Health inequities in the digital age:

beyond neoliberal solutions

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Thank you

To the organisers for inviting me

To you all for attending and engaging

To my research team, university, collaborators and funders

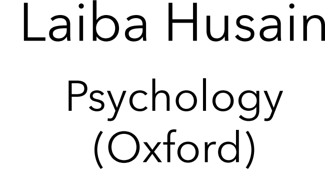
Acknowledging the next generation

Francesca Dakin

Anthropology (Oxford)

Sarah Rybczynska-Bunt

Sociology (Plymouth)



Laiba Husain

Psychology (Oxford)

Inter [or trans] disciplinarity
Not just collaboration across disciplines but the active harnessing of *contestation* and even *conflict* among disciplines

The ‘neoliberal’ approach to digital health inequities

Background: the changing nature of healthcare work

Fragmentation

when delivery of a single episode of care is spread across a large number of providers

Taskification

when healthcare is reduced to tasks

De-professionalisation

when professionals’ elite status, exclusive knowledge and advanced skills are undervalued and even derided

Complexification

task complexity:

number of individuals, technologies, interactions and sub-processes

value complexity:

clashes of professional norms and scope of practice

Distanciation

the stretching of social systems across time and space

Disembedding

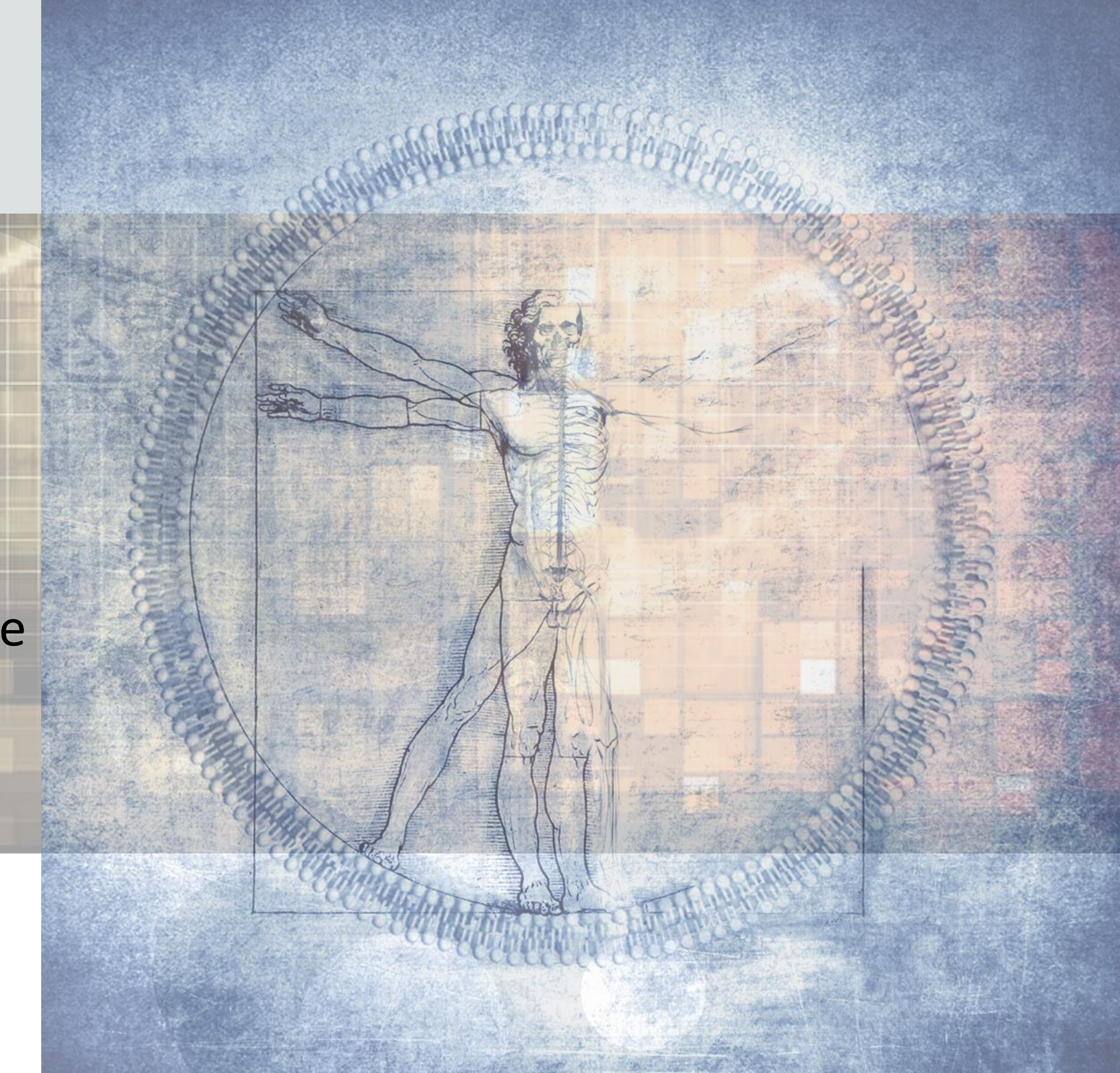
social activities increasingly occur at a distance, removed from the immediacies of context

