An Accessibility Of Health Care Services In Sheffield

1.1 ACCESS TO HEALTH CARE

Accessibility to health care in this study will focus on the investigation of whether people have easy access to health care services in Sheffield. Joseph and Phillips (1984, p52) expressed that the availability of services does not essentially warrant the use nor does the use of the same amount of health care warrants a population of evenly healthy individuals in a society, is one statement that stresses the importance of even distribution of health care facilities in a given geographical environment, hence factors which hinder an individual's access to these health centres are the major concern of this research..

There are different ways of defining equity, in a study Joseph and Phillips (1984, p51) stated that equity is taken to be the same as equality, thus equity in health care provision really matters as such a pure equity approach would require a focus on health outcomes, that is the availability of health care services in an equal manner that will evenly serve the population of a given area is of paramount importance which will in turn provide an equitable and accessible health care system for all.

Cox and Reynolds, (1974) expressed concern over health care issues as cited byJoseph and Phillips (1984, p52), that health care as a major part of public services is not equally accessible to all persons and this is due to the reason of health care not being a pure public good, thus one of the main cause for public services being impure is geographical in nature which has to do with the actual location of these services across space of the environment.

In their study, Dear 1974; Messam 1975 as cited by Joseph and Phillips (1984)explained the reasons for services being impure as geographical in nature, is that the need for public services originates from individuals who in total are continuously i.e. unevenly dispersed across space of the geographical environment, while majority of public services are spread from distinct facilities within permanent location, therefore even accessibility would exist only if every individual had direct and endless possible access to facilities supplying needed services in a given geographical area.

It is believed that the provision of services in a given area is a requirement for accessibility of individuals or groups to the needed services in that area. Therefore factors of geographical location of facilities would not be of great concern if services are accessible (Joseph and Phillips, 1984).

Donabedian (1973) expressed his concern over the factors that affect access to health care supply which are grouped as socio-organizational and geographic factors, in which

he stressed that the socio-organizational factor which affects health care accessibility is taken from the attributes services which entail cost, intake policy, and specialization of the provider of health care service. This will give an increase to different access to health care on the part of individuals or group of people in a given society. In addition to the socio-organizational factor which affects accessibility to health care, it is stressed that the social class, living standards, services rendered by the health centre are of utmost importance in the provision of health care accessibility.

More so, Ambrose (1977), Mosley (1979), Phillips and Williams (1984) as cited by Joseph and Phillips (1984) expressed their concern over the meaning of effective accessibility which involves the following:

- To whether a particular health care facility is always available or open or
- Whether it is communally or financially available to people
- And whether a person's time or distance to the facility permits him to use the services provided by the health authorities concerned.

That is effective accessibility stresses if an individual's has access to certain health care facilities within easy reach without any barriers ranging from transports, distance to a health centre or any economic barriers.

The economic barrier depends mainly on the nature of the health care system. The economic factor in health care accessibility is obviously of great importance, because it is the financial possessions of individuals and communities that greatly determine the nature and quality of health care that an individual is likely to obtain in a given society. As such the economic barrier tends to decide on the quality and standard of care an individual will get in a health centre, this will be a factor that will affect health care accessibility in the given environment in cases where it is only the affluent in the society that tend to have effective access to health care facilities. While the low income earners find it difficult to get access health care facilities in the community, (De vise, 1973).

Although Beck (1973) takes a different view by expressing his concern over elimination of financial barriers as cited byJoseph and Phillips (1984),that the removal of financial or economical barriers will result in equitable access, in addition the absolute importance no matter the size of the population, is that since health care can be affordable and accessible by any individual which in turn will promote health care accessibility. The complete relevance of geographical factors affecting accessibility would also depend upon the geographic separation of these health care facilities and possible consumers and also the consumer's mobility to the health centre.

1.2 HEALTH CARE IN THE UNITED KINGDOM

The most broadly researched and best documented health care scheme in the world is the National Health Service (NHS), the NHS came into existence from the identification

that access to health care was not equal for all and neither where health care resources evenly or rightly distributed across the environment, in addition the NHS bill became law in 1946 and the NHS began existence in 1948, (Joseph and Phillips, 1984, p17).

