Chapter One: Introduction

1.1 Introduction

This dissertation is a critical analysis of the structural barriers of access to the National Health Service (NHS) for single parent families. The topic of equality and equity in accessing the NHS is vast. I will therefore utilise literature to map the context of access to NHS services, with a focus on single parent families. The focus of single parent families will be explained more clearly in the background literature regarding their increasing number in society and their need to access the NHS as consumers thus confirming its relevance to study from a nursing perspective. Literature will be critically analysed with the aim of illustrating the difficulties this societal group experiences in accessing the NHS.

Sociologists such as Jones (1994) would question my motivation for this dissertation. I aim to make conclusions that would promote equity in access to services for single parent families with the broader aim of improving the NHS in general. Jones (1994) would argue that improving NHS services is actually negative since it has the overall result of producing an ageing population living with chronic diseases. I would counter argue that the fact the NHS is improving our life expectancy (amongst other factors) is very positive; what needs to be improved is the quality of these services that we provide.

The recently published NHS Constitution (Department of Health, DoH, 2009) establishes core principles relating to equality in access to NHS services and service provision following recommendations from the Acheson Inquiry (1998). A critical review of the literature related to accessing the NHS demonstrates how far the NHS has achieved its core principles in relation to the specific group of single parent families. Questions that will be

addressed over the course of this dissertation include: If single parent families experience inequality in accessing the NHS, why is this the case? What is being done (particularly in relation to nursing) to prevent this access problem for single parent families?

The background literature in section 1.4 will later demonstrate this topic is relevant to many people in contemporary UK society; it has significance for practice and policy and therefore justifies study from a nursing perspective. As a nurse it is important to not just focus on the patients you see in front of you but to be critical and reflective in practice therefore questioning why particular groups in society are prevented from accessing your care. Consequently, throughout this critical review dissertation, links to nursing practice will continually be identified and implications for nursing practice discussed.

1.2 Aims and Objectives

The primary dissertation aim is to identify structural barriers to equity in accessing the NHS for single parents. The implications for nursing practice will then be discussed. A secondary aim is to discuss why single parents face these structural barriers in accessing the NHS. From addressing these aims it can be identified what (if anything) is being done to eradicate the health inequalities faced by single parent families and suggest nursing practice and potential policy recommendations to combat these.

In order to achieve these aims, specific objectives must be met. These are as follows:

- Map the context of access to NHS services focusing on the experiences of single parent families

- Review and critically examine the literature relating to the experiences of single parent families
- Identify the structural barriers that prevent equity in access for single parent families and suggest how equality can be achieved

1.3 Concept definitions

In order to write coherently and promote understanding for the reader, terms used in the dissertation title will now be defined. Obviously, it is clearer if the terms are put into context, so for the benefit of the reader, the title of this dissertation and the subsequent important concept definitions are presented below:

'An analysis of the structural barriers to equity of access to the NHS and their implications for nursing practice: illustrated through the single parent.'

- Structural barriers:-

This is a difficult term to define since whilst the phrase and concept is commonly used in sociological literature, it has rarely been comprehensively defined. Hays (1994) defines structural barriers as the constraining nature of institutions on individuals in society. Based on my reading, I understand this 'constraining nature' to be physical limitations as well institutional rules. Therefore, in the context of single parent families accessing the NHS the structural barriers will be physical limitations such as income, transport and childcare arrangements, in conjunction with the rules and regulations put in place by the institution of the NHS on a macro level and individual hospitals and general practices on a micro level. Structural barriers discussed will be in terms of macro; that is based on the economy and societal structure, meso; based on governmental policies and micro, based on practice in the

NHS setting. The term barriers indicates something an individual cannot affect, however the interconnected nature of structural barriers and agency will be explored further in chapter five.

- Equity:-

Although the terms equity and equality will be used intermittently throughout this dissertation, equity will be used in the dissertation title based on Blane et al.'s (1996) definition, "equal provision for equal need," (34: 4-5). Therefore, based on this definition, if there were equity every UK citizen regardless of age, gender, ethnicity, income, disability, geography, or any other factor, would be able to access the NHS as equally as someone else. Klein (1989) states, "no service can offer equal treatment for equal need," (34: 15). So whilst I will be discussing equity in access, it is important to realise that this will not necessarily produce equality in the treatment given and its outcomes. To conceptualise the much used phrase of equality in this context it is defined by me as universal access to services. The UK tax system is based on a system of equity meaning the wealthier members in society contribute more, benefitting the less well off. Equity in relation to single parent families accessing the NHS means are this socially disadvantaged group as able to access the services they are entitled to as other members of society? In terms of equity, it could be argued that in being socially disadvantaged single parent families should be more entitled to these services. However, it is important to caution that equity in distributing NHS resources to those who most need them such as single parent families does not necessarily bring about equity in access (Klein, 2006). Chapter six will discuss these issues further.

- Single parents:-

Based on reading and my own definition, a single parent in this context is any parent who cares for one or more dependent children without the assistance of another parent or carer in the home. Throughout this dissertation it will be used interchangeably with the term lone parent.

- Institution:-

Although not featured in the title, this is a commonly used sociological term used throughout the dissertation. For the purpose of the reader, it is based on Berger and Luckmann's (1966) definition of a social structure and mechanism which helps govern our behaviour. Institutions such as the education system and the NHS are seen as structural barriers in this dissertation as well as the nature of the economy in contemporary UK society which is seen as a macro societal barrier. This is because policies affecting single parent families often have an economic influence. This will be discussed further in the main body of the dissertation.

1.4 Background literature

The first health system in Western society to offer free care at the point of delivery for everyone, the NHS was established in 1948. Following its creation which appeared to be based on egalitarian ideals, it was hailed a triumph of socialist ideology (Klein, 2006). The Bevan Labour government who founded the NHS envisaged a first class health service for all. This service was funded out of taxation whereby wealthier individuals contributed more towards costs while it was assumed that the socioeconomically deprived would benefit the most (Ackers and Abbott, 1996). However, the ideal of universally accessible free care was not so straightforward. You could question today whether NHS care is both free for all and universally accessible. Various studies, reports and inquiries over the course of the NHS'

sixty two year history have served the purpose of demonstrating wide scale inequalities in individuals' ability to access the care they are supposedly entitled to. This dissertation is not intended to attack the NHS, after all, since its introduction many have benefitted from its services, and successful immunisation programmes have all but rid the UK of diseases such as tuberculosis. Others such as Donaldson and Donaldson (2000) would argue that the health of the nation has improved dramatically not due to the introduction of the NHS but other factors such as universal access to clean water and sanitation. Klein (2006) notes that since the introduction of New Labour centralising power the government is now politically vulnerable. Media interest means the criticism of the NHS will be continuous, even if it is delivering to patients. I do not believe this critical review is being critical of the government and the NHS for the sake of it, I believe in the principles of the NHS; free care at the point of delivery for all and that we should question when and why these ideals are not being upheld. Some groups in society are not able to access these services or experience barriers preventing them in doing so. It is therefore important to highlight these particular societal groups and find out why they are experiencing barriers in accessing care in order to uphold the ideals of the NHS.

This dissertation illustrates the structural barriers encountered by single parent families in accessing the NHS.

Government statistics show that there are 3.1 million children living in lone parent families in the UK (Department for Work and Pensions, DWP, 2001) and that this is a population trend that is increasing. Although the trend for single parent families is rising, the ratio of lone mothers to lone fathers remains at a constant of nine to one (Duncan and Edwards, 1999). Perhaps significantly ninety thousand of these children are born to teenage mothers annually (Social Exclusion Unit, 1999) and the teenage conception rate in the UK remains the highest in the European Union (Mayhew et al.,

2004). Davey Smith (2003) states that whilst the growth of single parent families in the past twenty years has risen, so too have the levels of poverty these families in particular face. This is not something that is fixed, the fact that child poverty is higher in the UK than in other countries demonstrates that fact, despite the government's 2010 target to half child poverty (Dornan, 2009). The link between the poverty experienced by single parent families and the effect this has on their ability to access the NHS will be discussed later. Indeed, poverty due to government policy is seen in this dissertation as one of the major forms of structural barriers.

