and replacing the support provided by informal carers would cost £57 million – roughly equivalent to the total NHS budget (Glendinning and Arkesy, in press). As the population ages, many carers themselves are older people and the impact on their physical and mental health of their caring responsibilities can be substantial.

The importance of the role of informal care is relatively well recognised by the government in England and formal policy measures addressing carers' role and needs are well advanced compared to many other countries. Financial support is provided in the form of a Carer's Allowance for those who have minimal income from paid employment because of care responsibilities and some limited protection of carers' pension entitlements (Direct Govt 2007). In addition, there is a legal entitlement of carers to an assessment of their support needs and these have developed over the last 10 years, with a number of legislative improvements (see Glendinning and Arksey for a summary). Support is also provided through a variety of government and NGO services targeted at carers. A package of financial support for local authorities to provide support services for carers was announced in 2006. Carers have the right to request flexible working arrangements from employers. Despite the significant progress made in support for carers, there are still gaps and shortcomings and some commentators suggest that carers are still susceptible to social isolation and exclusion, as well as poor health, as a result of their caring duties. Despite the range of support for carers, it is still the case that no ring-fenced resources for carers are allocated from within the NHS budget.

3.2.5 Social and health care interface – long term care

Long-term care encompasses help with domestic tasks such as shopping and cooking, help with personal care tasks such as dressing and bathing, and nursing care. Provision of these services can take place at home or in a residential or nursing home.

The funding and provision of long term social care for older people has a long and complex history in the UK, centring around the distinction between living costs, housing costs and personal care costs and the responsibilities of different agencies to bear them. At the heart of the problem is the conflict between an NHS in which health care is provided on the basis of need rather than ability to pay; whereas access to publicly funded social care for older people has historically taken both needs and ability to pay into account. This can be seen as inequitable as people with illnesses for which health care treatments exist receive personal care free in the course of receiving medical care. Those with conditions that are less amenable to health care treatments do not receive free personal care. Variations also exist in the degree to which people in residential care homes are eligible for fully funded NHS care. There is widespread evidence that the regulations are complex, interpreted very differently between local authority areas, and are often unfair.

In 1999 a Royal Commission investigated this issue and recommended that the cost of long-term care should be divided into three categories and that personal care should be provided according to need without means testing, whilst housing and living costs should be subject to a co-payment depending on means testing. The Commission defined 'personal care' as the care needs, often intimate, which give rise to the major additional costs of frailty or disability associated with old age, including support from skilled professionals. The government's response was to decline to fund *personal care* which is means tested in England and Wales, although Scotland decided to provide free personal care to those aged over 65. There is still much debate about the fairness of this approach and pressure on the government to make personal care free of charge, e.g. Help the Aged, Age Concern and other parties are currently gathering public views on funding of personal care.

The government did agree that the NHS would fund all *nursing care* regardless of the setting in which it is provided (at home, in a nursing home or in a residential home). Other changes included additional investment in nursing and residential care and changes to the way in which the value of a person's own home is taken into account when assessing charges.

Other developments in social care around increasing the number of people supported in their own homes have met with mixed success. Evandrou and Falkingham (2005) show that resources have increased but greater targeting of a number of health and social care services (such as home help, meals on wheels, district nurse etc) towards those in greatest need has meant an overall decline in the number of households being supported. Concern has been expressed about those with intermediate needs (Tanner, 2003). Excluding those at lower levels of risk in favour of "crisis" services means that the potential for prevention and rehabilitation is diminished. The government has addressed this by releasing funds for promotion of independent living and encouraging councils to adopt thresholds that do not screen out such large numbers of older people with intermediate needs (ie to undertake positive "case finding"). However, this appears to have had limited success, possibly because it takes place within the context of fixed budgets.

Policies that address the co-ordination between health and social care are especially important for older people and closer integration has been addressed through giving PCTs shared responsibility for commissioning social care in addition to their responsibilities for health care. However, commentators express concern at the abilities and resources available for PCTs to carry this out effectively. Greater use of Individual Budgets and Direct Payments described in section 3.3 may give more choice and control to older people over the nature of the social care they receive.

3.2.6 ***Interactions with ethnicity***

Past and current migration trends and the ageing of the population suggest that the issue of health and social care for older people from ethnic minority groups, will become more important. Higher rates of some diseases are found in specific population groups, e.g. stroke, hypertension, diabetes, CHD, hip fractures and renal failure in South Asians (Khan and Ghosh, 2005). A recent survey of minority ethnic elders in the UK undertaken as part of a wider European project, reported relatively high levels of overall satisfaction with health and social care services amongst most groups, but also noted significant language barriers amongst South Asians and Chinese/Vietnamese people in accessing services (PRIAE, 2005). Many service providers felt services failed (at least in part) to meet the needs of these groups and suggested unmet need existed.

3.2.7 Older people and mental health care services

Of particular concern is access to mental health care services by older people. As outlined earlier, there are various reasons why under-detection of mental health disorders such as dementia and depression is characteristic of this group and is especially a problem amongst those living in care homes. Older people from black and ethnic minorities may also face specific issues in accessing these services, as discussed earlier. Whilst policy directed at improving care for those of working age had been made some time ago (eg a care management approach that stresses the need for an integrated process), this had not been rolled out to older people at the time of writing. A recent report highlighted several problem areas including under-detection of mental health disorders, low emphasis on prevention and high levels of unmet need (Lee, 2007).

In recognition of these problems, one of the areas covered by the NSF for older people is mental health care and there is also a separate NSF covering mental health care services generally. However, the latter covers people of working age only which seems in contradiction to the principle of equal access regardless of age (see section 4 for more details). The NSF for older people covers the range of interventions that should be accessible in promoting good mental health, diagnosing and managing mental health disorders and accessing specialist services. The emphasis is on arranging a good assessment process (the single assessment process); integrated working between health and local authorities; provision of support for the person and their carer; and the provision of effective treatment (in the community or in-patients setting) that adheres to national guidelines and good practice standards. Progress in achieving the general goal of integrated mental health services for older people has been called "patchy" (Dept. of Health, 2007) and there is still a gap between services available to those of working age and older people (eg out of hours services) (Commission for Healthcare and Audit Inspection, 2006). The emphasis to date has been on getting the organisational processes in place (ie shared protocols for care, community mental health teams). Descriptions of schemes are provided on-line as examples.

3.3 People with mental health disorders

Section 4 – Case Study on mental health – provides further details about access to mainstream health services by those with mental health disorders.

3.3.1 Children and young people

The Action Plan on Social Exclusion (Cabinet Office, 2006) identifies the tendency for children with certain mental health disorders to have more problems later on in life requiring contact with foster and residential care, use of state benefits, special education and contact with the criminal justice system. They plan to pilot some interventions that have proved promising in international and locally based research (eg multi-systemic therapy).

3.3.2 Adults

A major policy effort to address the impact of mental health disorders on social exclusion was launched in 2004 when the Social Exclusion Unit (SEU) reported on Mental Health and Social Exclusion (Office of the Deputy Prime Minister, 2004b). They compiled many statistics and research findings to illustrate the fact that adults with mental health disorders are one of the most excluded groups in society. In particular, they identified four groups as having additional barriers to getting support: ethnic minorities, young males, parents and adults with complex needs (eg homelessness, substance abuse). The report presented a 27 point action plan organised within six categories: stigma and discrimination, role of health and social care, employment, supporting families and community participation, “getting the basics right” (housing, finance, transport) and “making it happen” (implementation plans). Specific actions targeted at tackling inequalities in access to health services were somewhat long-term: it included planning a review of the physical health inequalities experienced by people with mental health disorders; a review of access to and cost-effectiveness of treatment for adults with co-morbid drug use and mild-moderate drug problems; plans to commission research to develop evidence based ways of overcoming barriers to access of mental health services by people who are homeless; discussions of the possibility of new national targets for waiting times to psychological therapy. For social care there were plans to promote the greater use of the Direct Payments system for this group. Direct Payments were introduced into social care as an alternative method of providing community care services. They provide a cash payment to service users following assessment of their needs and allow the user and/or their carer to purchase suitable services directly rather than having services arranged and provided by the local authority. The pros and cons of this system (to service users and to providers) are a matter of much debate, but whatever their status, it is important that they are available equally to all groups.

A review of the implementation of the action plan was undertaken at the end of 2006 and progress at the national and local level was demonstrated in a number of areas (CSIP, 2006b). Nationally, most progress had been made in terms of issuing guidance to commissioners and employers, dissemination of guidelines about treatment and services, improvement of communicating with users, carers, media, employers, and training staff. They state that 58% of the action points were completed with 38% underway but also noted that many other developments outside this initial remit had also taken place through other initiatives. The access action points appear to have largely been met although many of these are process related and do not indicate whether access has actually improved. The exception appears to be that the large effort made in providing guidance, information and training on Direct Payments, was translated into a substantial increase (78%) in the use of Direct Payments amongst people with mental health disorders over a one year period. Whilst it is not obvious that this is completely beneficial, some examples suggest they can, when used well, contribute to activities that promote social inclusion (eg attendance at a creative arts group through pooling of Direct Payments between five people). At the local level, examples are cited but not evaluated.

A major cross-government initiative has been the “Supporting People” programme which is aimed at enabling vulnerable people to live independently. Over 200 out-reach teams support “hard to reach” clients in the community, and this includes a large number of people with mental health disorders (18,700 people in 2006).

The Care Programme Approach is designed to provide systematic arrangements for assessing the health and social care needs of those admitted into secondary mental health services. This is especially important for those with multiple needs as they may not reach the thresholds to receive services from individual programmes but their multiple disadvantage makes them very vulnerable.