The NHS decree was established on four important ideologies which remain significantly unchanged today. The first important principle driving the NHS is ‘comprehensiveness' that is the NHS is primarily aimed to meet identified medical needs and condition to individuals, the second important principle was ‘universality' that is the medical services was rendered free to all residents and legal visitors without further requirements, and thirdly it is believed to be of ‘collective financing' obtained from general dues (taxation) instead of charges to users of the health care services, the final important principle guiding the NHS is ‘professional independence' which is applicable to the medical groups in the medical services,(Joseph and Phillips,1984).

All the above narrated important principles guiding the NHS are aimed towards provision of accessible health care system by the resident, as such the role of health care accessibility is of great importance since the NHS came into existence from the identification for the need of the provision of access to health care for individuals which is not equal for all and there was no even distribution of these health care facilities across space.

1.3 STRUCTURE OF THE NHS IN ENGLAND

According to Ham (2004, p15) explains that the structure of the NHS (National health scheme) was a sign of what was possible rather than what have been desirable, he further stressed that the executive council of the NHS was appointed by partly the local professionals, partly by local authorities and partly by the ministry of health and they where funded directly from the ministry of health, the executive council where not management bodies, thus they simply administered the contracts of family practioners (GP, dentist, opticians, and pharmacist).The local authorities where responsible for health services ranging from maternity and child welfare clinics, health visitors, midwives, health education, vaccination and immunization. The funding of the local health authorities services was provided partly by central government grant and partly by revenue raised by local authorities.

In addition, hospitals where administered by wholly new bodies that is the regional hospital boards (RHB), the hospital management committees (HMC) and board of governors. The regional hospital boards (RHB) were appointed by the ministry of health and which in turn appointed the hospital management committee, thus the finance for the hospital services was from the ministry of health through (RHB) and on to the (HMC).

Hence, with all these outlined services by the NHS, the provision of accessible health care is still a pending issue in most areas of the country.

Ham (2004, p53) believed that for the vision of the new NHS, identified new NHS policy principles behind the government plan which include:

- To renew the NHS as a genuinely national service
- To make the delivery of health care against these new national standards a matter of local responsibility
- To get the NHS to work in partnership
- To drive efficiency through a more thorough approach to performance and by cutting bureaucracy
- To shift the focus onto quality of care so that excellence is guaranteed to all patients
- To rebuild public confidence in the NHS.

However, with the invention of these new health policy principles the is still perceived gaps in NHS care which in turn affects accessibility to health care.

1.4 CANCER CARE

Since the research is going to look at CancerCare in Sheffield, and also find out if there is even distribution of health care facilities, as such Cancer Services is of utmost consideration in this research that is having information about a sample cancer health care facility for determining accessibility of patients to these health care centres. In addition, the location of these health care facilities in relation to population size of an area is an important determinant of easy access to health care facilities.

According to Abbott et al (2004, p34) the NHS Cancer plan which was published in July 1999, is established to set out the first comprehensive national Cancer programme for England, with its aims outlined below:

- To save more lives
- Ensure people with cancer get the right professional support and care as well as the best treatment
- Tackle inequalities in health, for example where unskilled workers are twice as likely to die from cancer as professionals
- Build for the future through investment in the cancer workforce, through strong research and through preparation for the pharmacogentics being developed.

This comprehensive national cancer care programme provides a complete strategy for bringing together prevention, screening, diagnosis, treatment and care for Cancer, and the venture required in delivering these Cancer Care services towards provision of improved staffing, equipments, drugs, treatment, and information systems. Thus, all these services are vital for evaluating whether health care services are reaching the population in a given area.

The Cancer plan has three new commitments amongst which are:

- In addition to the smoking kills' target of reducing smoking in adults from 28% to 24% by 2010, as such new national and local targets will be set to tackle the gap between socio-economic groups in smoking rates and the consequential risk of Cancer and heart diseases.
- The reduction of smoking among manual groups from 32% in 1998 to 26% by 2010 and also the setting of local targets making explicit, what this means for 20 health authorities with highest smoking rates.
- Improved goals and targets to reduce waiting times for diagnosis and treatment, so that no one should wait longer than one month from an urgent referral for suspected Cancer to the beginning of treatment except for a good clinical reason or through patients' choice.