The statistics mentioned above show that ninety per cent of single parents are female (Duncan and Edwards, 1999). Whilst male lone parents will not be excluded in the text, the significance of being a female single parent will be discussed further. In chapter four, one of the main sociological perspectives applied will be feminism in order to demonstrate the structural difficulties female single parents face in accessing NHS care compared to males.

Other structural barriers which may affect a single parent's motivation for accessing the NHS include hospital rules and regulations; this particularly will be discussed within the context of nursing as it will promote recommendations for future nursing practice.

Chapter five will put forward the debate questioning whether it is indeed structural barriers affecting a single parent's ability to access the NHS or individual motivation and choice.

It is hoped that the conclusions formed will be able to inform social knowledge, make recommendations for future policies, both social and health related and inform nursing practice.

Chapter Two: Methodology

2.1 Why choose a critical review?

A literature review is a comprehensive study and interpretation of literature which includes searching, appraising and analysing (Aveyard, 2007). Draper (2008) evolves this definition in that a critical review also adds argument from the perspective of the writer. This style, rooted in the social sciences is appropriate since it will answer why equity in access to services is experienced by single parent families and therefore requires interpretation and argument. Critical literature reviews are important since collaboration of literature can lead to new insights, only possible when seen in the context of other information (Aveyard, 2007). Evidence based practice is important within nursing, therefore looking at a variety of articles can lead to better understanding of the difficulties faced by single parent families and therefore inform future nursing practice.

2.2 The research process

A literature search was the first element of constructing this dissertation. It was conducted following Hek et al.'s (2000) literature review framework (figure 2.1).

Figure 2.1 Stages of the reviewing process (Hek et al. 2000)

Stage One	Electronic database search
Stage Two	Focused manual search- hand searching journals
Stage Three	Searching reference lists and authors
Stage Four	Management and acquisition of literature
Stage Five	Literature appraisal
Stage Six	Literature review
Stage Seven	Thematic literature review

An initial electronic database search was conducted using the following keywords: "access + NHS," "equity," "access + NHS + equity," "single parents + equality," "single parents + NHS + access," "lone parents," "children + access +NHS." This search resulted in numerous relevant articles for analysis. In order to yield as many relevant articles as possible, a number of databases were utilised in the literature search stage of the research process. These are identified below (figure 2.2):

Figure 2.2 Literature search databases

Database	Coverage	Relevance
British Nursing Index	Database of widely used English language nursing journals from the UK	Useful for discussion of implications for nursing practice
Medline	Coverage of biomedical literature from 1966 to present	Not very useful considering the sociological nature of this critical review
Cumulative Index to Nursing and Allied Health Literature	Coverage of English language journals for nursing and the allied	Useful for discussion of implications for nursing practice

(CINAHL)	health disciplines	
Applied Social Sciences Index and Abstracts (ASSIA)	Database of social science and health literature from 1987 to present	Number of relevant articles found
Excerpta Medica database (EMBASE)	Coverage of a large number of journals including nursing and medicine	Few relevant articles found
Social Science Information Gateway (SOSIG)	Database of social science literature	Number of relevant articles found

Following the initial search, a main search strategy was devised. Although the keywords above were used, papers not written in the English language were excluded. This is because this critical review dissertation focuses on the NHS; the UK healthcare system and so foreign language papers would most probably not be relevant, and even so, the cost and time constraint of interpreting justified this exclusion. Articles were also excluded on the content of their abstract. That is whether the abstract related directly to the dissertation title and had any relevance to nursing.

Stage two of Hek et al.'s (2000) reviewing process included hand searching relevant journal articles. Of particular usefulness were sociological journals listed in the university library such as Social Science and Medicine and Sociological Theory. By generating a volume of relevant literature supplementary searching of reference lists and authors could be commenced (stage three of the research process). By far, the greatest volume of relevant literature was obtained through reading and appraising a number of books from both the university and public county libraries. As the literature search process progressed, articles were being amassed and information

collaborated as described in stage four of the process. Stages five and six of the Hek et al.'s (2000) literature reviewing process, the literature search and appraisal involved critiquing further the literature, using relevant quotes , ideas and authors to inform the main body of my dissertation text. I also utilised websites which were particularly useful in the gathering of the statistical information needed to promote the argument. I was careful to ensure I used accredited websites which had been cited by others, such as www.direct.gov.uk and www.cpag.org.uk (Child Poverty Action Group).

My methodology can be criticised for not being predetermined, I am aware of this drawback, however, the nature of a critical review is the exploration of ideas. A critical review will draw discussion as the question as to why something is the way it is will always provide debate. If the reader of this article disagrees with the conclusion I have reached this is fine; they will however be able to see the supporting evidence and literature as to why I have drawn this conclusion and my argument shaped in such a way. Therefore at this stage in writing the dissertation I know specifically what I want to find out with regards to the structural barriers faced by single parents in accessing the NHS, I know where to search for this information but the implications for nursing and route of the argument remains fluid at present.

Chapter Three: Structural barriers faced by single parents in accessing the NHS

3.1 The NHS and access

The NHS Constitution (DoH, 2009), is a publication designed to make clear the responsibilities of the NHS as an organisation, the healthcare professionals working for it and the UK citizens who will be accessing it. It states that the NHS has a duty, "to each and every individual that it serves," (3.1; 4-5). This would seemingly include the single parent families featured in this dissertation. Its affirmation of equality promotion and the rights of every individual to access its services demonstrates the level of service it strives to achieve. However, this is merely recommendation, these are the services it aims for, not necessarily the level of service it is currently giving, which will later be demonstrated. The constitution also states that the NHS needs to pay attention to groups in society whose health may not be as good as in other sections of the population. As a nurse working for the NHS as an organisation, it is important to practice in a non discriminatory way. The wording 'paying particular attention' suggests recognition of the need for equitable care, which is providing for those most at need, including single parent families. Implications for nursing practice mean that as well as focusing on an individual and their rights, it is important to focus on population groups that might be excluded and try to prevent this.

Single parent families according to the DoH (2009) have just as many rights as anybody else to access NHS care. However, this does not mean they access the NHS equitably and this does not account for the structural barriers preventing access. As Moram (1999) observes, consumer groups trying to change NHS policies are normally middle class and put forward their own interests. This is because this societal group are seen to have more knowledge about the services available and are able to better

articulate their demands. This all leads to the NHS being unrepresentative and therefore justifies the need to promote the inability of single parent families to gain access to the care they are entitled to.

3.2 How single parent families are disadvantaged in society

As Denny and Earle (2005) discuss low incomes and social deprivation are associated with poor health at all ages throughout life. Wilkinson (1996) studied health statistics from a number of countries and found that the widest gaps in health inequalities were found in countries with the widest gaps in incomes. He found that low incomes and social deprivation are both associated with poor health and earlier age of death. Though low income and social deprivation are not automatic by products of single parenthood, they are commonly associated. The Child Poverty Action Group (2009) states that the risk of a lone parent household living below the accepted poverty line in the UK is fifty times greater than other individuals or groups in society. The Black Report (1980) concluded that poverty causes ill health so policies eradicating socioeconomic deprivation would directly change patterns of illness. The report noted the key social issues affecting health were unemployment, lack of education, poor housing and inadequate transport connecting people with medical facilities. It is important to highlight that the terms poverty and deprivation in the context of this dissertation are related to relative poverty and relative deprivation; that is relative to need (Townsend, 1979). Therefore in an unequal society these single parent families experience higher levels of poverty and deprivation compared to other members of society and are subsequently disadvantaged because of this. Though the reference to Townsend (1979) may seem old and perhaps lead you to question whether or not relative deprivation and relative poverty is still a feature of contemporary UK society, the fact that income poverty increased from 2006/7 to 2007/8 justifies its relevance