In line with the overall policy focus on tackling social exclusion through employment based initiatives, the Social Exclusion Task Force notes that rates of worklessness are highest amongst people with mental health disorders (89%). A survey of users of mental health care by the Healthcare Commission in 2005 showed that many people would like to work. There are many initiatives in place to try to help find work opportunities for people with mental health disorders. For example, the Individual Placement and Support (IPS) approach seeks vocational opportunities and examples of implementation show that it has a high success rate in finding employment, education and voluntary work, often for those with severe mental health disorders (Cabinet Office, 2006). The government plans to support the further development of existing programmes such as Pathways to Work and Shift anti-stigma programme to address with employers the specific issues around people with mental health disorders (CSIP, 2006b). They also aim to create dedicated regional teams drawn from existing public, private and voluntary employment organisations to provide further support for the implementation of good practice.

In terms of “what works”, the National Institute for Mental Health in England recently identified 10 “high impact” examples of service and process redesign that appear to have a substantial effect on improving the quality of mental health care services (CSIP, 2006c). This was undertaken through a process of case study review and data collection from around the country, as well as examination of the literature. Of most relevance to this project are the themes: “Improving the flow across health and social care by improving access to screening and assessment” – this includes projects that achieved reductions in waiting times for all users, better discharge policies; “Manage variation in access to all mental health care services” – this included providing better single access points and booking systems and improvements in liaison with other services. Some of the projects targeted older people’s teams and reduced “did not attend” rates substantially in this group; “Improve service user flow by removing queues” – this included use of a gateway co-ordinator whose work had a substantial impact in terms of reducing waiting times and making new referrals to appropriate services.

The National Service Framework (NSF) for mental health care was published in 1999 and was based on a substantial body of research evidence and expert advice (Dept. of Health, 1999). In providing a rationale for a national service framework, the Department of Health noted the wide range of adverse factors associated with social exclusion and that mental health disorders can also be a cause of social exclusion. For example, they noted that unemployed people are twice as likely to have depression as people in work, children in the poorest households are three times more likely to have mental health disorders than children in well off households, people with drug and alcohol problems have higher rates of mental health disorders, between a quarter and a half of people using night shelters or sleeping rough may have a serious mental disorder, and up to half may be alcohol dependent. Some black and minority ethnic communities (especially refugees) are diagnosed as having higher rates of mental health disorders than the general population. The aim of the NSF (as for all of them) is to specify what should be provided, to whom and when. Thus it addresses access in a broad sense.

The NSF covers the full range of care, setting national standards and defining service models and establishes milestones and monitoring processes. Seven standards were set out relating to: mental health promotion and tackling discrimination and social exclusion; primary care and access to services by anyone with any type of mental health problem; effective services for people with severe mental health disorders; support for individuals who care for people with mental health disorders; and the action necessary to achieve the national target to reduce suicides. The framework emphasises the need for integrated working between multiple agencies involved in providing care and the agreement of protocols and service models. The NSF was accompanied by substantial new investment from central government. The standard on access to services focused mainly on the availability of round the clock services and use of NHS Direct. Shortly after the publication of the NSF, the NHS Plan (Dept. of Health, 2000) confirmed mental health to be a priority for the NHS and reiterated many of the aims of the NSF as well as launching specific clinical initiatives, in particular to target community care eg assertive out-reach, early intervention, home treatment and carer support.

The Department of Health's review after five years experience with the NSF (Dept. of Health, 2004b) concluded that most progress had been made in relation to services for the severely mentally ill and on clinical guidance; progress on primary care and access had been reasonably good but less had been achieved on health promotion and social exclusion. In terms of the specific standard on access, this review noted that the "gateway workers" introduced as part of the NHS Plan whose role was to co-ordinate and ensure prompt access to care, were very well embedded across the country; 24 hour access to crisis resolution and assertive outreach teams was not available everywhere but was increasing; training had been undertaken with NHS Direct advisers to equip them to deal with mental health risks; almost all areas had directories of local services available and extra resources had been provided to improve access to crisis services. Other commentators have noted the gaps in achieving equal coverage in some areas – for example, MIND noted that the spread of assertive outreach teams was not uniform across the country (MIND, 2004). There is an important interface with older people in that the NSF for mental health applies only to people of working age. The exclusion of those who are older than this clashes with the policy of equity expressed in the NSF for older people which starts from the principle that access should be determined by need, not age.

3.4 Conclusions

The general picture in relation to policy on social exclusion, inequality and access has already been summarised in section 2.10. The broad features likely to be associated with promising policy initiatives have been identified in that section and are applicable to all three groups covered in section 3. However, the specific features of policy targeted at these three groups that appear to be beneficial are summarised below:

- Co-ordinators, special advisers, gateway workers, link workers to help ensure access to appropriate services for groups who may not be well served by mainstream providers. This support needs to span the administrative and organisational boundaries between sectors and services rather than being focused just on a single service or sector.

- Adequate training and support for health (and other) professionals who come into contact with people who have special requirements. A great deal of specialist knowledge is sometimes required to help guide people through complex services with various eligibility requirements. Knowledge and understanding of cultural issues is also important.

- Streamlined assessment processes that reduce the burden of multiple assessments with different service providers. However, it is essential that those undertaking the assessments are equipped to do so and have knowledge of the full range of health and social care needs.

- Cross-agency collaboration.

As described throughout section 3, there are various monitoring processes in place that aim to check progress in terms of policy for vulnerable groups. The Action Plan on Social Exclusion (Cabinet Office, 2006) states that the single most important conclusion from looking at "what works" is that there need to be clear responsibilities and tailored responses for those with "chaotic lives and multiple needs", a description which clearly applies to the three groups considered in this report. This relates to both the strategic level in terms of planning services and at the level of individual case management. The Social Exclusion Task Force aims to develop and test alternative approaches to improving outcomes for these groups including evaluation of what is being done locally, pilot the most promising and disseminate early results.

There are several challenges and several gaps in policy and research:

- The situation of those living in institutions is seriously under-researched. Compared with the volume and quality of research that has focused on those living in households, there is a dearth of information on the health and social care needs of this group, their access to care and the extent of their social inclusion. Policy has tended in general to focus on the financial issues around providing care in the institutional setting. Whilst this is clearly important, especially in England where cost-sharing for social care is prevalent, this means that policy to tackle other potential barriers to health care has been less rigorously addressed.

- Where service use is spread across administrative and/or organisational boundaries, there is scope for people to face multiple barriers at every point of entry. The most severely disadvantaged groups are therefore faced with complex journeys through the care pathway and research could usefully focus on the implications of this for access.

- In some services, policy has focused on targeting those most seriously in need or those in 'crisis' situations. Whilst this is a reasonable strategy, there is a danger that those with low level, but multiple needs, will slip through the net because they will not reach the threshold required to qualify for any single service. Unless the full range of needs and circumstances is taken into account, this may precipitate further disadvantage for those in vulnerable positions.

- The provision of preventive and health promotion services appears to be associated with particularly severe barriers to access for the vulnerable groups considered in this report. This may contribute to a cycle of inequality in terms of health outcomes.

- Despite the large volume of literature identifying barriers to access for many different groups, there is far less knowledge about the eventual impact of reduced access on health status. Policy could usefully be targeted at reducing the barriers that are likely to have the most significant impact on health.

4.The case study on mental health

4.1 Introduction

4.1.1 The law

The Disability Discrimination Act 1995 (DDA 1995) and the Disability Rights Commission Act of 1999 (DRC 1999) seek to protect those with disabilities from being treated differently from those without disabilities. Disability is defined as a physical or a mental impairment which has a sustained and long-term adverse effect on day to day activities. The Disability Equality Duty (DRC 2005) came into force in December 2006 and requires all public services to actively promote disability equality and to narrow the gaps in inequality in areas of employment, governance, service delivery, public consultation, research, partnership working and policy development. There is some concern that the focus (especially of employers) has been largely on physical rather than mental disabilities, but the legislation is intended to cover both. The new Commission for Equality and Human Rights will bring together the Commission for Racial Equality and the Equal Opportunities Commission. New equalities legislation will eventually supercede the DDA.

There are circumstances in which people may be subject to compulsory detention and treatment, largely in the interests of their own health or for the safety of others (Mental Health Act 1983). The new Mental Health Act (2007) in England seeks to update legislation concerning the types of professionals who have the authority for detention and the categories of people who may be subject to compulsory treatment. This has proved very controversial and there is some concern amongst commentators that it is based more on issues to do with public order, rather than therapeutic benefit, and that it may increase rather than reduce stigma, especially amongst black and ethnic minority groups where rates of compulsion are particularly high (Crichton and Darjee, 2007).

4.1.2 Stigma and discrimination

A recent in-depth review of the issues of stigma and discrimination faced by those with mental health disorders concluded that on the basis of global evidence about stigma, “there is no known country, society or culture in which people with mental illness are considered to have the same value and to be as acceptable as people who do not have mental illness” (Thornicroft, 2006, page 11). This review summarised substantial evidence from across the world about stigma and discrimination in home life, personal relationships and at work and flagged up mixed evidence from the UK on trends in attitudes to people with mental health disorders. Some research shows signs of greater understanding amongst the general public over a ten year period, whilst other signals are less favourable, such as greater levels of fear of, and perceived danger from, those with mental health disorders (Dept. of Health, 2006).

Anti-stigma activities in England are encapsulated in a number of different policy initiatives, rather than in a single policy. These include recommendations from the Social Exclusion Unit on tackling exclusion as experienced by people with mental health disorders (Office of the Deputy Prime Minister, 2004b); a Strategic Plan to tackle exclusion published by the Department of Health (NIMHE, 2004) and the National Service Framework for Mental Health (Dept. of Health, 1999) which includes sections on combating discrimination and stigma. The National Action Plan (NAP) for Social Protection and Social Exclusion (European Commission, 2006) mentions anti-discrimination in relation to people with mental health disorders, but does not set out any specific policies over and above those contained in the above documents.

4.1.3 Role of NGOs

NGOs and groups working in partnership with the government, play a major role in mental health policy and support in the UK. A list and brief summary of their role and remit is provided in Appendix 2.