In their study Abbott et al (2004, p34) expressed their concern over the post code lottery of health care, that is majority of Cancer patients receive excellent treatment, however the health care services for Cancer patients are inconsistent, that is too much equipments are out of date and insufficient, and the NHS has too few Cancer specialists of every type of Cancer case.

In addition patients in different parts of the country receive varying quality and type of treatment, which in turn will result to different experience of cancer care by patients that is with some form of variability, in instances where some patients say they receive excellent care while others report being given bad news in a deeply incentive way, and also being left in the dark about their condition and poorly informed about treatment and care.

According to Abbott et al (2004) by 2006 there will be about 1000 extra Cancer specialist, more radiographers, more nurses and targeted actions to respond to shortages of other staff who contribute to Cancer diagnosis and treatment, and also there will be more accessible information to help recognize signs and symptoms that could be Cancer in order for the patients to seek medical advice early. Based on all the above mentioned statistical figures for proper health care delivery, easy access to health care is not properly addressed to which forms the basis of this research.

2.0 METHODOLOGY

“The aim of this research is to investigate whether people have easy access to location based health centers in Sheffield”. The major focus is on, what is taken to be, an important existing example of access to health care and relates this to a proxy measure of deprivation and need. Access to health care for patients and their families with cancer encompasses the use of treatment and care ranging from palliative treatments, symptom control, and the general delivery of health care that enables comfort for individuals.

This work therefore extends information available relating to accessibility to health care for different group of people most especially those with cancer in Sheffield and also examine equity of access to care provided by, voluntary, community, secondary and primary care services and extends the focus on health care access of resource allocation to ease access to health care for a specific disease area across a variety of health care providers.

In addition access to health care is a complex concept with many dimensions, it therefore cannot possibly be monitored by a small number of "high level" indicators, in particular, as well as data about utilization of health services, data are needed on resources available for care, the characteristics of the geographical areas for which services are provided, the health of the population and the socio-economic characteristics of groups within the population Macfarlane A. (2009).

2.1 LONG TERM LIMITING ILLNESS

Information is readily available about the users of health care services and also on details generated by registration processes such as births and deaths, but there is little information about general health of the whole population of a given area. Some of the sources and issues surrounding information about those making contact with health services are important in finding out if people have easy access to health care facilities.

In their study Payne, N and Saul, C (2000) believes that long term limiting illnessassessment from the census, acts as a better proxy for some aspects of population health than others although it may under-estimate the absolute prevalence. Although it may be of use inidentifying relative needs as in the case of health care accessibility, mortality is associated more strongly with differences inlimitinglong-termillness than is health service utilization. This may be as much a result of mismatch between use and need as of any deficiency of the measure itself.

Using long term limiting illness as a secondary source of data will give rise to the issues of just choosing a particular aspect of population health which in turn will not give an detailed information needed for assessing the ease of health care accessibility because it under-estimate the actual prevalence of a health activity.

2.2 ISSUES WITH THE USE OF SECONDARY SOURCES OF DATA.

According to Rosero-Bixby, L. (2004) expressed that there are no centrally available up-to-date lists of health facilities in a given area, nor knowledge of which health care facility are actually functioning, and even less, any details on physical and human resources available in each one, thus this is a pending issue when considering secondary sources of data, however information about the location of both the populations demanding health services and the facilities supplying them has average errors which are inevitable.

3.0 REFERENCES

1.ABBOTT, Williams; BLANKLEY, Nick; BRYANT, John; and BULLAS, Sheila (eds.) (2004). Current Perspectives: Information in Healthcare. British Computer Society, Health Informatics Committee.

2. AMBROSE, P., (1977).Access and Spatial Inequality, Unit 23, D204, Fundamentals of Human Geography. Milton Keynes: Open University Press.