today (Department for Work and Pensions (DWP), 2008), In fact, statistics published by the DWP (2008) show that 13.5 million people in the UK are experiencing income poverty. Marmot and Wilkinson (1999) discuss how inequalities in society are more important factors in maintaining good health than biological factors which is why relative poverty and relative deprivation are important topics in contemporary UK society. The term relative deprivation was developed by Runciman (1966) whereby individuals subjectively perceive themselves as unfairly disadvantaged compared to other members of society. Whilst I cannot account for how single parent families see themselves I use the term relative as statistics and literature will later clearly demonstrate a disadvantage compared to others. The term absolute is not appropriate since single parent families do have access to food, housing healthcare provision etc. it is the discrimination and inequalities faced by them that deems it relative. Having ill health does not mean there will be problems in accessing NHS care; I am simply demonstrating why single parent families may need to access care more frequently than some societal groups thus justifying a need for equitable care. Adelman and Bradshaw (1998) have highlighted the high rates of poverty experienced by single parent families and the link this has to lifelong negative consequences this has for children's health. Examples of this include the fact that three year olds in households with incomes below £10,000 are two and a half times more likely to suffer chronic illness than children in households with incomes above £52,000 (Child Poverty Action Group, 2008). However, some would argue these lifelong consequences be more associated with individual education and motivation than societal problems, this is a very simplistic individual blaming view which I feel is inappropriate in explaining such a wide scale problem. Morral (2001) for example discusses a genetic factor which would mean some individuals in society are predispositioned to have bad health and be social underachievers.

If things really were this simplistic and we follow a 'natural selection' route, then why would there be a need for a National Health Service in the first place?! Lundberg (1991) contests this viewpoint since research findings show social selection is not appropriate in explaining the statistical relationship between UK mortality rates and income distribution. Mason et al. (2001) draws an association between deprivation, poor health and educational attainment which will be discussed further in this chapter.

As mentioned in the background literature previously Population Trends (1999) showed a large number of teenage lone mothers in the UK (approximately ninety thousand). With regards to health, this group are seen as disadvantaged since there is a higher probability of a low birth weight baby, increased risk of sudden infant death syndrome and higher rates of childhood accidents (Griffiths and Kirby, 2000). This again demonstrates this particular group's need to access the NHS more frequently than perhaps other individuals in society.

Now that lone parents and their families' needs as consumers of the NHS have been established, their ability to access this care will now be discussed. Since the DWP (2001) estimates 3.1 million children live in lone parent households in the UK, this discussion about accessing NHS care affects a significant proportion of the population.

Mason et al. (2001) associates poor educational attainment and the socioeconomic deprivation experienced by single parent families of which I have utilised as an explanation of a structural barrier preventing access. This is because the education system is viewed as an institution that through negative stereotyping and labelling discriminates against children from lone parent families (Dearden and Becker, 1997) thus providing them with an insufficient standard of education. This is why I have identified the UK educational institution and schooling system as a structural barrier. Blackburn (1991) studied drug users in the UK and the effect negative

stereotyping had on their experience of healthcare, whilst the link between drug users and lone parents and their children may not be implicitly clear, it highlights that negative stereotyping on groups in society has a negative effect on how they perceive themselves (and their consequent mental health), how others perceive them (since constant stereotyping makes people think it is socially acceptable to behave in such a way) and as a result discourages people from accessing the services or institution that has treated them negatively. The Department for Children, Schools and Families (2007) seem to validate this viewpoint (though it is not proven to be the result of negative labelling) by finding that of the children eligible for free school meals only thirty five and a half per cent achieve five GCSE grades A* to C in contrast to sixty two point nine per cent of children who do not receive free school meals. Therefore, if a single parent family is accessing NHS services it is important as a health professional to keep them actively engaged and not negatively stereotype this group so that they access services again. It is important to remember that people may be receiving treatments that require a follow up; why would people want to follow up their access to services that had previously treated them in a negative manner? Dearden and Becker (1997) interviewed a number of children and found that this negative labelling at school was for a variety of reasons including: coming from a single parent family, reliance on benefits and problems associated with poverty. Whilst this study could be criticised as not being representative since they only interviewed fifty five children, it is valuable in giving the perspective of the children from single parent families, even though an old study. Single parent families may also fear discrimination; that is being 'looked down on' by highly educated medical professionals. Indeed, research has shown that a literate population has better access to health services than an illiterate one (Barker, 1996). However, this is old research; developments that promote education for

children from socioeconomically deprived and single parent families such as the Sure Start scheme may help to alleviate such structural barriers. The Sure Start scheme was introduced by the Labour government to target disadvantaged groups in England by providing education, childcare, healthcare and family support. The success of the scheme is questionable however and will be discussed at a later point in this dissertation. In relation to nursing practice, this study once again clarifies the importance of non-discriminatory care. I propose that health professionals should talk in a manner that their clients/patients understand by eliminating unnecessary medical jargon, as a means of 'breaking down' the educational structural barrier and making individuals feel more comfortable. This is needed since Morral (2001) has found a distinct negative labelling by some medical practitioners who view some patients as deliberately putting themselves at unnecessary risk, and treat them poorly as a result.

Another structural barrier identified as a means of preventing single parent families accessing the NHS is welfare provision; in particular the income deprivation already indicated that is a common experience to lone parent families. Benefits and tax credits supposed to help single parent families are in fact too low to protect these families from poverty, the government has set their value significantly below the poverty line Child Poverty Action Group, 2009). Although the NHS is defined by its constitution (DoH, 2009) as free at the point of access, there are other costs associated. Barnes et al. (1999) identifies that discrimination is present in all areas of society including the provision of public transport and welfare. It is important to note that accessing services can cost not only in terms of finance but in time as well. Harsh criticism to the NHS comes from Wistow and Henwood (1991) who argue that for a large majority of the population rights to universal and free healthcare have in fact been removed as a result of these structural barriers. Barker (1996) reinforces this, in saying that in

order to access NHS services all individuals are going to be disadvantaged in terms of transport expenditure and time, obviously these costs are amplified for single parent families who will need to access NHS services more frequently. Welfare is discussed further by Davey Smith (2003) who states that the government reducing the single parent premium has had a damaging effect on children from lone parent families. By having less money, single parent families directly will not have the money for transport required to access the NHS. Indirectly, having less money will mean poorer health with regards to eating a healthy diet, living in a heated house and other confounding variables (Benzeval et al., 2000). The Food Standards Agency (2009) looked at the diet of low income families and found their intake of fresh fruit and vegetables less than recommended amount of five portions per day and overall levels of health poorer than the rest of the population. This study included interviews, questionnaires and physical examinations of three thousand, seven hundred and twenty eight individuals. I think it is reliable evidence since interviewer bias is eliminated with the usage of a physical examination and the study included such a large number of people as well as being up to date and relevant. This again provides evidence for single parent families being higher than average consumers of NHS care relative to their high level of need. Reducing welfare entitlements for single parent families may be seen by some as a positive commitment in that it will discourage state dependency and encourage lone parents to work. Clearly, many lone parents do work, I am not implying that all single parents are in receipt of state welfare benefits; this would be a reductionist approach. However, single parent families are fifty times more likely to be are socioeconomically deprived (Child Poverty Action Group, 2008) as previously discussed which is why this explanation is both relevant and of importance. Whilst indeed, some lone parents would be able to participate economically it is also true to say that this would not change inequalities in mortality rates

