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U.K.'S RESPONSE ON UEMO QUESTIONNAIRE ON GP'S SERVING DEPRIVED POPULATIONS

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UEMO questionnaire on

GP's serving deprived populations

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1. Do GPs in your country face problems in access of services or in delivering health care towards certain sub-populations (people in socio-economic poor condition, people in deprived areas, immigrants, asylum seekers, refugees, eg)? Please give a brief general answer and enclose relevant documents.

Yes, there is a huge research base. We know that poorer patients have more serious illness but tend to be diagnosed later and take longer to access effective treatment (eg Pell JP, Pell ACH, Norrie J, Ford I, Cobbe SM- Effect of socio-economic deprivation on waiting time for cardiac surgery: retrospective cohort study. BMJ 2000; 320: 15-18).

Poorer patients appear to have much less access to preventative health care, probably because they are overwhelmed or distracted by more immediate problems (eg Atri J, Falshaw M, Livingstone A, Robson J – Fair shares in health care? Ethnic and socio-economic influences on recording of preventative care in selected inner London practices. BMJ 1996: 312:614-7) Poor health is linked to poor education, poor housing and poor standards of living.

There are often language difficulties and poor communication in informing and treating. Refugees and asylum seekers have particular health care problems (eg Levenson R, Coker N – The Health of Refugees, King's Fund 1999). Deprived people tend to congregate in certain areas and there can be difficulties in providing good quality health care in specified areas.

2. What is the distribution of these problems in your country. Is it a general problem, does it occur only or mainly in large inner cities or is it a problem that occurs in rural areas?

- 2.1 Please give a brief description and make a distinction between rural and urban areas.

Deprived people tend to move to large cities in order to look for jobs and to seek other people in similar situations with whom they can find solace. Therefore, there is undoubtedly a concentration of problems in deprived inner city areas, but there are also areas of very serious rural deprivation which tend to be more hidden and perhaps even harder to address.

- 2.2 Is there a system of identifying deprived areas? Yes

In case there is, please give a brief description and enclose relevant documents or policy paper.

The Jarman Index, designed to identify deprived areas, has been used for a scheme of deprivation payments for GPs since 1990. It uses eight key factors which a panel of GPs identified as responsible for increasing their workload or contributing to their pressure of work. The eight factors were: elderly living alone; under 5s; unskilled; unemployed; single parent households; overcrowded households; persons who have moved house; residents in ethnic minority households. By weighting each factor according to its perceived impact on workload, Jarman created the basis of his index of deprivation, using census data for each electoral ward in England and postcode area in Scotland to derive a list of scores. (Jarman B. Identification of underprivileged areas. BMJ 1983;286:1705-8) The indices are not infallible, and have been subjected to much justified criticism.

3. It is well known that mortality and morbidity in a population in poor socio-economic status is high compared to the country's average.

3.1 Is there any data or research specific to the situation in your country. Please give a brief overview and enclose relevant documents

The 1998 Acheson Report of the Independent Inquiry into Inequalities in Health (The Stationary Office 1998) summarises the effects of socio-economic inequalities on health in the UK, and includes 529 references to other research on the issues.

4. Does the health status of the people living in deprived areas influence the work or the workload of GPs delivering cure and care?

GPs working in deprived areas are caring for populations who are carrying a disproportionately high burden of disease and therefore inevitably, if a high standard of health care is to be delivered, the workload will be higher. Such GPs also face a much greater preventative health agenda. All this is compounded in those ethnic minority communities where English is not a first language. Consultations which require the services of an interpreter inevitably take at least twice as long as a similar consultation where both parties speak fluent English.

5. In deprived areas, do GPs experience problems during delivering cure and care:

5.1 Towards knowledge/skills

In areas of socio-economic deprivation, there are high levels of morbidity and inevitably there are large numbers of individuals suffering complex multiple morbidities. As most biomedical research is based on single disease conditions there is very little secure knowledge to inform the management of these patients.

It is also difficult to transmit knowledge to the patients (ie in the matter of self help and taking responsibility for one's well being).

5.2 Towards co-operation with other health organisations

The greater a population's need for social support, the less is its community likely to be able to offer, and the more over-stretched are all the local agencies, including health organisations, all of which impairs effective liaison and joint working.

5.3 Towards financing the work of GPs. In other words, does the extra effort or the co-operation with other health organisations lead to extra funding?

Deprivation payments help a little but in no way reflect the additional workload. As the Acheson report pointed out, the present extent of health inequalities demands a combination of “upstream” and “downstream” solutions. Upstream, societal changes are required to prevent further damage, while downstream, the existing damage demands medical treatment for those already affected. General practitioners and other primary care professionals in deprived areas, already struggling with an excessive burden of ill health, also face a much greater challenge in the extent and power of the socio-economic determinants of ill-health that they need to confront. There is an urgent need to find ways of measuring this double jeopardy so that it can be more appropriately reflected in the allocation of resources, both within and outside the National Health Service.

6. Are these problems reported?

6.1 Please give examples or refer to literature

There is an enormous and constantly growing body of literature, best summarised in the 1998 Acheson report (see question 3.1)

7. Are these problems known by your (local) government or the medical organisation?

Yes, but the primary function of government and politicians is to be re-elected at the next election, and therefore the problems are subsumed into the electoral calculations. The BMA constantly argues for the patients.

8. Are these problems acknowledged by your (local) government or the medical organisation?

Yes, see Q7. Acknowledgement does not necessarily follow awareness (and if it is forced to, it is often dealt with by placing the blame elsewhere)

9. Is there a special policy to support GPs working in deprived areas or GPs working for deprived populations? Give details.

In London, the London Initiative Zone Education Initiative (LIZEI) scheme used education as an incentive to attract general practitioners to enter, stay in, or return to, general practice in inner cities, but this scheme has now been discontinued. Apart from a few isolated local schemes, only the deprivation payment scheme supports GPs directly, and the methods of defining deprivation are subject to criticism. More indirect support is provided by the government’s wider initiatives including Sure Start for vulnerable young families and Health Action Zones, but, as yet, these do not cover all deprived areas.

10. Please give your suggestions for the UEMO policy paper on GPs serving deprived populations.

The paper should demand clarity in the approach to serving deprived populations vis-a vis

- (i) funding
- (ii) availability of medical personnel
- (iii) a clear link-up with education and employment