3. BECK, R. G., (1973).Economic Class And Access To Physician Services Under Public Medical Care Insurance, International Journal Of Health Services, 3, 341-355.

4. COX, K.R., and REYNOLDS, D.R., (eds.) (1974).Locational Approaches to Power and Conflict. Beverley Hills, California: Sage.

5. DEAR, M.J., (1974). A Paradigm For Public Facility Location, Antipode (6) p46-50

6. DONABEDIAN (1973) as cited by Joseph and Phillips (1984) Accessibility and Utilization, Geographical Perspectives on Health Care Delivery. 1st Ed

7. HAM, Christopher, (2004). Health Policy in Britain. 5th Ed.

8. JOSEPH, A.E., and PHILLIPS, D.R., (1984). Accessibility and Utilization, Geographical Perspectives on Health Care Delivery. 1st Ed.

9. MASSAM, B.H., (1975). Location and Space in Social Administration. London: Edward Arnold.

10. MOSELEY, M.J., (1979). Accessibility: The Rural Challenge. London: Methuen

11. PHILLIPS, D.R., and WILLIAMS, A.M., (1984). Rural Britain: a Social Geography. Oxford: Blackwell.

12. VISE De, P., (1973). Misused and misplaced hospitals and doctors, Commission on College Geography Resource Paper 22. Washington; Association of American Geographers.

4.0 BIBILIOGRAPHY

1) AHMED, N., BESTALL, J.C., AHMEDZAI, S.H., PAYNE, S.A., CLARK, D., NOBLE, B., (2004). Systematic Review Of The Problems And Issues Of Accessing Specialist Palliative Care By Patients, Cares And Health And Social Care Professionals. Palliative Medicine 18, 525-542.

2) AMBROSE (1977), MOSLEY (1979) PHILLIPS AND WILLIAMS (1984) AS CITED BY JOSEPH AND PHILLIPS (1984)Accessibility and Utilization, Geographical Perspectives on Health Care Delivery. 1st Ed

3) BRENNAN, F., (2007). Palliative Care As An International Human Right. Journal Of Pain And Symptom Management 33, 494-499.

4) CINNAMON, Jonathan, SCHUURMAN, Nadine, and CROOKS, A, Valorie. (2009). Health and Place: Assessing the suitability of host communities for secondary palliative care hubs: A location analysis model. [Online]. Last accessed 5 April 2010 at:http://www.sciencedirect.com.

5) Dear 1974; Messam 1975 as cited Joseph and Phillips (1984): Accessibility and Utilization, Geographical Perspectives on Health Care Delivery. 1st Ed

6) DE VISE (1973) as cited by Joseph and Phillips (1984) Accessibility and Utilization, Geographical Perspectives on Health Care Delivery. 1st Ed.

7) DORNABIEN, A., (1973). Aspect of Medical Care Administration. Cambridge, Mass.: Harvard University Press.

8) MACFARLANE, A. (2009). Response to a National Framework for Assessing performance, A consultation document document. [Online]. Last accessed 18 April 2010 at: http://www.radstats.org.uk/no069/response2.htm

9) PAYNE, N., and SAUL, C. (2000) what common disorders do that reporting limiting long-term illness experience, and what is their survival and health service utilization experience? Journal of public health vol.22, pg 324-329. [Online]. Last accessed 15 April 2010 at: http://jpubhealth.oxfordjournals.org/cgi/content/abstract/22/3/324

10) ROSERO-BIXBY, L. (2004). Spatial Access to Health Care in Costa Rica, and its Equity, A GIS based Study. [Online], Last accessed 20 April 2010 at: http://ccp.ucr.ac.cr/bvp/pdf/salud/Rosero-SocSc58-7.pdf

11) WORLD HEALTH ORGANIZATION, (2007). Palliative care. Cancer Control - Knowledge into Action - WHO Guide for Effective Programmes, Gene

12) STJERNSWARD, J., FOLEY, K.M., FERRIS, F.D., (2007b). The Public Health Strategy for Palliative Care. Journal of Pain And Symptom Management33, 486-493.