There is a wide range of voluntary organisations across the mental health community, each one operating with its own specific remit. Some organisations focus activities on mental health specifically, others target on social problems and support all those affected. There are good examples of collaboration between the voluntary sector, professionals and the government (e.g. the Mental Health Alliance involving 80 organisations) (Pinfold and Teasdale, 2007).

4.1.4 Public opinion

There are many voluntary campaigning groups that seek to correct mis-representations of mental health disorders and campaign for more accurate portrayals in the media (eg Mad Pride, Mind Freedom – see Appendix 2 for more details).

The way in which mental health issues are covered in the media has been the subject of more specific campaigns such as SHIFT. There is also a very wide range of local, targeted policies aimed at raising awareness amongst specific groups of professionals who come into contact with people with mental health disorders, with the aim of reducing discriminatory behaviour. These include medical staff, school children, journalists, police, employers and church leaders. A coalition of organisations (including MIND) has just been awarded £18 million funding to combat stigma and discrimination.

The most successful type of intervention in this context appears to be those that rather than just being "educational", involve a direct contribution by service users/ consumers. Research suggests that the most effective contact is with a person who "moderately disconfirms a pre-existing stereotype", rather than reinforcing it or providing an "exceptional" example of extreme disconfirmation (Thornicroft, 2006). Many general public educational campaigns exist in the UK but there is limited evidence on their effectiveness.

4.1.5 Mainstream health services

People with mental health disorders are served by both the mainstream health services and specialist services. Specialist services exist in the community, primary, secondary and tertiary sectors. The vast majority of people with mental health disorders are managed within the primary care setting by GPs, gateway workers and mental health primary care workers. In the secondary sector, services include community mental health teams, assertive outreach teams, crisis resolution teams and early intervention teams.

In principle, mainstream services are available equally to all users without distinguishing between those with and without mental health disorders (see earlier description of the relevant legislation). However, as outlined in section 4.3 and 4.4 below, the reality of the situation is that those with mental health disorders often face substantial barriers to access in practice.

4.2 Methods

A focused literature search of MEDLINE was carried out (by the Centre for Reviews and Dissemination at the University of York) using appropriate terms for "mental health" and "primary care" to identify relevant papers (from 2002 to date) about access to mainstream health services for people with mental health disorders.

In order to identify unpublished reports and papers the websites of key voluntary sector organisations (as below) were also scanned:

Disability Rights Commission
http://www.drc-gb.org/default.aspx

Institute of Psychiatry
http://www.iop.kcl.ac.uk/

Mind
http://www.mind.org.uk/

Mental Health Alliance
http://www.mentalhealthalliance.org.uk/

Mental Health Foundation
http://www.mentalhealth.org.uk/

Sainsbury Centre for Mental Health
http://www.scmh.org.uk/80256FBD004F6342/vWeb/wpKHAL6S2HVE

Government websites were searched for national guidance and legislation.

The reports obtained from the above sources and the journal papers were searched for further relevant references and these were followed up as appropriate.

The mental health field is served by a large number of non-governmental organisations, pressure groups and campaigning organisations. These are listed, along with brief descriptions, at Appendix 2.

4.3 Access to general health care for people with mental health disorders

A recent formal, independent investigation of the physical health status of people with learning disabilities and/or mental health disorders, undertaken by the Disability Rights Commission (DRC), summarises a large amount of existing evidence relating to inequalities in health status, as well as presenting the results of primary research based on health records of 488 GP practices in England and Wales (DRC 2006a; 2006b). This has been used as a key resource for the case study as it summarises the most up to date evidence available and was also under-pinned by several pieces of new primary research.

The main findings from the literature review relating to inequalities in health status amongst those with mental health disorders (Nocon, 2006) are:

- Higher mortality rates amongst those with mental health disorders, even after accounting for deaths from suicide
- Higher than average rates of physical illness amongst people with mental health disorders
- The above includes cardiovascular disease (ischaemic heart disease, stroke, hypertension), with rates up to 1.9 times higher than general population.
- Also includes diabetes, with rates of between 2 and 4 times that of the general population
- Also, respiratory disease, with chronic obstructive pulmonary disease (COPD) and emphysema being more common
- Rates of HIV/AIDS and hepatitis B and C; and sexually transmitted disease are higher in people with mental health disorders
- Cancer rates have generally been found to be similar to the rest of the population
- Oral health is often poorer amongst this group.

The main findings of the national data analysis from England and Wales on the prevalence of physical health disorders among people with schizophrenia or bipolar disorder (undertaken as part of the DRC review) generally support the findings from the existing literature, reported above. The analysis suggested higher rates of ischaemic heart disease, stroke, elevated blood pressure and diabetes in both these groups as compared to people without either disorder (Hippisley-Cox and Pringle, 2005).

The analysis also explored cancer rates and in contrast to published research, suggested higher prevalence of breast and bowel cancer amongst those with schizophrenia (Hippisley-Cox *et al.*, 2006a). The clinical analysis also suggested that not only are those with mental health disorders more likely to develop some conditions than those without such problems, but they also develop them at a younger age and once they have them, die faster than others with the conditions – for example, for coronary heart disease, diabetes, stroke, respiratory disease (Hippisley-Cox *et al.*, 2006b). Overall, five-year survival rates show lower survival for patients with mental health disorders for almost all key conditions (Hippisley-Cox *et al.,* 2006c). This finding remains even after allowing for suicide rates.

The reasons for such inequalities in health outcomes are varied and complex. There is a strong link with social deprivation as mental health disorders are more common amongst the unemployed and those who are living on low incomes. There are also greater risk factors in this group eg higher than population average rates of smoking and obesity amongst those with schizophrenia and bipolar disorder (Nocon, 2006, summarises a wide range of international studies). The use of antipsychotic medication, and multiple medications, is linked to a wide range of adverse effects on health (aside from obesity) which may exacerbate health problems (Nocon, 2006).

The degree to which access barriers are a contributory factor is considered in the next section.

4.4 Barriers in access to general health care for people with mental health disorders

There are no explicit legal or administrative barriers to access for services for people with mental health disorders and cost-sharing and eligibility criteria for services do not vary according to mental health status. The legislation referred to in Section 4.1 (particularly the DDA 1995) makes it illegal to provide goods, services, or facilities to a disabled person (including those with mental health disorders) on terms which are unjustifiably different from those given to other people. In terms of insurance (including health insurance) this makes it illegal to charge higher premiums or refuse insurance unless the provider can demonstrate statistically higher risks as a direct result of the mental health condition for that particular person.

However, in the health sector, there is some evidence of unequal treatment patterns:

- Despite experiencing higher rates of coronary heart disease, lower rates of screening in primary care for raised cholesterol has been found amongst people with mental health disorders (DRC, 2006a); similarly people with mental health disorders who have diabetes are less likely to have their body mass index checked than those with diabetes without such problems (Samele *et al*., 2006a). Although consultation rates with GPs are 3-4 times higher than for the general population, some studies have found that people who use psychiatric services are less likely to be offered health promotion interventions (summarised in Nocon, 2006).

- However, health promotion in the form of dietary advice for obesity appears to be available equally to those with schizophrenia and bipolar disease but less common amongst those with depression. More people with serious mental health disorders appear to receive smoking advice and smoking cessation medication as compared with the general population, although rates of cessation treatments are low overall (Hippisley-Cox and Pringle, 2005).

- People with serious mental health disorders do not seem to be high users of exercise by prescription from GPs (Nocon, 2006).

- Evidence on the availability of regular physical health checks is mixed but some studies report relatively low rates amongst those with mental health disorders, despite the strong presence of risk factors; others studies suggest high coverage but limited recall amongst patients of the specific checks undertaken (Nocon, 2006).

The empirical work undertaken for the investigation by DRC found that:

- People with schizophrenia and coronary heart disease had fewer blood pressure or cholesterol tests that people with coronary heart disease without such problems (86% and 68% compared with 92% and 80%) (Hippisley-Cox and Pringle, 2005).

- There were no differences between groups with and without mental health disorders in terms of rates of some procedures (eg investigations following bleeding; lung function and inhaler technique checks).

- Slightly fewer people with schizophrenia with coronary heart disease who have had a stroke are on aspirin; and fewer people with schizophrenia who have coronary heart disease are on statins compared with those without mental health disorders. (Hippisley-Cox and Pringle, 2005 and Hippisley-Cox, *et al.,* 2006d).

The literature focuses on the practical issues of access, many of which are similar to those experienced by other groups whose needs are multiple and who have chaotic lives, making planning difficult to achieve. Research highlights a sense of frustration amongst people with mental health disorders about the attitudes of health professionals in primary care, with concern that they are often classed as “difficult” patients (DRC, 2006a). Registering with GPs may be more difficult for those with mental health disorders who also lack a permanent address. Practical issues arise in accessing primary care when people are required to phone early to book consultations or are booked for early appointments that they cannot keep. There are also problems if waiting rooms are noisy or waiting times are prolonged (Lester *et al.*, 2005).

There is evidence that the willingness of people to declare a mental health problem in order to seek help is influenced greatly by the fear of stigma and discrimination that might be attached to them as a result, including the fear of compulsory treatment and detention (international evidence summarised by Thornicroft, 2006). Negative attitudes by reception and clinical staff may reinforce the reluctance to seek help (Nocon, 2006; Greater London Authority, 2007).

Health care professionals may also lack the experience and confidence to deal adequately with peoples’ problems. Many studies find evidence of lack of training and specialist knowledge amongst staff (summarised in Nocon, 2006). This may produce a mismatch between the expectations of users and the staff. For example, whilst many people with mental health disorders see primary care as the cornerstone of their health care, health professionals often view the care of people with serious mental health disorders as too specialised for them to deal with in primary care (Lester *et al.*, 2005). Recent research undertaken in London found that the majority of people with mental health disorders use their GP as a point of access for other specialist services (Greater London Authority, 2007). However, some experience problems because of GPs’ lack of knowledge about services.