for children under one year old (Adelman and Bradshaw, 1998) since most parents for children of this age cannot work for childcare reasons. It is important to remember that the government is not passive in relation to single parent families and they are trying to combat the problem of poverty and income inequality. For example, over eighty percent of single parent families are in receipt of benefits including: income support, housing benefit and working families' tax credit (Haskey, 1998). Government spending has increased from £5.7 billion in 1989/90 to £13 billion in 1994/95 (Bradshaw, 2002). Explanations for this societal group making up such a substantial group of economically deprived individuals include a low earnings power and inadequate provision of childcare (Ziehl, 1994). Although the government has evidently increased it's spending on welfare, the fact that the wealth gap between rich and poor (and therefore inequality) continues to grow (Wilkinson, 2005) indicates that welfare spending is not sufficient enough. Indeed the government's commitment to reducing inequalities can be questioned. Edwards (2005) has found that the £3 billion Sure Start programme has not actually made any improvement in target areas. This would lead one to believe that simply 'throwing money' at a problem is not adequate enough; equality in society runs deeper. However, the programme has been successful in some areas and Ward (2005) states it is too early to evaluate its effectiveness. Despite the Black Report (1980) recommending that child benefit should be fixed at 5.5% of average gross earnings to reduce inequalities in child health, no such policies have as yet been implemented (Berridge, 2002). Adelman and Bradshaw (1998) draw attention to the fact that whilst increasing child benefit may be deemed positive, there is still a long way to go. This is because in comparison to the economic growth the real value of child benefit has fallen substantially thus making family living standards even more deprived. The Black Report (1980) can therefore be criticised for being largely ignored. It demonstrates that no

matter how influential a piece of research is, if not supported by the government, nothing is done about the problem identified. With regards to spending and welfare provision it could be argued that the Labour government of present day do not have as much control over the macro social barrier of the economy compared to governments of the past, implying they do not have as much control over spending. This is because the UK economy works in conjunction with the economies of other countries in the world. It is not simply a case of increasing spending on welfare for single parent families, there are political and economic consequences in changing the budget (Sennett, 2006). In fact, despite the pledge of the Labour government to half child poverty by 2010 and eradicate it completely by 2020, the recent Budget 2009 did nothing to narrow the inequality gap, this leads one to question the agenda and motives of our government. By this I mean it is easy to make promises and pledges but this means nothing to economically deprived groups such as single parent families if it is not translated into actions which would produce positive outcomes for them. Moral (2001) recognises how the vested interests of enterprises has an effect on how health is maintained; examples of this include food production, drugs and tobacco companies. As a recommendation aside, it would seem logical that enterprises who are making money by endangering people's health should be taxed more and that this money should be put back into the NHS services these individuals would need to access as a consequence. Policy will be addressed further in this chapter and Kane and Kirby's (2003) findings related to welfare and income for women lone parents will be examined in the subsequent chapter.

There are of course now some NHS services that require payment, whilst these are often subsidised for low income single parent families, the costs for eye tests and dental care mean such families are disadvantaged with respect to their financial status (Bond and Bond, 1994). Worryingly,

although the structural barrier discussed is welfare, this scenario demonstrates the NHS directly as an institution providing the mechanism of structural barrier in that it will only be accessible to those who can afford to pay. The NHS as an institution can also directly prevent equity in access in other ways. Although an extremely old study, the Central Health Services Council (1959) found it to be beneficial for young children requiring an overnight stay in hospital to be accompanied by their parents. Despite this finding, Bond and Bond as recently as 1994 found that some hospitals still would not routinely offer parents accommodation. However, personal experience in a hospital ward environment has been very positive in respect that parents have been offered on site accommodation and facilities. For lone parent families there is the issue that whilst the parent may be able to stay in hospital with a sick child, any additional children would require childcare since a hospital would not cater towards this situation.

3.3 Policy recommendations

As this chapter has demonstrated the NHS should be and aims to be universally accessible for all, however, structural barriers such as: welfare provision, the education system and the NHS itself causes problems for single parent families in accessing its services. This is not acceptable according to the DoH (2009) therefore changes need to be made in order to obtain equality in access.

However, although this dissertation is focused from a nursing perspective, looking in broader terms at how single parent families are disadvantaged in society suggest policies just focused on NHS access would not solve the problem, therefore policy implications are on a society wide scale.

Firstly, based on findings by Berridge (2002), The Black Report (1980) and Bradshaw (2002), it seems critical that welfare provision for single parent families is increased in order to close the gap in income inequalities.

State welfare is so important since lone parent families only have the potential for one adult's earnings, and this can be seriously affected taking into account the need for childcare provision. Feinstein (1993) argues that single parent families' access to the NHS is not solely based on material factors; it is also influenced by behaviour. However, the importance of increasing welfare provision cannot be underestimated. I would strongly contest Feinstein's (1993) argument since evidence shows that it is not just the behaviour of the individual who is accessing the NHS that is important; Berkwits (1998) notes that the behaviours of health professionals are just as important. Consequently, in relation to practice it is of importance to not label or stereotype single parent families and be as accommodating to their social situation as is possible in the maintenance of the therapeutic relationship.

Relating directly to NHS policy and recommendations, if there were a limitless budget, it would seem appropriate to abolish all services that require payment for low income groups in society. However, budget constraints make this task an implausible feat, therefore policy needs to be realistic. I propose free transport for areas geographically located far away from NHS services in order to save money on unnecessary travel costs. Specifically targeted at lone parent families it may be beneficial to trial crèche schemes at hospitals in order to eliminate the problem of a lack of childcare affecting an individual's ability to access NHS care. It may also be beneficial to provide overnight accommodation for the whole family if one member has to stay in hospital. This way the parent can support the child in hospital without the need for paying for childcare. Support for this view comes from Goddard (2008) who recognises that for lone parent families there may be difficulties in obtaining the social support needed in order to organise care for children whilst travelling to access NHS services.

Even if it is not possible for the NHS to achieve equality in access, it may be possible to redistribute resources to those in society deemed most 'at need' (Barker, 1996) such as single parent families. Although Periera (1990) would criticise this simplistic way of addressing the NHS budget; for example in terms of access it would be deemed insufficient in spending money to bring NHS services to patients. Martin (2004) emphasises the need for patient choice so if resources cannot be redistributed to the single parent families who need them perhaps a compromise could be met enabling these families to have more choice about the type and location of services they could access. As practitioners this means empowering individuals in our care to make their own decisions and respecting these.

Specifically targeted at the nursing profession, as already established, it is important to provide non-discriminatory care addressing the lone parents in an understanding way, avoiding medical jargon (this recommendation is universal, and not just specific to single parent families!). If a lone parent accesses NHS services with children due to childcare constraints, it is important to engage the children in the care process and ensure their safety in the NHS environment whilst carrying out a consultation with the parent.

Obviously established is the need for policies to address access to NHS services but the wider social disadvantages faced by single parent families need to be targeted in order to improve the health of this group. In order to produce equitable access to NHS care it is important to eliminate inequalities in society (Barker, 1996). The bridging of inequalities should not be overestimated; research by Wilkinson (1992) found that inequality has such a negative effect on health that life expectancy is significantly higher in countries with an equitable income distribution. If the current Labour government held traditional left wing views, they should utilise such research to better serve some of the socioeconomically deprived individuals they are representing. Whilst as indicated above it may be possible to

achieve this equity in access with some change in NHS policy what seems more important are policy changes instigated by the social sector. It is important to create and regularly review policies in the NHS in order to give context and consistency to delivering health care. As a health professional, these policies enable us to deliver evidence based practice and produce equality in health related interventions.

A problem with making policy recommendation is that the nature of modern society means that the powers making decisions in central government have less influence now compared to say Bevan's labour government who invented the NHS in the first place. This is because the nature of the economy means there are vested interests in health from many different areas. The governments motivation in making policies to eradicate inequalities can be questioned as since the introduction of the government in 1997 there have been many reports into the inequalities in health including: Independent Inquiry into Inequalities in Health (1998), Saving Lives: Our Healthier Nation (1999) and Tackling Health Inequalities- A Programme for Action (2003), yet here we are in 2010 with inequalities in health persisting. It is commendable the government has acknowledged the link between inequality and health yet despite all these publications no decisive policies truly dedicated to eradicating inequality in all areas of society have arisen. The single parent families facing structural barriers in accessing the NHS need decisive government action with regards to policy. This highlights the importance of using your political vote to support your own interests.

