

Module Title and Code: Digital Skills and Research Methods LCHS4007

Component 2 - Research Report

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Introduction

Timely and fair healthcare is of the essence in the UK NHS, but the inequality-related problems can still be witnessed in terms of receiving care and in a timely manner. In addition to being universal, it is shown that individuals in underprivileged regions and ethnic minorities have to wait much longer before treatment, deteriorating health conditions and wellbeing (ONS, 2024). The secondary data in this report informs the discussion of the problem of NHS waiting times and access differences in England and is critical of the research and policy evidence, as well as outlines appropriate research methods and data sources to use in future research.

Selection of a Research Topic

Identifying the Issue

Access to the NHS is characterised by disparities, in particular, the waiting time in the elective and secondary care, which is a major health issue in the UK. NHS England monitors such indicators as Referral to Treatment (RTT) waiting time, and millions of patients have to wait longer than the official standard because of systemic limitations (ONS, 2024). Studies indicate that people in underprivileged communities or those of ethnic minorities are overrepresented, which is a manifestation of broader socioeconomic and structural inequalities.

Affected Population and Importance

Over 6 million have been awaiting non-emergency treatment in a hospital across England, and millions have been over 18-week referral-to-treatment goals (The Kings Fund, 2024). Long waits may exacerbate health status, cause decreased life quality and create more healthcare utilisation (James, Denholm and Wood, 2024). NHS disparities also undermine confidence among the populace, as the level of satisfaction is at an all-time low, especially because of delays in services and access blocks to them. The challenge overlaps with socioeconomic deprivation, geographic disparity, and ethnicity, and is a serious social justice and social health issue.

Rationale for Topic Choice

The issue is relevant to the UK health policy priorities, i.e., the decrease in health disparities and the enhancement of access to care (ONS, 2024). It is important to address these inequalities in order to meet the NHS strategy and public health objectives. The reason I am interested in this is that I am aware that fair access is critical to the performance of the system and social life. As a future researcher, I will have a chance to impact the health policy reform

by learning the patterns of healthcare access and providing evidence to address policy solutions in the future, particularly when it comes to persistent waiting-time disparities.

Evaluating Information Sources

In order to carry out this secondary research, three credible sources were selected and evaluated in terms of relevance, rigour and contribution to inequalities in NHS access:

Source 1: “How can health systems approach reducing health inequalities? An in-depth qualitative case study in the UK”

Parbery-Clark et al. (2024) investigate how health systems can help to decrease socioeconomic health inequalities. They use a thorough qualitative research in one of the local urban authorities in UK. Interviews and document analysis are employed in the study to find out facilitators (integrated population health plans, cross-agency collaboration, community assets and strategic coherence), but the attempts to explicitly reduce inequalities are not established in practise yet. Structural barriers, data sharing problems, and system pressures still exist. The source is valuable as it presents empirical data on the use of system-level strategies and challenges, and this information can contribute directly to the topic of the report about NHS access inequalities and the necessity of changing the system.

Source 2: “Harnessing deliberative regulation to address inequities in accessing healthcare services in England”

Germain and Veronesi (2024) discuss the impacts of regulatory structures in England on access to NHS services by maintaining that decisions made at the system level in terms of commissioning, resource allocation and prioritisation are factors that lead to ongoing inequalities in access. They suggest a deliberative regulation model, the focus of which is the participative and open decision-making process with the deliberate involvement of marginalised populations. The article, on the one hand, emphasises the fact that present-day governance practises are unintentionally limiting access and reforms are proposed to bring equity and accountability to policy, which supports the idea that inequities are policy-driven, rather than clinical problems.

Source 3: “Effects of the COVID-19 pandemic on NHS England waiting times for elective care”

According to a report in The Lancet, a modelling study conducted by Shah, Robertson and Sheikh (2024) revealed that with the COVID-19 pandemic, NHS England elective care was

significantly disrupted, resulting in a backlog of more than 7.2 million patients who needed hospital treatment as of October 2022. The study estimates the results in diverse capacity-increase cases and also brings out the difficulties of planning towards recovery. It highlights the impact of pressure on the pandemic on access to elective services, which increased wait time and systemic pressure. The value of this source is that it measures the increase in waiting-time and justifies the report on the inequity of access in the area of the NHS.