Access to services may be restricted if health care professionals believe that specific types of interventions are not effective for people with mental health disorders. This may be particularly the case for health promotion and prevention therapies where evidence of effectiveness is limited generally anyway. There maybe a belief that people with mental health disorders are even less amenable than other population groups to such interventions, for example, because they are not good at adhering to long-term behaviour changes. The DRC investigation found that some practitioners expressed such doubts about the value of smoking cessation advice even though there is a small amount of evidence to suggest this intervention (and structured approaches to weight management) do actually appear to be effective for such groups (Samele *et al.*, 2006b). There is also a risk of “diagnostic overshadowing” whereby the mental health disorders obscure diagnosis of physical problems.

In terms of access to specialist mental health services, the National Service Framework for Mental Health (Dept of Health, 1999) states explicitly that services should be accessible to all who need them and available on the same basis regardless of where people live. A range of services is specified that should form part of a comprehensive local service. These include services for crisis response; multi-professional teams offering effective interventions through care packages, including home based care and assertive outreach; early effective interventions for those with severe mental health disorders; and adequate treatment and care facilities such as day, residential and hospital care. Analysis of the availability of, and use of, two key components of care - day hospitals and crisis resolution teams – suggests that such services are unequally distributed geographically when measured against some measures of population need and deprivation (Beecham 2005). It is suggested that this may be to do with the tension between providing standards for national universal services whilst still allowing local flexibility and devolved decision-making. The latter is important as it is often difficult to disentangle the individual components of a good, integrated local mental health service where some services may be substitutes for others. Other evidence suggests variation in the availability of specialist mental health workers at PCT level (Greater London Authority 2007). Long waiting lists, especially for psychological therapy exist in many parts of the country and may encourage inappropriate use of medication as an alternative.

Recent survey evidence from London suggests the largest barrier faced by people trying to access support and treatment for mental health disorders is the complexity of navigating the plethora of non-integrated service providers and the lack of communication that exists between different parts of the system (Greater London Authority, 2007). This was identified as a barrier not only for those individuals trying to access services and information for themselves, but also for health care and non-health care professionals (e.g. the police, prison service) who often need to refer individuals appropriately.

Overlapping disadvantages

Certain groups with mental health disorders faced even greater barriers than others.
Whilst low rates of mental health illness have been reported for some non-White groups (eg Asian people), the prevalence of depression and psychosis is higher among Afro-Caribbeans than amongst white people (Nazroo, 1998). Pakistani men aged 34-54 and Indian and Pakistani women aged 55-74 have higher rates of non-psychotic mental health disorders than white people (Weich *et al.,* 2004). Identification and treatment rates have nevertheless been found to be lower in some of these groups (reported by Nocon, 2006).

As Nocon (2006) reports, there is evidence to suggest a high incidence of mental health disorders amongst rough sleepers but low rates of treatment, some of which are due to difficulties with accessing services by not having a permanent address. Problems of timely access to good quality services have also been reported for those in prison and those in residential and nursing homes.

4.5 Policy initiatives and their impact on access to general health care for people with mental health disorders

The National Service Framework (NSF) for Mental Health was published in 1999 (Dept. of Health, 1999). It represents the central element of the government's mental health policy for working-age adults and it sets out a 10 year programme for improving mental health care. The remit of the NSF has been described in Section 3.3, along with evidence relating to how it has been implemented and this is not repeated here. However, it has been noted that although the NSF focuses on reducing smoking rates and improving services for long term physical health conditions, this has not translated into wider health policy initiatives such as primary care access initiatives or other relevant NSFs such as diabetes (DRC, 2006a). Subsequent policies have supported and expanded this initiative – for example, NICE guidance on schizophrenia (NICE, 2002) acknowledged the need for physical health checks for those with high risk factors for cardiovascular disease. The English strategy for public health (Dept. of Health, 2004a) commits to learning from eight pilot studies on improving physical healthcare for people with mental health disorders and rolling out lessons from Spearhead PCTs. The pilots involved specialist teams working in partnership with primary and social care providers to help support people with severe mental health disorders who are vulnerable to physical ill-health. The policy also reiterates the commitment to the mental health NSF and sets out some specific actions to help create employment opportunities and other measures aimed at reducing social exclusion of those with mental health disorders.

In primary care, financial incentives have been introduced for GPs to undertake annual health checks for people with mental health disorders (Dept. of Health, 2006b). These include checks related to alcohol and drug use, smoking and blood pressure, cholesterol (where appropriate), BMI, risk of diabetes from antipsychotic drugs, cervical cytology (as appropriate) and accuracy of medication. Analysis of the first year of the contract shows that 76% of practices reported having carried out such checks to at least 90% of their patients with mental health disorders (who had agreed to be included on the practice register) (DRC, 2006a).

Much of the policy action on reducing inequalities is currently targeted at geographical areas of high deprivation. Whilst this can benefit those with mental health disorders to some degree given that many people in this group live in poverty, general health promotion and treatment programmes may fail to adequately address their health and access needs "in passing" (DRC, 2006a). Indeed, new services such as walk-in centres and choice may leave them falling further behind as others are better equipped to exercise choice. Commentators note that there has been a failure to mainstream services, thus research for the DRC investigation found that health needs of people with mental health disorders often were “off loaded” onto specialist services rather than being addressed more appropriately through primary care (Samele *et al.,* 2006a).

The key recommendations from the DRC investigation focused on the requirement to ensure that governments acknowledge the specific needs of those with mental health disorders (and learning disabilities) and centrally target the needs of these groups in national health inequalities programmes, incentivising providers and performance managing them to ensure targets are met. Specific policies they wish to see activated include further incentives in the GP contract to deal with the needs of these groups; the strengthening of commissioning of services including the development of new service models and evidence based collaborations between primary care and voluntary or specialist services (e.g. community mental health teams and residential services); improve the evidence base about the health and needs of people with mental health disorders and develop specific treatment guidelines where needed, and improve training for health care professionals to be better equipped to deal with mental health care needs. Recommendations from a report based on a survey undertaken in London included the need for more coherent sources of information about services for users and professionals; more strategic commissioning of some services such as language support services and forensic services; and better measurement of outcomes amongst this group in order to assess the effectiveness of services (Greater London Authority, 2007).

It is important to consider the evidence of effectiveness of interventions aimed at improving the physical health of people with mental health disorders. There is little point in improving access to services that are ineffective and as many of the relevant interventions are in the area of health promotion, where evidence is often limited, this is an important consideration. The conclusions of a recent systematic review suggest that the organisation of services appear to be key factors in providing effective services (Samele *et al.,* 2006b). The review found evidence that locating a primary health care team close to mental health services with good links between primary care staff and mental health staff is highly effective in improving the physical health of those with severe mental health disorders. Other examples of integrated services with good links between primary care and secondary mental health services were also identified as being effective. Over the last three years, efforts have been made to develop a flexible, responsive workforce in the area of mental health and to initiate what are termed, “new ways of working”. A recent update suggests that substantial progress has been made, initially for psychiatrists, but now also embracing most other relevant professions (CSIP/NIMHE, 2007). The key theme in this initiative is to recognise the multi-agency and multi-disciplinary nature of mental health services and to develop a “Capable Teams Approach”. These are multi-disciplinary teams focused on supporting service users in self-management where possible and also supporting the voluntary sector and primary care by providing assessment, treatment and care navigation for those with more severe problems. This initiative has involved extensive collaborative work between NIMHE and all the professional bodies, as well as a wide range of carer and patient representatives.

In conclusion, quite a lot of effort has been made by government and non-government organisations to identify the range of general and specialist services that should ideally be made available for people with mental health disorders. However, evidence suggests that there are some apparent inequities in access to mainstream services for some physical health problems, between those with mental health problems when compared with individuals with similar physical problems but without mental health disorders. Availability of specialist mental health services is also apparently not distributed geographically according to need. These problems are fairly well recognised but some would argue that it is necessary to adopt targeted policies towards people with mental health disorders rather than expecting general policies aimed at improving access generally, to address adequately the needs of this group.

4.6 Conclusions

There is evidence that people with mental health disorders suffer worse physical health that those without such problems. There is also evidence of some inequities in access to general mainstream health services amongst this group. Access to preventive services appears to be a particular issue. The evidence suggests most access barriers experienced by this group are similar to those experienced by other groups of disadvantaged people who live chaotic lives. Additional barriers relate mostly to perceptions of stigma and discrimination and to the lack of specialist knowledge by the medical staff most likely to come into first contact with this group (e.g. GPs and primary care workers). Health professionals may also perceive, despite lack of evidence, that certain interventions are less successful for people with mental health disorders.

Research suggests that the organisation of services is key to the success of meeting the needs of this group, with integration, co-ordination, communication and seamless provision across health and social care sectors being of vital importance. Financial incentives to increase the number of physical health checks undertaken on people with mental health disorders, appear to be an effective approach to increasing utilisation of mainstream services.

Policy has focused on defining the range of services to which people with mental health disorders should have access (both general and specialist services). Two main issues have been the focus of policy: (a) geographically based policies aimed at improving access and inclusion for disadvantaged groups generally; (b) delivery options for mental health care, focusing on multi-agency and multi-disciplinary team work that addresses the complex needs of those with mental health disorders. In terms of social exclusion, much emphasis has been placed on providing greater opportunities for people with mental health disorders to participate in the workforce and in the community more generally and successful policies (such as the New Deal) have been rolled out to this group.

The Disability Equality Duty requires public authorities to produce Disability Equality Schemes that must indicate how progress towards closing inequality gaps will be monitored. The Secretary of State for Health in England the First Minister in Wales will be required to produce a report every three years from December 2008 on progress towards disability equality in the health sector.