Responsibilisation

when people are rendered individually responsible for tasks which previously would have been the duty of another

Facsimilisation

Creating a ‘digital facsimile’ of the patient on the electronic record and ‘treating’ that facsimile



Summary so far

We cannot examine the digitalisation of healthcare without also engaging with its fragmentation, taskification, deprofessionalisation, complexification, distanciation, disembedding, responsibilisation and facsimilisation

Time for
some data

The Remote by Default 2 study
Acknowledging the RBD2 research team, participating practices, PPI groups and NIHR

Based on research on 12 UK GP practices, July 2021- Dec 2023

Research question:

What has been the impact of the shift to remote and digital modalities for triage and clinical care in UK general practice?

Definitions

Remote encounter: when the patient and the staff member are not co-located

Digital encounter: undertaken with the aid of digital technologies

We collected a mostly-qualitative dataset

WORKSHOPS

SAFETY INCIDENTS

The current context for delivering general practice care

Financial austerity

Fewer GPs, more non-medical clinicians, wider range of support staff, new roles

Loss of in-person interactions between staff

More patients, more complex patterns of illness

Our 12 practices varied in digital maturity

Digital trailblazer	• all the kit, all the know-how
Digitally strategic	• thinking and planning with tech
Digitally curious / digitally reactive	• playing around, following the must-dos
Digitally hesitant	• unsure, under-equipped, lacking knowledge and leadership
Strategically traditional	• serving deprived communities ('Deep End') via in-person care

Some groups had access challenges

NB intersectionality

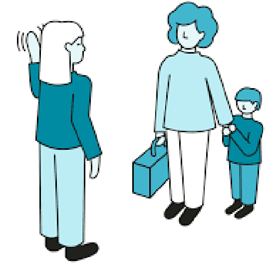
poverty

older age

low health literacy

low digital literacy

non-white ethnicity



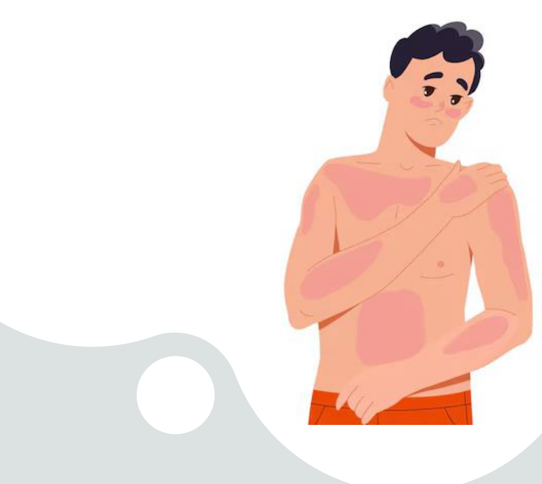
displaced groups

specific impairments

multi-morbidity or social complexity

poor housing

Three patients with intersecting disadvantage



George: unable to create a digital facsimile

Contents lists available at ScienceDirect

Social Science & Medicine

journal homepage: www.elsevier.com/locate/socscimed

Access and triage in contemporary general practice: A novel theory of digital candidacy