Gaps in Current Research

The research on the issue of NHS access inequalities is normally focused on the individual-level and lacks a comprehensive analysis of the problem that incorporates a mix of socioeconomic, geographic, and clinical variables (Parbery-Clark et al., 2024; Germain and Veronesi, 2024). The secondary data on multilevel can only causally explain the long-term outcomes of waiting-time disparities and causal pathway (Shah, Robertson and Sheikh, 2024) and, therefore, might need a deeper level of evidence on a combination of quantitative data to explain the structural inequities in access comprehensively.

Research Methodologies

Quantitative, Qualitative, and Mixed Methods Defined

- In quantitative research, numerical data are used to test and quantify the variables, which are best suited to the measurement of patterns and correlations (e.g., waiting list lengths, demographic differentials) (Clark et al., 2021).
- Qualitative studies investigate meanings and perceptions in non-numerical data such as interviews and focus groups, which are appropriate to identify the lived experience of access to healthcare (Johnson and Christensen, 2024).
- Mixed methods are used to bring together both to have a broad perspective, which brings both breadth and depth of understanding (Clark et al., 2021).

Selected Methodology

In the present case, the quantitative approach is the most suitable as the researcher will be interested in analysing the secondary data, i.e., the data on the NHS waiting times and the differences between the demographic groups, to produce the evidence regarding the magnitude, pattern, and associations of the access disparities. Both the NHS and ONS administrative datasets, which are large, will be statistically analysed to measure the disparity and trends over time, which will allow testing the hypothesis about the factors associated with unequal access (Grønmo, 2024).

Justification

The quantitative approach to research meets the objective of the research to evaluate the degree and condition of disparities in the accessibility of NHS services, making it possible to objectively measure the difference and its trend. It additionally facilitates strong generalisation within the English population and is appropriate with secondary sources of data like national surveys and administrative records (Clark et al., 2021).

Data Collection

Primary vs Secondary Data

- Primary data are gathered directly through the researcher in the form of surveys, interviews or experiments in order to provide specific research-related information (Creswell and Creswell, 2018).
- Secondary data are initially gathered for different purposes and re-analysed, including administrative records, national health statistics and surveys, and are useful in large-scale studies where there is no new collection (Flanagan and Beck, 2024; Kelly, Peters and Farber, 2024).

Chosen Data Type

The secondary data that will be utilised in this research will be NHS England waiting-list statistics, Office for National Statistics health surveys and quantitative research results published in peer-reviewed journals. The use of secondary data is adequate because the research question is wide and extensive, and abundant, rich datasets are available without any necessity to collect new data (Flanagan and Beck, 2024; Kelly, Peters and Farber, 2024). Secondary data enables an affordable study of the population-wide patterns and trends, which can facilitate a strong investigation of inequalities in NHS access between demographic groups (Kelly, Peters and Farber, 2024).

Advantages and Challenges

Advantages: Secondary data are cheap, one can study large groups of persons over time, and the research can be conducted on likely comparisons between the categories of the demographics (Kelly, Peters and Farber, 2024).

Challenges: The potential biases in measuring, the inability to control the initial data gathering, and the absence of data on certain subgroups are the main challenges that need to be evaluated and addressed concerning the corresponding statistical methods (Kelly, Peters and Farber, 2024).

Conclusion

The disparity in access to NHS services and wait times in England is a social health issue which is unevenly distributed across the deprived and marginalised groups. The evidence of secondary data indicates that disparity in access to care is caused by systemic factors such as resource allocation, regulatory frameworks and post-pandemic backlogs. The national datasets can be quantitatively analysed to provide a means of determining the areas of priority intervention as a way of policy formulation and ensuring equity. Evidence based reforms can be directed through further research which consists of secondary data. These reforms can enable the NHS to retain its commitment of equal access.

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