5. Overall conclusions

Research evidence suggests that substantial inequities of access to some healthcare services exist for specific vulnerable groups. Barriers to access are identified on both the demand and supply side and seem particularly problematic in areas such as preventive care and health promotion. Those living chaotic lives and who find it difficult to organise the physical, social and financial resources to access services are most at risk.

The three groups considered in detail in this report (immigrants and asylum seekers; older people; and people with mental health disorders), all face difficulties in accessing services, often arising from problems navigating an entry point into complex services, especially where such services cross administrative and organisational boundaries. The situation of those living in institutions is seriously under-researched but the little evidence available suggests some serious inequities of access exist for this group when compared with those living in the community.

The report considers policy developments at two levels: overarching national policies to tackle social exclusion, most of which cut across a number of government departments; and specific, often local, initiatives aimed at improving access for each of the three groups. Whilst it is difficult to assess much of the policy development that has taken place at a small-scale local level, because robust evaluations do not exist, some key features of promising policy developments have been highlighted. In particular, policies aimed not just at increasing supply, but at supporting people in accessing services, through co-ordination, collaboration and integration, are likely to reduce the complexity of navigation through the system for disadvantaged groups. Providing a national context and framework within which local initiatives take place and incorporating financial incentives, are also important factors.

Finally, it is worth noting that despite the large volume of literature identifying barriers to access for many different groups, there is far less knowledge about the eventual impact of such variations in access on the health status of individuals. This is an important gap in the research evidence.

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Appendix 1. Brief details of literature search

The search was carried out by the Centre for Reviews and Dissemination at the University of York.

Identifying the relevant research literature involved adopting a number of differing and complementary approaches: electronic database searching; internet searching and citation searching.

The MEDLINE and HMIC databases were searched using a highly precise strategy. This seemed more appropriate given the time constraints of the project. The general, high level search strategy (which is outlined below) was supplemented with more focused searches for specific topic areas to ensure that research dealing with specific policy areas had been retrieved. So, for example, additional focused searches were conducted for the National Service Framework for Older People, costs of residential and nursing home care, and entitlement to health and social care by asylum seekers. This dual approach offered the benefit of not retrieving large numbers of irrelevant records but at the same time ensuring that key papers had not been overlooked.

Relying solely on database searches was not appropriate in this topic area as it would have risked not retrieving useful policy papers so internet was used as well. Focused scanning of websites was undertaken to identify policy papers produced by either central government or non-governmental organisations.

Citation searching was used to track papers which had referenced a number of previously identified key papers. This ensured that recently published material was included.

```
HMIC Health Management Information Consortium
Database: HMIC Health Management Information Consortium
Database coverage period <from inception to March 2007>
Search Strategy:
--------------------------------------------------------------------------------
1    (equity adj2 access adj health$).mp. [mp=title, other title, abstract, heading words] 2    (equality
adj2 access adj health$).mp. [mp=title, other title, abstract, heading words]
3    (barrier$ adj2 access adj health$).mp. [mp=title, other title, abstract, heading words]
4    (gap$ adj2 access adj health$).mp. [mp=title, other title, abstract, heading words]
5    or/1-4
6    health action zone$.mp. [mp=title, other title, abstract, heading words]
7    health improvement program$.mp. [mp=title, other title, abstract, heading words]
8    5 or 7
9    limit 8 to yr="2000 - 2007"
```