Francesca H. Dakin [a,*], Sarah Rybczynska-Bunt [b], Rebecca Rosen [c], Aileen Clarke [a], Trisha Greenhalgh [a]

Amir: unable to navigate algorithms or negotiate access at the digital front door

ORIGINAL ARTICLE

SOCIOLOGY OF HEALTH & ILLNESS

The reflexive imperative in the digital age: Using Archer's 'fractured reflexivity' to theorise widening inequities in UK general practice

Sarah Rybczynska-Bunt[1] | Richard Byng[1] | Sophie Spitters[2] | Sara E. Shaw[3] | Ben Jameson[4] | Trisha Greenhalgh[3]

Selma: bewildered and alienated by the fragmentation and taskification of her care

British Journal of General Practice, Online First 2024

Developing user personas to capture intersecting dimensions of disadvantage in older patients who are marginalised:

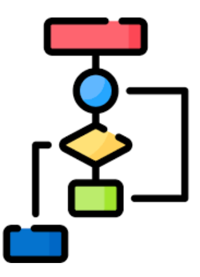
a qualitative study

Laiba Husain, Teresa Finlay, Arqam Husain, Joseph Wherton, Gemma Hughes and Trisha Greenhalgh

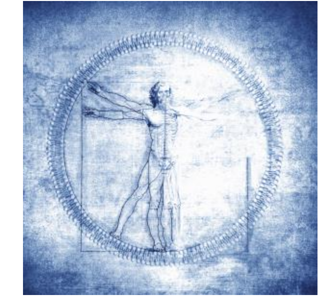
Instead of a model of equity based on individual deficits...

....we need to address the structural causes of inequity that are built into the system...

Structural causes of “digital” inequities: a preliminary hit list



Expectation that patient can follow algorithms and make judgements in real time



Expectation that patient must populate their own digital record

Remote-only access routes (walk-ups are sent home)

Unconsciously stereotyping “deserving” kinds of disability

Deconstruction of the patient into fragments, each of which is managed by the cheapest person who can do a task

What happened to our 12 practices?

Digital trailblazer	→ continued to innovate
Digitally strategic	→ adapted workflows; withdrew tech that didn't add value
Digitally curious / digitally reactive	→ many progressed to digitally strategic over the study period
Digitally hesitant	→ mostly made little progress
Strategically traditional	→ persisted in a non-digital strategy (and could defend it)

What happened to our 12 practices?

Instead of classifying strategically traditional organisations as digital "laggards", we should reward them and learn from them

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Protocol and baseline findings

Final findings (case study and synopsis)

More to come here (in press for NIHR Library)

Some papers from the RBD2 study

Access and equity

'Technostress', staff wellbeing and team relations

PLAIN ENGLISH RESOURCES

- Patient leaflets
- Competencies for staff providing remote care
- Quick-read briefings for practitioners and policymakers

Continuity

Staff training needs including core competencies

Safety

Quality

Details of our data sources

Ethnographic observation in 12 GP practices: 500 hours

Interviews: 132 staff, 31 patients, 39 remote care stakeholders

Online patient reviews of practices: 208

Online multi-sector workshops: 8 hours, 184 participants (recorded)

Documents: reports, surveys, training materials

95 safety incidents reported to various national bodies

Data analysis

Multi-site case study methodology

Each site analysed as its own case

Commonalities and contrasts

Written up as an in-depth narrative

Cross-cutting themes e.g.

Quality = effectiveness + efficiency + access/ equity + continuity + patient-centredness + safety

Staff: training needs + wellbeing