Chapter Four: Sociological explanations for the inequalities experienced by single parent families- a critique of perspectives

4.1 Introduction to chapter

Whilst the dissertation title, *'An analysis of the structural barriers to equity of access to the NHS and their implications for practice: illustrated through the single parent,'* is specific, it also emerges the generalised and broad subject of inequality. There have been a number of different viewpoints or disciplines in the field of sociology, each offering varied arguments for the cause of inequality and how this benefits or detriments individuals in society. Although this may seem very unspecific with regards to the research question, it is hoped that by analysing these theories, the reasons for structural barriers can be addressed as well as the reason it appears single parent families are being discriminated against in terms of their equity in accessing NHS services. Each prominent sociological theory or explanation will be critiqued separately with a conclusion at the end of this chapter clarifying the importance of addressing these viewpoints in answering the research question with reference to implications for nursing practice. Structural barriers and inequalities experienced by lone parent families in accessing the NHS have already been identified, it is hoped that this chapter will provide the reader with explanations as to why this is the case.

4.2 Functionalist explanations for inequality

Durkheim's (1895) theory of functionalism suggests that everything in society serves a purpose; this includes the structural barriers and institutions previously mentioned in preventing equity of access to services. Functionalists therefore believe that inequality itself serves a purpose since it acts as an incentive for individuals to work hard and improve their societal position. Parsons (1977) argues that in society, inequality is inevitable since

the distribution of talent amongst individuals is unequal, and it is quite rightly so that it is the most talented members of society that are rewarded the greatest. If this theory were to be correctly believed, then are socially deprived single parent families in this position due to a lack of talent?

I agree with the viewpoint of the Marxist theorist Offe (1967) who discredits functionalist theory by stating that individuals who have the most talent or who work the hardest are not always the people in society who are most rewarded. It is important to remember that some lone parents may not be economically active yet in criticism to functionalist theory they are still contributing to society by looking after their children and in doing so are probably working very hard. However, the relatively low rate of state welfare these families receive means they are not rewarded adequately for their hard work. Are the structural barriers that prevent equity in access to the NHS for single parent families functional to the rest of society? In my opinion NO they are not.

As a health professional, if a societal group are unable to access NHS services you will not have the expertise in dealing with them and the particular needs they may have therefore it is important that no one is excluded from accessing care. It is not functional for the NHS who will not be able to make provisions for such needs. Functionalist theory can be criticised for being far too simplistic. If indeed inequality was so functional to society government policies and initiatives to create equality simply would not exist. Surely a more equal and equitable society would mean healthier individuals and this would in fact be more functional. The research by Wilkinson (1996) has already been used as an example to demonstrate how inequality is dysfunctional for health. The poverty associated with inequality in society is said to cost the UK at least twenty five billion pounds every year since limiting children's educational attainment has the knock-on effect of impeding economic growth (Joseph Rowntree Foundation, 2008) surely

these statistics discredit the functionalist viewpoint as a means of explaining equality as a functional element to society.

4.3 New Right explanations for inequality

New Right sociologists such as Sauders (1995) develop the functionalist ideas relating to the concept of inequality to the free market. They argue that income inequality is essential in order to motivate people to improve their situation. One feature of the New Right theory is the concept of the so called 'trickle down effect' whereby if the wealth of the richer people in society increases, it will have a positive effect on the socioeconomically deprived as they will benefit also. New Right theorists who include King (1988) believe that government intervention through the provision of welfare is unhelpful since it takes away the focus of individual's taking responsibility for their own lives. However, since some lone parent families depend on government welfare that is fixed, surely they will not benefit in any way from the 'trickle down effect.' Also, lone parents that do depend on government benefits do not do so based on an inability to take responsibility for their own lives. They are simply in a situation that dictates they cannot work as they have children to support.

From a nursing perspective, findings by the Acheson Inquiry (Independent Inquiry into Inequalities In Health) (1998) demonstrate that societal inequality leads to poorer health outcomes therefore detrimental to the health of the population we are serving. Critics such as Hutton (1996) state that there is little support for the free market 'trickle down effect' as the solution to equality dilemmas. Currently we have a free market economy and the inequality gap between rich and poor continues to grow (Shaw et al., 2005), therefore I would discount this theory. Hills (1994) echoes the findings of Shaw et al. (2005) and adds that in every developed market economy in the world there is no evidence proving a positive outcome for

socioeconomically deprived individuals arising from the 'trickle down effect.' Since the wealth gap is growing, surely in terms of an equitable society instead of waiting for wealth to 'trickle down,' the taxation system should be amended ensuring the socioeconomically deprived including single parent families, receive a better welfare package. In the same way the NHS could be developed to be more equitable ensuring those most in need of services who currently experience structural barriers get the access they are entitled to.

4.4 Feminist explanations for inequality

Firstly I would like to acknowledge the existence of the many branches of feminism. However, due to word count limitations and keeping relevant to the dissertation aim, I am just addressing feminism as a broad group united in their belief of a detrimental patriarchal society. Feminists such as Annandale and Hunt (2000) see the inequality experienced by women related to a patriarchal society. The oppression of women (by men) is most evident in economic terms since women have less earned income than men (Office for National Statistics, (ONS), 2009), although the pay gap is now starting to narrow. The Women's Unit (1999) state that although women rival men in their participation in employment, the structure is very different insofar as women tend to work shorter hours and have lower wages. It could be argued that the Women's Unit (1999) had the agenda of highlighting sexual inequalities, is a criticism coming from myself as an impartial source, but equally if inequality is highlighted it can be addressed, this is positive no matter what the agenda of the researcher. Byrne (1999) confirmed these observations and found that only one third of women have an income that is above the poverty level (set at less than fifty percent of the average income). This is of importance since Kane and Kirby (2003) found that in lone parent families women are the head of the household in ninety percent

of cases. Therefore the issues of inequality feminists' address are important and relevant for the majority of lone parent families. With regards to accessing the NHS, it is demonstrated above how perhaps lone parent families headed by females may lack the income needed to afford transport to get to NHS services and pay prescription and service charges. It is important to be aware that whilst economically women may work fewer hours than men, in reality they do an awful lot of unpaid care work including looking after children. This in itself can have a detrimental effect on female health thus substantiating the claim that single parents are higher consumers of health care (Centres of Excellence for Women's Health, 2002). Denny and Earle (2005) justify this point by discussing how women are high consumers of NHS care when visits regarding menstruation, pregnancy and childbirth are taken into account. This also justifies my research in looking into feminist explanations for inequality. Feminists may also argue that the medical institution is a patriarchal one and therefore does not sympathise with women's' health issues (Witz, 1995). This can affect access since the lone mother may feel intimidated by a male doctor and therefore choose not to access services. However, this is itself is a stereotype in whereby the medical institution is seen as patriarchal and the assumptions that a doctor will be male. Even if this were the case it could be accommodated that women request female doctors who may be able to empathise with feminine health issues. This justifies the need for patient choice and patient input into the services they expect to receive form the NHS. Abbott and Wallace (1997) state that women in stereotyped caring roles are responsible for bringing up healthy children. Health care professionals such as health visitors and social workers 'police' them to ensure this has been achieved. It is important to eradicate this type of attitude by being approachable. I suggest that health visitors and social workers use a model of health promotion in order to seem less intimidating to single parent families. They are after all the healthcare

professionals in the primary setting. If single parent families develop a distrust, they may perceive nurses in a secondary hospital settings have the same police-like attitude thus affecting motivation to access NHS care.

