Health Equity Evidence Centre

What works: Mitigating inequalities in patient self-referral to specialist services

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EVIDENCE BRIEF

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Summary

General practice is currently under considerable pressure because of a mismatch between supply and demand. Self-referral of patients directly to specialist services may help relieve pressure from GPs; however, concerns have been raised that this may increase inequalities.

Based on our review of 19 studies, we found evidence that generally, self-referral services tend to be used more by higher socio-economic groups, white groups, women, and young populations, although these patterns were not consistent in every context.

We did not find any evidence of interventions to mitigate the potential of self-referral to increase inequalities. In the absence of direct evidence, we developed the following recommendations based on transferable evidence-informed principles to address inequalities: targeting self-referral at those in greatest need, such as rolling out in areas of socio-economic disadvantage; increasing capacity in those areas; prioritising conditions linked with disadvantage; ensuring the pathways are flexible, culturally competent, and co-designed; and monitoring use and outcomes disaggregated by disadvantaged groups.

Current challenges

General practice is the gatekeeper for most secondary care services. However, it is under considerable strain with a mismatch between demand and capacity. This has led to a drop in overall patient satisfaction in general practice to the lowest recorded. Data from the GP Patient Survey found that overall satisfaction in general practice is down from 83% in 2019 to 71% in 2023 (1). Patient satisfaction with access has also dropped substantially; from 68% in 2019 to 50% in 2023 (1).

One approach to help improve access for patients is self-referral or direct access pathways: routes to accessing specialist care without referral from a GP. As of May 2023, over 30,000 patients self-refer each month in the NHS for sexual health services, antenatal care, optometry, audiology, physiotherapy, alcohol and drug services, smoking cessation, and some psychological therapies.

Those in favour argue that self-referral empowers patients to take control of their own health while reducing the workload for GPs. However, critics raise concerns about inappropriate use of specialist services and an increase in inequalities because those with greater health literacy are more likely to be aware of and navigate self-refer pathways.

Summary of evidence

There was no evidence examining interventions to address inequalities in self-referral. However, we identified 19 articles which examined the relationship between self-referral and health inequalities. Nine studies focused on physiotherapy, six on mental health and psychology services, and one each on cancer specialists, chronic venous insufficiency, health coaching, and hepatitis C support.

Socio-economic status

Ten studies reported on socio-economic status. Four studies found that the most affluent patients were most likely to self-refer (2-5). Six studies found that the most educated groups with higher levels of qualification were more likely to self-refer (3, 6-10). Looking at physiotherapy referrals, Leemrijse (2008) found that higher education was the strongest predictor for self-referral, and those with a higher level of education were twice as likely to self-refer in Scheele (2014) and Lankhorst (2020) (7, 8, 10). Bishop (2017) found no difference between self-referral or GP referral rates to physiotherapy amongst those with no qualifications (4). Of the six studies that explored employment status, two found that those who were employed were more

likely to self-refer.
However, Brown (2014) found unemployed people were more likely to self-refer to psychological services, perhaps because of a higher prevalence of mental illness, while the other studies found no difference between employment groups (11).

Ethnicity

Eight of the studies explored the association between ethnicity and self-referral. Of these, five of the studies found that minority ethnic groups had lower rates of self-referral, suggesting a widening of inequality (2-4, 6, 11). Brown (2014) found no difference by ethnicity; however, the authors did find that ethnic groups were overall under-represented in all referral routes to psychological services11. By contrast, Clark (2009) found that in the more ethnically diverse site of Newham, individuals from the black community made up a significantly larger proportion of the self-referral group (22.2%) to psychological services compared to the GP referral group (15.9%) (12). However, the authors found no difference in the predominantly white community of Doncaster. Finally, Horrell (2014) found that, compared to the demographics of the local population, the proportion of self-referrals to psychological services was more than 1.5 times likely to be Black and more than twice as likely to be Asian or of mixed ethnicity (13).

Age and gender

Eight studies, of which three explored referrals to psychological services, found no significant difference between the genders in terms of rates of self-referral (2, 3, 8, 9, 11, 14-16). Four studies found that women were more likely to self-refer, accounting for 73.8% of self-referrals in O'Hara (2015) and 80% in Horrell (2014) (4, 6, 13, 17).

Fifteen studies explored the association between patient age and self-referral. Of these, seven studies found no significant difference in self-referral rates by age (3, 4, 6, 13-15, 17). Seven other studies, however, found that self-referral patients were more likely to be younger (7, 8, 10, 11, 16, 18, 19). Hoffmann (2019) was the only study to find that self-referral patients were slightly older (3.4 years) than referrals from GPs to psychological services (9).

What works: key recommendations

We did not find any evidence of models of self-referral which seek to address inequalities. The available evidence highlights the potential for self-referral services to be used more by higher socio-economic groups, white groups, women, and young populations. In the absence of direct evidence, the following recommendations are given, based on the following evidence-informed principles:

- Addressing geographic inequalities in the distribution of services
- Focusing on conditions which have the strongest association with disadvantage
- Flexible and convenient
- Culturally competent

Recommendation	Target audience	GRADE certainty
Consider implementing self-referral in areas of greatest need first, before rolling out more widely	Practices/	⊕◯◯◯ Very low
Health planners should ensure that capacity is distributed proportionately to need, such as providing more appointments in socio-economically disadvantaged areas	PCNs/ICBs	⊕⊕⊕◯ Moderate
Consider direct access for conditions that are intrinsically linked with disadvantage, such as smoking, drug and alcohol addiction and obesity. Additionally, consider direct access for specifc patient groups, such as those with severe mental illness, homeless populations or people seeking asylum and refugees	ICBs/ Nationally	⊕⊕◯◯ Low
Self-referral pathways should be flexible to allow access for people without digital access, transport or other needs	Practices/	⊕⊕◯◯ Low

The process for self-referral should be as easy as possible for patients because activities which require more effort or resources from patients tend to increase inequalities	PCNs/ICBs	Low
Ensure that pathways are designed in a culturally competent manner, such as ensuring information in different languages and considering patients' preferences regarding staff gender	Practices/	Low
Data disaggregated by socio-economic group and ethnicity is needed to understand and track inequalities in the use of self-referral	PCNs/ICBs	Low
Decision makers should include the lived experience of disadvantaged patients in the design and monitoring of services	ICBs/ National	Low

Case study

Insight Healthcare in the East Midlands undertook an initiative to increase access for refugees and people seeking asylum to Improving Access to Psychological Therapies (IAPT). The team identified a substantial shortfall in the number of refugees and people seeking asylum who had been referred to IAPT. Through a multi-agency approach, a transparent pathway for refugees and people seeking asylum was established. Forging effective relationships with refugee forum staff and clients, as well as training professional interpreters in Cognitive Behavioural Therapy, was key to the increase in self-referrals at the end of the 6-month evaluation.

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