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MEDLINE
Database: Ovid MEDLINE(R)
Database coverage period <1996 to March Week 2 2007>
Search Strategy:
--------------------------------------------------------------------------------
1    health services accessibility/
2    delivery of health care/
3    ((access or barrier$ or gap or gaps) adj2 (health$ or care)).ti,ab.
4    1 or 2 or 3
5    Health Policy/
6    (policy or policies or programme$ or initiative$).ti,ab.
7    National Health Programs/
8    5 or 6 or 7
9    4 and 8
10    limit 9 to (research support, nih, intramural or research support, us gov't, non phs or research
support, us gov't, phs)
11    9 not 10
12    exp africa/ or exp asia/ or exp south america/
13    11 not 12
14    (england or united kingdom or britain).ti,ab.
15    england.cp.
```

16 great britain.cp.
17 united kingdom.cp.
18 uk.ti,ab.
19 14 or 15 or 16 or 17 or 18
20 13 and 19
21 nhs.ti,ab.
22 19 or 21
23 13 and 22

Appendix 2. Mental health – voluntary organisations in the UK (With brief descriptions from their websites.)

http://www.adapt-tynedale.org.uk/
Local charity which aims to improve the quality of life of people with sensory, mental health problems, physical and learning disabilities, their families and carers in the West Locality area (as defined by Northumberland Care Trust) to include the district of Tynedale and parts of Castle Morpeth. Services include advocacy, training, transport, PCV driver training, befriending, sports and leisure activities.

http://www.freewebs.com/aimhighpeakgroup/
A self-help group for service-users of Mental Health Services covering the High Peaks.

http://www.band.org.uk/
A voluntary mental health organisation committed to user-involvement at all levels. Provides social, recreatinal and educational activities for people with mental health problems. Westhoughton, Lancs.

http://www.artists-in-mind.org.uk/
AIM is a charity that supports artists suffering with enduring and acute mental health problems. We provide studio spaces, with artists materials, mentoring and professional support and development. We also facilitate and manage creative projects with patients in hospitals.

http://www.pastoral.org.uk/
APCMH is a Christian based, voluntary association of individual members and affiliated groups who recognise the importance of spiritual values and support in mental health. It has a network of supporters throughout the United Kingdom and it welcomes and encourages people whatever their own faith or belief system. Governed by its National Committee, APCMH is primarily concerned to promote and encourage "being alongside" (healing presence) with people experiencing mental or emotional

http://www.apni.org/
Provides support to mothers suffering from post-natal illness, increases public awareness of the illness, and encourages research into its cause and nature.

http://www.bhas.org.uk/
A voluntary sector agency based in Bristol which provides free information and advice about welfare benefits to people with long-term health problems. The web-site includes free guidebooks on welfare benefits for people with mental health problems.

http://www.befriendersbedsandluton.org.uk/
Offers support, in a social setting, to individuals who have or are recovering from mental health difficulties. Individual befriending on a one-to-one basis also offered.

http://www.befriending.co.uk/
National organisation for befriending. Offers supportive, reliable relationships through volunteer befrienders to people who would otherwise be socially isolated. Services include provision of information, projects, training and support.

http://www.bipolarscotland.org.uk/
The aims of Bipolar Fellowship Scotland are to provide information, support and advice for people affected by manic depression, and all who care; to promote Self-Help throughout Scotland to inform and educate about the illness and the organisation.

http://www.resourcedirectory.co.uk/
The project aims to provide sheltered voluntary work experience for individuals recovering from mental and emotional distress in order to enable them to be enter open employment if and when they choose to do so. Managed by Mind in Birmingham, an innovative mental health project run by a team of employed and voluntary staff, many of whom have personal experience of mental distress

http://www.mhist.co.uk/
Provides a friendly and confidential service to support and voice the interests of mental health service users and/or their carers. Services include:

- Counselling
- Craft social group
- Advocacy in the community
- Mental health “A-Z” directory
- Befriending (BRIDGES @ MhIST)
- Advocacy at the Bolton Royal Hospital
- Information and support for individuals
- Self help groups

http://www.borderlineuk.co.uk/
A national user-led network of people within the United Kingdom who meet the criteria, or who have been diagnosed with Borderline Personality Disorder (BPD) or, as it is often known in the UK, Emotionally Unstable Personality Disorder (Borderline Type).

http://www.brighterfutures.wel.sh/
User-run group for people whose lives are affected by mental health difficulties in Wrexham. It offers users drop in facilities, user representation and input into mental illness planning and provision, access to welfare rights and advocacy services, photocopying, computer and internet access, and point of contact for professionals and volunteers if needed.

http://www.bromleymhpartnership.org.uk/
Bromley Mental Health Partnership: Supporting Service Users and Carers. This site is designed to provide information to adults on mental health in the Bromley area.

http://www.thecalmzone.net/
Calm, the Campaign Against Living Miserably, raises awareness of depression amongst young men across Manchester, Merseyside, Cumbria and Bedfordshire. It was launched in response to the fact that suicide is the biggest killer of young men after road accidents. Working with big names from the music, sport and club scenes, calm encourages young men to 'open up' and sort out their problems.

http://www.cmhc.org.uk/
Camden Mental Health Consortium (CMHC) is the largest User Group in the London Borough of Camden. Its members are people who use or have used the Mental Health services and live or work in the Borough. Associate Members are people or organisations who for some reason have an interest in the Mental Health Services provided in the Borough and support the objectives of CMHC.

http://www.mdfwales.org.uk/
Offers help, information and support for people with manic depression (bi-polar affective disorder). The Group is made up of people with similar problems who meet together to share their experiences and knowledge on ways of coping. The group also provides support and the opportunity for people to meet in a non-threatening atmosphere. Area: Carmarthenshire.

http://www.cause.org.uk/
A Northern Ireland based charity providing peer-led emotional and practical support to carers and families of people with a serious mental illness. Services include Support Groups, a Helpline - 0845 60 30 291 - available 9.00am to 9.00pm 365 days per year, Carer Advocacy, Educational Programmes for carers and mental health professionals and Representation of Carers’ Views.

http://www.brad.ac.uk/acad/health/research/cccmh/index.php
The University of Bradford, and Bradford District Care Trust have established the Centre for Citizenship and Community Mental Health (CCCMH), with Drs. P. Bracken and P. Thomas (Consultant Psychiatrists Bradford Home Treatment Service and Assertive Outreach Service) and Mr. Simon Gelsthorpe (Consultant Clinical Psychologist / Honorary Visiting Senior Research Fellow). The centre is informed by a conceptual and philosophical critique of mental health practice that prioritises social, cultural and political contexts, and has an ethical rather than technical orientation. In practice, this means that the centre's academic work focuses on the health inequalities and social exclusion

experienced by ethnic communities and service users. The centre is using a Community Development model to build alliances and partnerships with ethnic communities and service user groups (locally and nationally) as a means of tackling social exclusion and health inequalities. This ethos, of philosophical critique and action through community development, lies at the heart of the CCCMH.

http://www.ccmh.uce.ac.uk/
The Centre for Community Mental Health works to improve services and life opportunities for people with severe and enduring mental health problems. The Centre concentrates on tackling social exclusion and the development of innovative approaches to service provision through training, education and research. The Centre supports policy and service development for mental health services in the U.K. It is part of a network of international expertise in practice and service innovation.

http://www.changes.org.uk/
CHANGES is a user-led mental health charity providing a recovery service to those in mental distress, based on users attending weekly mutual help groups and following CHANGES 12 step recovery programme, (developed from users own experience in recovering from mental distress).

http://www.cmha.org.uk/
Charity which exists to preserve and safeguard the mental health of people of Chinese ethnic origin.

http://www.cnhlc.org.uk/
We aim to promote healthy living, and to provide access to health services, for the Chinese community in the UK. The Centre takes an holistic approach, tackling both the physical and psychological aspects of health.

http://www.cliffordbeersfoundation.co.uk/
UK charity devoted to the promotion of mental health, they have developed a range of initiatives and collaborative ventures with colleagues throughout the world. Initiatives include the International Journal of Mental Health Promotion was the first such publication in this field and the Annual European Conferences have developed to become the World Conferences on the Promotion of Mental Health and Prevention of Mental and Behavioural Disorders.

http://www.combatstress.org.uk/
COMBAT STRESS, The Ex-Services Mental Welfare Society is the only charity dedicated to giving care, comfort and reassurance, backed by skilled clinical support, to men and women of all ranks and all Services suffering from varying degrees of mental illness as a result of traumatic battle experiences.

http://www.cmh.org.uk/
Concern for Mental Health is a Voluntary Sector Organisation providing Day Services to those adults living in south Kirklees who have severe enduring mental health problems.

http://www.creativesupport.co.uk/
A specialist independent provider of mental health services, Services include supported living, rehabilitation and home care. Also provides services for people with learning disabilities.

http://www.crosswayscommunity.org.uk/
Crossways Community is a Christian charity caring for people with mental health difficulties.

http://www.depressionalliance.org/
A leading UK charity for people with depression. It works to relieve and to prevent this treatable condition by providing information, support and understanding to those who are affected by it. They also campaign to raise awareness amongst the general public about the realities of depression. A member-led organisation, DA co-ordinate a national network of self-help groups so that people with depression can share experiences and coping strategies with others in similar situations.

http://www.turning-point.co.uk/
Turning Point is a charity with services in 200 locations across England & Wales working in the areas of drug and alcohol misuse, mental health and learning disability. They also campaign on the issues that affect their service users to ensure that their voices are heard by government, policy makers, the

media and the general public. Durham Support is a residential scheme for people with learning disabilities and complex needs.

http://members.lycos.co.uk/jiggeryqua/elig/