However it can be seen that these views make assumptions about the social roles of men and women. For example, a lone parent father also has the necessity to work part time hours due to the constraints of childcare thus experiencing the same income inequalities as females. Comparatively, there are also highly paid, competitive professional women who have worked their way into prominent positions in employment, despite their lone parent status; these females are however in the minority. Whilst feminist perspectives can go so far in explaining the reason for the income deprivation experienced by lone mothers it does not explain the structural barriers that have shown to affect equity in access to the NHS such as the welfare system and the education system. In fact evidence from Clark (1996) shows that contrastingly females achieve higher than males in the education system with reference to exam results. Feminism as an explanation for structural barriers could be seen as excluding lone fathers who equally experience inequity in access to the NHS. However, some feminists would view lone fathers in caring, feminised roles experiencing the same inequalities as women in patriarchal societies, therefore to some this explanation of inequality is all encompassing with regards to the inequalities experienced by single parent families.

4.5 Weberian explanations for inequality

The renowned sociologist Weber (1922) argued that divisions in society are related to more than just a social class or division but to interactions between, 'class, status and party.' Therefore in relation to the position of single parent families identified in this dissertation, it may not just be the poor socioeconomic position of a large majority that affects their ability to

access the NHS. The status held by single parents may also have an effect; for example negative stereotyping by the media may contribute to a lack of incentive or motivation to access NHS services for fear of judgement.

In terms of equity, individuals would be deemed to have equity according to my definition with regards to service provision and access by the NHS directly and the state. However, to produce equity in terms of the Weberian ideas of class, status and party would be practically impossible since it is based on how an individual is viewed by others.

As a health professional, it is important to treat people equally in terms of non discriminatory care, however, just as important is recognising individual differences and acknowledging the particular needs of certain groups in society.

These explanations for inequality can be heavily criticised in that this theory only offers description rather than any explanation as to the reason these three factors are identified as the only reasons for social divisions in society. Class, status and party are fairly abstract concepts and therefore impractical to use.

4.6 Postmodernist explanations for inequality

Waters (1997) characterises the society we now live in as, 'classless.' Inequality in society is therefore caused not by social class but by other factors including: gender, ethnicity, political preference, educational level, consumption and lifestyle. A brief example of consumption includes evidence from the Food Standards Agency (2009) who found low income families eat less fruit and vegetables than the recommended five portions a day and this has negatives effects on their overall levels of health. This emphasis on cultural rather than economic divisions reflects the New Right theorists stress on individuals' choices and behaviours. However, single parent

families may be trying to access NHS services, it is the structural barriers therefore policies and institutions that prevent this access. The ideal of individual choice and behaviour influencing action will be discussed further in chapter five.

Devine (1992) criticises Postmodernist theorists in that on many occasions lifestyle choices are in fact limited by income inequalities, therefore economic divisions are still important. In the case of single parent families accessing the NHS, economic divisions could mean an inability to pay for childcare and transport; this is despite perhaps an individual's motivation to access such services. Madry and Kirby (1996) continue this criticism in that they state individuals actually do not have as much choice as postmodernists imply. Institutions such as the NHS effectively take away individual choice in some situations by implying rules and regulations such as visiting times and provision of parental accommodation.

4.7 Marxist explanations for inequality

Marxist theory states that inequalities in income and wealth are not the result of differences in social class but indeed the cause of these inequalities in the first place (Marx, 1867). Ham (1992) describes the UK government's attitude towards healthcare in Marxist terms. That is the NHS is supporting a healthy workforce so maintaining it is important for the economy.

However, this is a very reductionalist viewpoint, implying that the sole purpose of the NHS is to maintain a healthy workforce. As a future employee of the NHS I do not view the care I give as maintenance of a healthy workforce, I view it in terms of making an individual comfortable and improving their personal health and wellbeing. If Ham (1992) were correct in the motivation behind the NHS, then surely structural barriers preventing groups in society such as single parent families would not exist. This is

because the government would want all individuals to be able to access the NHS in order to maintain the health of its workforce and provide means for economic growth.

It is possible that a Marxist thinker would criticise my thinking in that I could have been led to believe my work was for the good of the individual when in fact its real, concealed nature is for the protection of the economy. This demonstrates how depending on your perspective, it is possible to look at sociological literature and interpret it in very different ways; we all view things differently and thoughts as to why single parent families face structural barriers could be subjective. I think by addressing a number of perspectives I have however overcome this problem. I have also given the reader a variety of different viewpoints so it is possible to make up your own mind on this matter.

4.8 Chapter conclusion

Whilst the inequalities experienced by single parent families in accessing the NHS were undoubtedly established in chapter three, what is more difficult is an explanation as to why this societal group experiences such inequalities. It was thought that reviewing several different sociological perspectives would 'shed light' on the reasons behind such inequalities.

It is clear that sociological thinking in the broadest of terms is divided in two ways:

1. Sociological perspectives that take into account individuals choice and motivation as a reason for inequality
2. Sociological perspectives that view inequalities as produced by differences in society

These two very different explanations for experiencing inequalities will be discussed in terms of single parent families accessing the NHS in the subsequent chapter.

Personally, there is not one perspective I perceive as being all encompassing in explaining the inequalities in society experienced by single parent families. However, elements of all the theories discussed above offer useful viewpoints since it is good to familiarise oneself with alternative perspectives on inequality. Personal preference is to favour feminist explanations as I feel these are particularly useful in explaining the inequalities experienced by lone mothers in society. Whilst it is relevant insofar as ninety percent of lone parent families are headed by females (Kane and Kirby, 2003), these theories do not account for the inequalities experienced by single fathers unless you view their caring as a lone parent as feminised work. However, a critic of this dissertation may argue that as a female in the female dominated nursing profession (Witz, 1995), I would sympathise with such theories. Gender issues aside, I favour the feminist perspective since I believe it best accounts for the socioeconomically deprived position of a number of single parent families. What is apparent to me in addressing these theories is that I agree that the structural barriers are the main determinant preventing single parent families accessing the NHS and that these are created by society, I do not believe individual motivation is explanation enough in explaining such wide scale proven inequality. Chapter five however, will 'shed more light' on this issue.

Chapter Five: Exploration of the structure versus agency debate

5.1 Introduction to the concept of structure and agency

The purpose of this chapter is to explore issues that have arisen throughout this dissertation as to whether single parent families experience structural barriers preventing them from accessing the NHS due to individual choice or societal restrictions. In order to promote understanding for the reader, I will firstly define the concepts of structure and agency.

Sociologists such as the functionalist Durkheim (1895) would define structure as the social institutions that exert rules and constraint over individuals; an example of such an institution would be the NHS.

In contrast, the term agency requires individuals making decisions and choices regarding their lives therefore taking responsibility for these. In conflict with the functionalist view on structure exerting constraint over individuals Giddens (2001) would argue that structure may operate constraint but it does not determine what we do; we do not respond passively to rules and regulations. Symbolic interactionists such as Blumer (1969) and Goffman (1959) would state, "We are not the creatures of society, but its creators, "

Whilst these may be contrasting terms, Hays (1994) notes that it is important to recognise the interrelated connection between structure and agency. These will be addressed later in this chapter.

5.2 Are structural barriers really the confounding factor affecting single parents from accessing the NHS?

This question will be answered in terms of structure and agency. Therefore it will be analysed if single parent families cannot access the NHS due to their own agency or whether social structure/ social barriers prevent this.

As identified in chapter three, the factors affecting single parent families from accessing the NHS are poverty- particularly in the form of income, education, geography and NHS rules and regulations. These factors will now be discussed in terms of structure and agency.