A voice on mental health services: Speaking up for mental health service users in East Lothian Speaking out against stigma and discrimination Working in partnership with the service providers Showing where there are gaps in mental health services

http://www.comcarenet.co.uk/eise/
The EISE Project is for people who have at some time experienced a mental health problem and who live in Manchester, Salford or Trafford. The EISE Project helps people access information about Employment, Education and Voluntary Work.

http://www.erewashmentalhealth.org.uk/
Provides support and assistance to individuals experiencing and recovering from mental health problems. Aims to be supportive via a process that involves a variety of activities designed to raise self-esteem, confidence and morale. These include Information Technology, Art, Cookery, Relaxation and Confidence Building, Aromatherapy, Reflexology, Complimentary Therapies, Badminton, Table Tennis, Line Dancing, Keep Fit and occasional visiting speakers.

http://www.federationmentalhealth.co.uk/
The Federation is open to people in Derbyshire Dales North who have mental health problems and those who have a common interest in the promotion of mental health and alleviating social and personal stress. The area is bounded by Edale to the north, Tansley to the east, Cromford to the south and Chelmorton to the west.

http://www.depressionanon.co.uk/
National association of people with experience of depression or suicide. For those with depression, their partners, families and friends.

http://www.flourishhouse.org.uk/
Flourish House is a Clubhouse located in the Woodlands area of Glasgow and is a community based rehabilitation project for people experiencing severe or enduring mental health problems.

http://www.gamh.org.uk/
The Association pursues aims which are primarily concerned with the health, social welfare, and the attainment of social justice, for people with mental health problems and their carers, who live in the Glasgow area. The Association exists, to provide high quality care and support services to adults with mental health problems and their carers; to promote understanding of mental health and mental illness; and to enalbe users of services and their carers to have a voice in the wider community,

http://www.hearing-voices.org
charity which works to relieve the distress and meet the needs of people with mental health problems, who are voice hearers, by promoting the development of Hearing Voices Support. To advance education through training and research, including training workshops, availability of training packs and the publication of any appropriate research.

http://www.hafal.org/
Hafal (meaning 'equal') is the principal organisation in Wales working with individuals recovering from severe mental illness and their families. Launched in April 2003, they are a new organisation managed by the people they support - individuals with severe mental illness and their families. Providing support across all 22 local health board areas of Wales, Hafal is dedicated to empowering people with severe mental illness and their families to: achieve a better quality of life

http://www.health-in-mind.co.uk/
Health in Mind was established in 1981 under the name of Edinburgh Association for Mental Health. In June 2003 they changed their name to Health in Mind to reflect the intention of the organisation to include the wider issues of wellbeing within its activities. Health in Mind is a limited company under guarantee with charitable status.

http://www.mentalhealthleeds.info/
Information for Mental Health (IMH) is a partnership between Leeds Mind and Leeds Social Services. They provide resources and information that aim to help people make informed choices about their lives and mental health, and to help professionals and carers supporting them to do so more imaginatively and effectively. They also carry out a range of mental health promotion work.

http://www2.jewishcare.org/
Jewish Care is a voluntary organisation operating in London and the South East. Jewish Care offers a variety of services including community psychiatric assessment by professional staff trained in mental health services. Jewish Care also runs two mental health hostels, group homes, day centres, employment projects and evening social clubs. Jewish Care provides a number of support services for 18-65 year olds. These include carer support groups, social work and counselling services, and advice

http://www.musicworkshop.org.uk/
The Music Workshop Project is a scheme in Kidderminster, England, which aims to help people with mental health problems by involving them in various music-based activities. The project, one of the 1998 winners at the prestigious Lilly Schizophrenia Reintegration Awards has also released its own CD for sale to the public.

http://www.geocities.com/knowsleymind/
Describes itself as a democratically organised group of mental health services users and carers based in the Knowsley Metropolitan Borough area near the city of Liverpool, with many associate members elsewhere on Merseyside.

http://www.lampdirect.org.uk/lamp/
LAMP is a voluntary sector mental health organisation working throughout Leicester, Leicestershire and Rutland. They work independently from Health and Social Services and provide advocay and advice & information services. LAMP's aim is to promote good mental health for all and we believe that those who use mental health services, and their families and friends, should have a say in the way services are planned and run.

http://www.leeds.ac.uk/lpop/
Dedicated to improving the care of older people with mental health problems in general hospitals. Provides background information explaining what liaison psychiatry services for older people are, why they are needed and what they do, along with information, about current developments and news and views from others interested in this area of care.

http://www.ctono.freeserve.co.uk/
Mad Pride

http://www.makingspace.co.uk/
Advice and support for people with schizophrenia or enduring mental illness, their families or carers. Provides advice on mental health and benefits. Network of family support workers across northern England. Self help groups. Day centres. Befriending schemes. Help for carers. Training. Sheltered employment shemes. Holidays. Provides residential care.

http://www.mdf.org.uk/
Self-help organisation for people with manic depression, their relatives and friends. Has a network of 150 support groups. Quarterly journal, factsheets and publications available.

http://www.mentalhealthalliance.org.uk/
The Mental Health Alliance is a coalition of 80 organisations which share common concerns about the Government's proposals to reform the Mental Health Act (1983). Mental Health Alliance membership Core members: Afiya Trust; AWAAZ (Manchester); British Association of Social Workers; British Psychological Society; Critical Psychiatry Network; Ethnic Health Forum North West; GLAD; King's Fund; Maca; Manic Depression Fellowship; Mental Health Foundation; Mental Health Nurses Association; etc!

http://www.cobwebs.uk.net/mhm
Mental Health Charity providing: drop-in centre; information service; housing service; community advocacy; training and education; lobbying and campaigning.

http://www.mentalhealth.org.uk/
Mental Health Foundation. “Maintains an extensive directory of organisations and websites that deliver mental health services or offer support and information. These organisations and websites cover international, national and local services.”

http://www.mentalhealthsupport.co.uk/mentalhealth/
Mental Health Support is a website aimed at service users, health professional and carers, providing information about mental health news and issues and services available to people locally and nationally. The website is a partnership between Rhondda Cynon Taf county council and New Horizons Mental Health Resource Centre. The website houses a mental health forum which is moderated and updated on a daily basis.

http://www.mindfreedom.org/
MindFreedom. MFI vision: Unite in a spirit of mutual cooperation for a nonviolent revolution in mental health. MFI is an independent nonprofit coalition defending human rights and promoting humane alternatives in mental health. While the majority of MFI members have personally experienced mental health system abuse, membership is open to all who support these goals.

http://www.yorkmind.org.uk/
A local association of Mind, a mental health charity in England and Wales, working for a better life for everyone with experience of mental distress. Covers York and district. Range of services for people experiencing mental health problems and their families and carers. Information line. Advocacy service. Counselling services. Support for user led groups. Also provide supported housing. [Many local branches of MIND have their own websites; this is one example.]

http://www.nsfscot.org.uk/
National Schizophrenia Fellowship (Scotland) works to improve the wellbeing and quality of life of those affected by schizophrenia and other mental illness, including families and carers.

http://www.nopanic.org.uk/
No Panic is a totally voluntary charity, whose aims are to aid the relief and rehabilitation of those people suffering from panic attacks, phobias, obsessive/compulsive disorders, other related anxiety disorders, including tranquilliser withdrawal, and to provide support to sufferers and their families and or carers.

http://www.niamh.co.uk/
Charity which provides a wide range of services for people with mental health problems throughout Northern Ireland. Services include:

- Local self help groups
- Day centres
- Housing support
- Residential accommodation
- Advocacy
- Mental health promotion
- Information service
- Employee assistance programmes

http://www.keme.co.uk/~oldfox/ofox.htm
Old Fox House is a Clubhouse, located in Stowmarket, Suffolk, U.K. Old Fox House is a community-based rehabilitation day programme for people experiencing severe or enduring mental health problems. Members of Old Fox House work in partnership with staff in the work ordered day, undertaking all the work and making all the decisions necessary to operate the Clubhouse. There is also an opportunity to participate in a supported employment scheme, known as Transitional Employment (T.E.).

http://www.papyrus-uk.org/
A voluntary organisation committed to the prevention of young suicide and the promotion of good mental health and emotional well-being. Provides resources and support for those dealing with suicide, depression or emotional distress – particularly teenagers and young adults. Also home for HOPELineUK, a service staffed by professionally qualified advisers who can give support, practical advice and information to anyone who is concerned that a young person they know may be suicidal.

http://www.panicattacks.co.uk/
Personal/commercial information and advisory service for people who experience panic attacks, phobias and anxiety.

http://www.penumbra.org.uk/
National voluntary organisation providing a range of community based support services for people with mental health problems.

http://www.rcmh.org.uk/
A local charity which provides a range of services to people with mental health problems and their carers in the London Borough of Redbridge. It plays an integral role in coordinating the consultation and responses from other local voluntary sector groups on issues such as legislation, and local service delivery. Services include:

- A Drop-in Centre
- A Befriending Scheme
- A User Forum
- An Employment Project

http://www.resource.uk.net/
A service for people with mental health problems who live or work in Reading, with opportunities for work and a place to socialise. Provides a service with opportunities for members to learn new skills eventually leading to employment in the field they have chosen.

http://beehive.thisiscornwall.co.uk/default.asp?wci=sitehome&id=5183&pageid=26190