Those who support the agency way of thinking would state that if an individual chooses to have a baby then they should have made the decision to save money and prevent the associated poverty in the first place. Therefore the income poverty associated with lone parenthood is a choice that these individuals have made. Such thinkers would believe that in order to overcome poverty an individual needs to make the choice and better oneself (Rogers, 1995). Equally, if a single parent family were not accessing the NHS due to lack of education; not realising medical care is required or fear of negative stereotyping from health professionals, it would be their fault for their lack of education. Again, it is possible to choose to take courses to improve education; the emphasis therefore is on individual inclination. With regards to geography, if you have children and you know you will be heavy consumers of NHS services then surely it would make sense to choose to live nearby such facilities? In conjunction with the health of single parent families, Morral (2001) would describe poor health as the result of unnecessary risky behaviour. This includes an unhealthy diet, indulging in alcohol, drug taking, cigarette smoking and unprotected sex. This explanation does not account for poor health as a result of illness with biological or genetic origins; it is too simplistic. The DoH (1992) took this cultural stance by stating that poor health is the result of individuals engaging in unhealthy behaviours. More difficult is explaining the role of agency and the individual concerning NHS rules and regulations. What can be said on the issue is that if the hospital rules and regulations are made

clear then the parent can act accordingly either obeying or rebelling against these rules depending on which best suits their interests..

However, I would strongly criticise this perspective. There is only so far one can influence their life choices, we have to for example live within the confines of the law and abide by rules and regulations or there are consequences in the form of sanctions. In relation to the agency utilised by single parent families again there is only so far agency can influence, they are ultimately confounded by the structural barriers of which will now be discussed. For example, if a single parent is discriminated against due to lack of education, surely to some extent this is due to the failing of the education system. All emphasis cannot be placed on the individual. Personally, I believe you can only be as good as the person teaching you. If a single parent does not receive sufficient welfare/ income to afford transport or childcare and this restricts their access to the NHS, surely this is due to a need to reform welfare funding. An individual cannot make this decision, it is a governmental issue and therefore a societal problem. An individual can however use their agency to use their political vote supporting their needs to reform the current welfare system. With regards to the issue of geography, more specifically locating close to NHS services if there is a need for access, this is an easy recommendation to make, much harder to implement. It depends on variables including: housing prices, housing availability and location to other important amenities such as schools and supermarkets (Furnham, 2007). Due to the poor socioeconomic position of a large number of single parent families described in chapter three, I am sure the reader can appreciate locating close to NHS services may just not be possible. NHS rules and regulations may be more easily manipulated than macro institutional barriers but in using agency and manipulating rules does

not mean that the single parent will obtain the access to care they are seeking. You can after all be asked to leave NHS premises by security!

5.3 Chapter conclusion

In conclusion to the structure and agency debate, whilst it is possible to use agency and influence personal ability to gain access to NHS services, ultimately access is determined by imposed structural barriers. This would indicate that no matter how much an individual tries to change their situation, they are always going to be confined to the nature of institutions in our society. Single parent families will continue to face these structural barriers in accessing NHS care unless there is change. By the nature of the structural barriers single parents face this change needs to be throughout institutions in society therefore requiring policy development of which will be discussed in the subsequent chapter six.

Nursing implications derived from the issues of structure and agency includes the need to be flexible. This is with regards to the enforcing of hospital rules and regulations in particular. For example visiting hours do not need to be unnecessarily strict if a single parent has difficulties in accessing transport or childcare. It is important to be empathetic to individuals' social situations and in acting in a flexible manner; rapport may be built up as part of a therapeutic relationship. It may also be possible to bring the care to individuals if geographical issues make it difficult for single parent families to access the NHS. However, as identified structural barriers are the main problem single parent families face in accessing the NHS. Therefore nursing practice alone will not solve this problem, it needs to be a focus of society as a whole, and it is not necessarily solely the NHS' problem.

Chapter Six: Would an equitable NHS be the solution to the access problems faced by single parent families?

6.1 Equality and equity- what is the difference?

Although the terms equality and equity were both defined in chapter one, a further explanation will be given here to clarify understanding of the chapter that follows for the reader.

In terms of access to the NHS, equality would mean equal access for all, that is the same standards of access for everyone. In terms of NHS services, equality would mean the same services for everyone. In comparison, equity in NHS service provision would mean services driven to those who most need them. Equity can therefore be viewed as a positive discrimination. That is high consumers receiving a larger share of services specifically dedicated to them. Equity in access would allow those who most need the services to access such services easily, in other words making the NHS more accessible. Therefore, in terms of single parent families equity in access to the NHS requires removal of structural barriers.

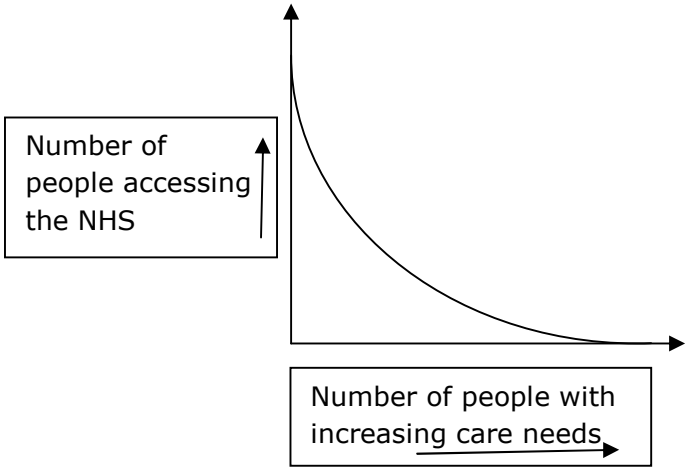
It is important to acknowledge that I am discussing equity purely in terms of access, that is services provided on the basis of need. There is also a related body of work in sociological literature advocating equity in terms of equal spending on all, equal treatment and equal treatment outcomes (British Social Attitudes Survey, 1994). I know this exists but am excluding it on the basis of being irrelevant to my dissertation aims.

6.2 'The Inverse Care Law'

Relating to the ideal of equity in access and positive discrimination in access to NHS services is Hart's (1971) Inverse Care Law. The diagram below (figure 6.2) is a representation of the curve graph Hart (1971) used to

illustrate the law. The term was used to describe how people in society most needing NHS services actually obtain them later and in small amounts. This is compared to individuals with less need for NHS services who use more. This dissertation has already discussed single parents higher than average needs as consumers of the NHS and difficulties in accessing the NHS. Therefore surely this societal group fit this law?

Figure 6.2 The Inverse Care Law (Hart, 1971)



If Hart published this work in 1971 making the serious observation that people most in need of NHS services were not receiving them, why was nothing done to address the issue? Why now are single parent families still experiencing structural barriers in accessing the NHS?

Hart can be criticised in that there was no published statistical evidence which would prove this 'law' true. It is difficult to categorize who is in the 'most at need' category and therefore I would consider the whole law to be very subjective. I also have an issue with the terminology; 'law' would imply something that is provable and true in all cases however there is no

research published that proves all societal groups in the UK most in need of NHS services do not receive them adequately.

In support of Hart (1971) is Moram (1999) who details how the NHS serves the interests of middle class people. As a practitioner this would lead me one to believe it is important to listen to the demands of single parent families and other groups disadvantaged in society. If services are shaped around their needs then maybe the inverse care law could be reversed. As a way of achieving this service questionnaires need to be distributed to all individuals and action taken based on the feedback received. This would serve the purpose of having an equitable health service who met the needs/ expectations of the highest consumers and at the same time serve the purpose of empowering individuals by giving them more choice and valuing their opinions.

6.3 What policies would better solve the problem?

So it has been established that for single parent families to equitably access the NHS structural barriers need to be removed. I will now suggest how this could potentially be achieved in the form of policy implementation. I will first recommend policies affecting the structural barriers in society before a specific focus on the NHS collaborating previous policy recommendations from chapter three with nursing implications that have been discussed throughout this dissertation.

6.3.1 Societal policy recommendations

1. Increased state welfare benefits for low income single parent families
2. Subsidised childcare for single parent families
3. Access to learning courses free for single parents
4. Provision of free pre-schooling for low income single parent families
5. Improved quality of council housing

6. Free public transport for low income single parent families
7. Increased taxation for wealthy
8. More spending on service provision for disadvantaged groups in society

6.3.2 NHS policy recommendations

1. Free transport to NHS facilities for single parent families
2. Increase contact with nurse/ G.P's in home environment
3. Free dental and sight tests for low income single parent families
4. Abolition of prescription charges for single parent families
5. Childcare facilities provided in hospital
6. Flexible rules relating to parental accommodation and visiting times
7. More spending on NHS for disadvantaged groups in society

It is hoped that these policies would not only provide equitable accessible care for single parent families but also bridge the inequality gap in society thus improving standards of health for everyone. However, the only way these policies could ever arise is if people use their political vote to elect governments who want to bring about equity in access to NHS care. An indirect recommendation for nursing practice is for nurses to use their political vote to influence these changes.

6.4 Problems of inequality in contemporary society

This dissertation has established that the inequalities experienced by single parent families prevent them from accessing the NHS. Single parent families are not the only group in society to experience this, and indeed other physical and environmental factors can make their experience of accessing the NHS even more fraught with unnecessary discrimination and problems.

For example ethnic minority single parent families experience the same structural barriers but also have institutional racism as an additional structural barrier to accessing the NHS. Wilkinson (1996) notes how racism can have a negative impact on the health of the individual in three distinct ways:

1. Firstly either individual or institutional racism in service provision and delivery;
2. Secondly, the effect of racism in society which can have an effect on health such as the provision of housing, the education system and the provision of social welfare;
3. Finally, the direct impact of racism on health such as internalised anger raising blood pressure and racially motivated physical assaults.

Related to ethnic minority single parent families, Cooper et al. (1998) have identified a lack of culturally appropriate children's health services. However, Henley and Schott (1999) have argued that if people do not use services it is not always the result of racism, it is because there is inadequate information about what services are available. Studies by Gerrish et al. (1996) have found that the NHS may sometimes portray negative attitudes to ethnic minority groups which can compromise care. It is therefore important in our multicultural society to ensure everyone knows their rights with regards to accessing the NHS. As a nurse I feel it is important to provide culturally appropriate care. This involves establishing care needs in a detailed care plan including: diet, religious needs and booking an interpreter if necessary to overcome language barriers.

Another example of how single parent families can experience further structural barriers in accessing the NHS is in living with a disability. Again this seems to echo Hart's (1971) Inverse Care Law since it would seem appropriate to assume that an individual living with a physical or mental disability would require a higher than average need to access NHS services.

Barnes et al. (1999) states that the structural barriers disabled people face are discriminatory; that is based on prejudice. Again, this structural barrier is not just unique to the NHS but a feature of our society. Discrimination is said to be present in the education system, housing sector, provision of public transport and welfare and social services (Barnes et al., 1999). Morris (1991) reinforces this viewpoint and concurs that prejudice creates negative attitudes, stereotypes and patronisation.

Recommendations for practice in such situations again reinforce the need for non discriminatory attitudes ensuring that the language used and interactions between disabled single parents are not patronising. It is important to remember that though disabled, the parent is still capable of single handedly raising children and coping with the associated demands.

Again even if the NHS take on the above recommendations, this is a problem deeply engrained throughout all areas of society which would suggest action needs to take place to promote equality throughout out institutions.

Chapter Seven: Conclusion

7.1 Research Findings

In critically reviewing the literature related to accessing the NHS, it has become clear that single parent families do experience structural barriers in equitably accessing the NHS. However, these barriers often have wider implications than solely accessing health care services, the impact of the social barriers affecting single parent families is experienced in all areas of society.

Below is a summary of the structural barriers I have identified; they are categorised as either macro, meso or micro depending on the nature of the barrier:

Figure 7.1 Table to summarise the structural barriers encountered by single parent families in accessing the NHS

Macro	**Meso**	**Micro**
Economy	Transport service	Hospital rules and regulations
Welfare and benefit system	Public service provision	Attitudes of health professionals
Education system	NHS charges	Individual motivation
		Child care

As a way of overcoming these structural barriers the implications for nursing practice will be discussed at a later point in this chapter. However, the policy recommendations listed in chapter six are a way of alleviating the inequalities experienced by single parent families as a result of these structural barriers.

I advocate the need for equitable access since single parent families higher than average needs as consumers are established due to the fact that

ninety per cent are headed by females (Duncan and Edwards, 1999) and the associated continuing health care needs of having children (Adelman and Bradshaw, 1998). I think that creating an NHS whereby societal groups most in need of care have better access to services we will better serve the population and improve overall levels of health. Health will also improve if the government delivers policies to eradicate poverty and promote equality (Wilkinson, 1996). Although indirectly linked to the NHS a review of the associated literature reiterates this is probably the most important determinant in improving health. With regards to the structural barriers experienced by single parent families, it is clear that micro and meso barriers despite requiring policy and budget changes would be plausible to achieve. However, the macro barrier of the economy is a limitation in that it is influenced by worldwide issues (Sennett, 2006). As I have little experience in economics it is hard to make recommendations regarding changing the nature of the economy, I can however recognise and acknowledge its importance in being a structural barrier preventing single parent families from accessing the NHS.

7.2 What do these findings add to the current sphere of knowledge?

Whilst I have not conducted any primary research the eclectic reading and literature I have reviewed and subsequently collaborated I feel has bought to the forefront the important issue in nursing and sociology of the structural barriers faced by lone parent families in accessing the NHS. I have found that despite government programmes like Sure Start and various NHS publications designed to tackle health inequalities, they still exist and that the health gap is actually widening. Rarely does the sociological literature I have reviewed as part of the dissertation process make recommendations regarding governmental policy. I feel I add this extra dimension; not only have I identified the structural barriers, more importantly I feel is that I

have made suggestions to overcome these structural barriers. This is important since to solve the access problem single parent families (and other societal groups) face decisive action needs to be taken.

I also feel that in writing this from my perspective as a student nurse another dimension is added to this dissertation. This is because I am able to give implications for nursing practice therefore helping to change the way single parent families access NHS care on a micro level in relation to therapeutic relationships and hospital rules and regulations.

7.3 Implications for nursing practice and the allied health disciplines

Implications drawing links to nursing practice and the other allied health disciplines have been discussed throughout the course of this dissertation. Below is a summary of the important findings related to practice:

- Provide non discriminatory, non judgemental care
- Be flexible with regards to visiting hours and accompanying children
- Include children present in the consultation and be vigilant for their safety whilst on NHS premises
- Where possible give useful information regarding accessing services closer to the home or using free hospital provided transport
- Offer the parent social and emotional support
- Tailor individualised care plans to fit the needs and expectations of the parent or child in your care
- Ensure single parent families are aware of their rights to accessing NHS care as set directed in the NHS Constitution (2009)
- Use political vote to support the party with an agenda to eliminate health inequalities and improve access for societal groups such as single parent families

It is recommended that in following the implications discussed above single parent families will achieve a better standard of NHS care which could encourage them to continue accessing such services in the future. This will also enable the nurse or other health professional to achieve optimal levels of care in the services given. Although I would also advocate the need for care to be equitable, this is a policy that needs to be implemented by the NHS on an organisational level thus deterring me from advising it as an implication for practice for nurse and other allied health professionals.

7.4 What the dissertation process has taught me

This process of creating my dissertation has reinforced to me the importance of both evidence based care and the need for health related policies based on the best evidence available.

In discussing nursing implications this had also led me to question personally the level of care that I give. I have reflected on what I consider to be best practice in order to generate the previously discussed recommendations for nursing practice and have more awareness of the future repercussions a positive therapeutic relationship can have for patients/ clients. I will continue using these critical, questioning skills in future as they are a way of bringing about change and moving practice forward in line with the needs and expectations of the population we are serving.

Reviewing such a vast amount of literature has personally led to new insights in the fields of sociology and nursing. I recognise the importance of continuing reading as a way of broadening knowledge in all areas of practice. Subsequent care will be better as it will be informed. Overall I found this process to be beneficial to me in both an academic sense and a practical one.