Promotes mental health in the rural communities of Restormel in Cornwall. Services include support groups away from the town centres; information base; twice yearly newsletter; a supported housing scheme. RCL is a project of Restormel Association for Mental Health.

http://www.rethink.org/
Rethink is the leading national mental health membership charity. It works to help everyone affected by severe mental illness recover a better quality of life. We provide hope and empowerment through effective services and support to all those who need us and campaign for change through greater awareness and understanding.

http://www.revolving-doors.co.uk/
The Revolving Doors Agency is the UK's leading charity concerned with people with mental health problems in contact with the Criminal Justice system. Since March 1993 they have worked in partnership with the Police, Health, Housing, Probation and Social Services in London to research the needs of this very vulnerable group and improve their access to care and housing.

http://www.richmondfellowship.org.uk/
Richmond Fellowship. One of the biggest providers of mental health care in England and Wales. 'Every year, we work with thousands of people who are living with the devastating effects of serious mental health problems, often exacerbated by issues such as sexual abuse, or drugs and alcohol. RF helps people to gain a new sense of purpose and fulfilment, making a massive contribution to the lives of our service users.'

http://rootandbranch.info/
Root and Branch. Located in an organic farm, this charity aims to provide recreational and theraputic opportunies for people with mental health difficulties in organic farming; conservation and other land based art and craft activites. The charity aims to develop employment opportunities; build confidence and create social networks for people to facilitate recovery.

http://www.scmh.org.uk/80256FBD004F6342/vWeb/wpKHAL6S2HVE
Sainsbury Centre for Mental Health. An independent charity that seeks to influence mental health policy and practice and enable the development of excellent mental health services through a co-ordinated programme of research, training and development.

http://www.sane.org.uk/public_html/index.shtml
SANE. One of the UK's leading charities concerned with improving the lives of everyone affected by mental illness. SANE has three objectives:

- to raise awareness and combat ignorance about mental illness and to improve mental health services
- to provide care and support to anyone concerned about mental illness
- to initiate and fund research into the causes, treatments and potential cures for schizophrenia and depression through its work at the SANE Research Centre in Oxford

http://www.sagb.co.uk/
Schizophrenia Association of Great Britain. The SAGB was the first Association for schizophrenia to be formed in the UK, was one of the first in the world and now has members all over the world. They offer help to everyone who needs information and support, as a sufferer, a relative friend of a sufferer, carer or medical worker.

http://www.samh.org.uk/frontend/index.cfm
Scottish Association for Mental Health. The leading mental health organisation in the voluntary sector in Scotland. They have acquired considerable experience, since the mid eighties of developing successful community care services and of working collaboratively with a range of statutory agencies. From the early development of training projects and supported accommodation, SAMH now provides a wide range of direct services to over 2300 people throughout Scotland.

http://www.sdcmh.org.uk/
Scottish Development Centre for Mental Health. The Scottish Development Centre for Mental Health is a not-for-profit organisation dedicated to the continuing development and improvement of mental health services in Scotland. The Centre offers local development support to agencies, organisations and individuals who wish to achieve acceptable, effective and sustainable local mental health services. Their website provides information about the centre, including lists of briefing papers and other publications, information about research, etc.

http://www.soundminds.co.uk/
Sound Minds is a day service for people with enduring mental health problems, focused on popular music and other arts activities. The arts are used to project positive images to the wider community, through performances and exhibitions, counteracting negative stereotypes of mental ill health Sound Minds attracts regular local and national media coverage. The majority of Sound Minds employees are mental health service users.

http://www.startmc.org.uk/
Start in Manchester: Arts and Mental Health Project for Adults. Start helps people who have experienced mental ill health to get back on the road to recovery. They use art as a tool to rebuild and reinforce good mental health. Their core philosophy is that everyone, given the right support, has the potential to succeed. Part of Manchester Mental Health and Social Care Trust, Start uses a person-centred approach to help its clients (students) learn new skills, regain self-confidence, and move on to futures of their choice.

http://stresshelp.tripod.com/
Stress, Anxiety and Depression Confidential Helpline. A voluntary, self-help organisation run by qualified health professionals who also suffer with anxiety and depression. Their mission is to advise people who are suffering stress, anxiety, depression and to help to destigmatise mental health.

http://www.stresswatchscotland.org/
Stresswatch Scotland helps people with stress-related disorders including Panic Attacks, Phobias and Anxiety.

http://www.thresholdwomen.org.uk/
Threshold is a Brighton based women's organisation which was set to protect women's mental health, to promote better mental health services for women and to provide women's mental health care. Services include Counselling; Drop Ins; National Women and Mental Health Infoline; Self Help Groups; Training; Crèches; Creative projects and events aimed at promoting women's positive mental health and well being; Conferences.

http://www.together-uk.org/servicesproject.asp?id=250
Together: Ailsa Road Registered Care Home. Registered care-home for people with mental health problems run by Together (a national voluntary organisation providing services for people with serious mental health problems) in partnership with South Essex Health Authority. The service provides a supportive home for residents, all of whom have their own rooms. Seven staff work at the house, with at least two social-care workers on duty during the day, and one sleeping in each night.

http://www.together-uk.org/?id=2661
Together: Ealing Forensic Mental-health Practitioner. Forensic mental-health Practitioner who will assess and refer people who have had contact with the criminal-justice system. Run by Together, a national voluntary organisation, in partnership with the London Probation Service and Ealing Magistrates' Court. Referrals accepted from Probation Workers, Court Workers, voluntary agencies working within the court system, community drug services and psychiatric services. The Service works with individuals who have a mental-health need.

http://www.together-uk.org/servicesproject.asp?id=146
Together: Lancaster and Morecambe Supporting People Service. Community-support services offer practical and emotional support to people with mental-health problems in their own homes. Run by Together, a national voluntary organisation in partnership in running this service Lancashire County Council Supporting People Team.

http://www.zitotrust.co.uk/
Zito Trust. National charity which was established to work for improvements in the provision of community care for people with severe mental illness, to support the victims of the failure of care and to carry out research and training in this field.

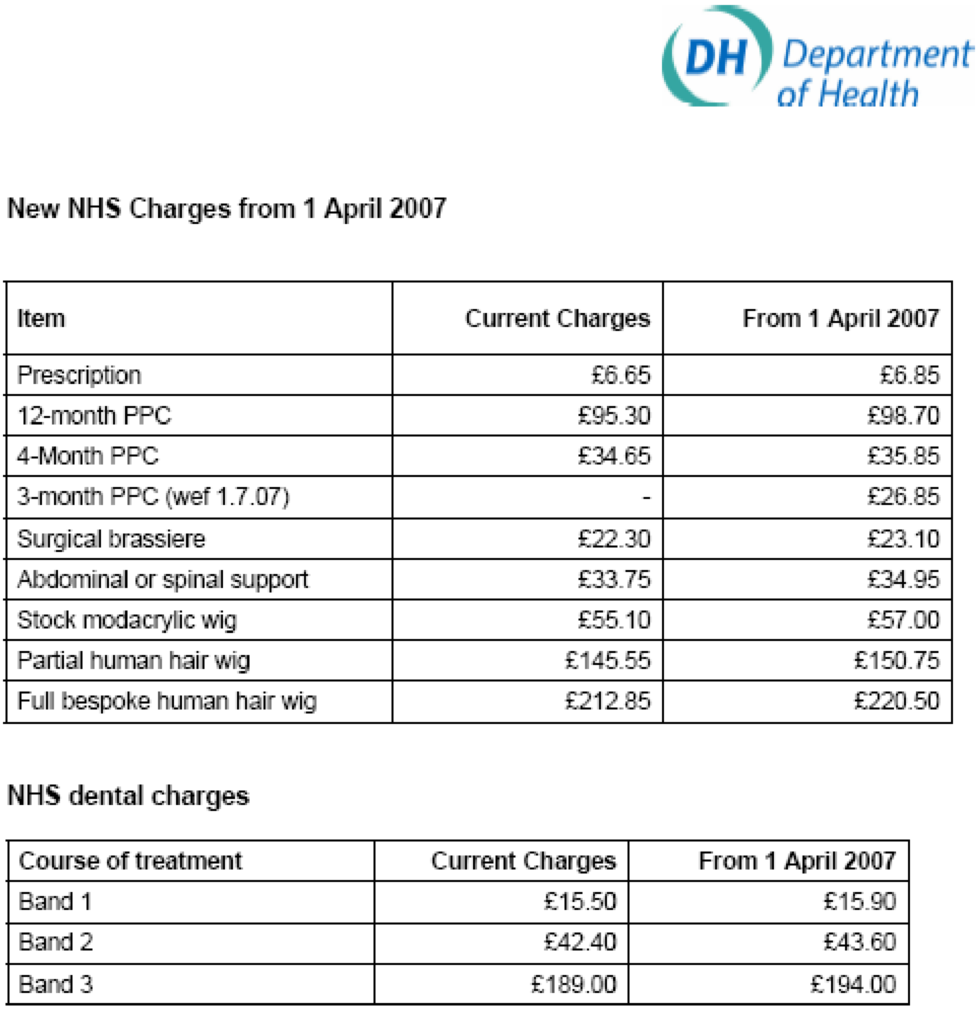
A Government sponsored organisation:

www.shift.org.uk
Shift is a five year initiative (2004-2009) in England to tackle stigma and discrimination surrounding mental health issues. Their work is set out in a plan called "From Here to Equality". Their aim is to create a society where people who experience mental health problems enjoy the same rights as other people.

To work towards this, they work with young people, public services, private, voluntary and professional organisations, and the media, drawing on expertise in public health and mental health promotion, communications, disability rights, service redesign, research and evaluation. Shift builds on the *mind out for mental health* campaign, which ran from 2001 to April 2004.

Shift is part of the National Institute for Mental Health in England (NIMHE), a Government organisation that is responsible for supporting positive change in mental health and mental health services.

Appendix 3. Prescription charges: England



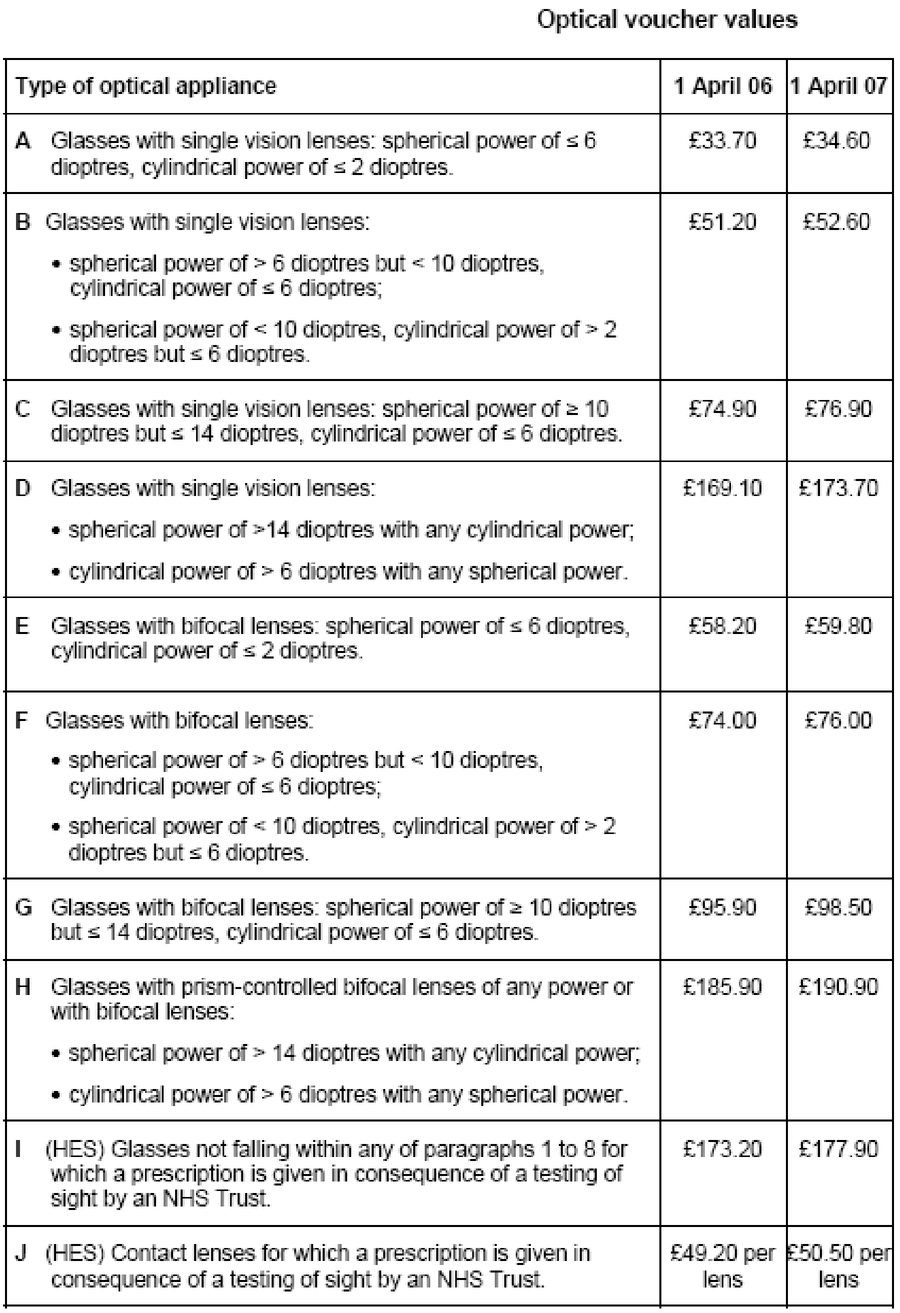
Department of Health

New NHS Charges from 1 April 2007

Item	**Current Charges**	**From 1 April 2007**
Prescription	£6.65	£6.85
12-month PPC	£95.30	£98.70
4-Month PPC	£34.65	£35.85
3-month PPC (wef 1.7.07)	-	£26.85
Surgical brassiere	£22.30	£23.10
Abdominal or spinal support	£33.75	£34.95
Stock modacrylic wig	£55.10	£57.00
Partial human hair wig	£145.55	£150.75
Full bespoke human hair wig	£212.85	£220.50

NHS dental charges

Course of treatment	**Current Charges**	**From 1 April 2007**
Band 1	£15.50	£15.90
Band 2	£42.40	£43.60
Band 3	£189.00	£194.00



Optical voucher values

Type of optical appliance	1 April 06	1 April 07
A Glasses with single vision lenses: spherical power of ≤ 6 dioptres, cylindrical power of ≤ 2 dioptres.	£33.70	£34.60
B Glasses with single vision lenses: • spherical power of > 6 dioptres but < 10 dioptres, cylindrical power of ≤ 6 dioptres; • spherical power of < 10 dioptres, cylindrical power of > 2 dioptres but ≤ 6 dioptres.	£51.20	£52.60
C Glasses with single vision lenses: spherical power of ≥ 10 dioptres but ≤ 14 dioptres, cylindrical power of ≤ 6 dioptres.	£74.90	£76.90
D Glasses with single vision lenses: • spherical power of >14 dioptres with any cylindrical power; • cylindrical power of > 6 dioptres with any spherical power.	£169.10	£173.70
E Glasses with bifocal lenses: spherical power of ≤ 6 dioptres, cylindrical power of ≤ 2 dioptres.	£58.20	£59.80
F Glasses with bifocal lenses: • spherical power of > 6 dioptres but < 10 dioptres, cylindrical power of ≤ 6 dioptres; • spherical power of < 10 dioptres, cylindrical power of > 2 dioptres but ≤ 6 dioptres.	£74.00	£76.00
G Glasses with bifocal lenses: spherical power of ≥ 10 dioptres but ≤ 14 dioptres, cylindrical power of ≤ 6 dioptres.	£95.90	£98.50
H Glasses with prism-controlled bifocal lenses of any power or with bifocal lenses: • spherical power of > 14 dioptres with any cylindrical power; • cylindrical power of > 6 dioptres with any spherical power.	£185.90	£190.90
I (HES) Glasses not falling within any of paragraphs 1 to 8 for which a prescription is given in consequence of a testing of sight by an NHS Trust.	£173.20	£177.90
J (HES) Contact lenses for which a prescription is given in consequence of a testing of sight by an NHS Trust.	£49.20 per lens	£50.50 per lens

Appendix 4. ‘Stakeholder’ consultation

The relevant extract from the draft report was sent to a small selection of non-government organisations. They were asked for general comment and feedback and also to indicate whether they felt the sections describing policy initiatives and summarising “what works”, were accurate and comprehensive.

Initial letters were sent in August 2007 and one reminder was sent to non-responders in September 2007. A response was received from all but one organisation (Shaping Their Lives) and comments were taken into account, as appropriate, in the final version of the report.

Organisations Consulted

Shaping Our Lives	Ms Fran Branfield
Refugee Action	Mr Mike Brown
Age Concern, England	Mr Philip Hurst
Refugee Council	Mr Andy Keefe
Rethink	Dr Vanessa Pinfold
Help the Aged	Ms Elizabeth McLennan
MIND	Ms Emily Wooster