Socioeconomic determinants of health

Health inequalities: relative or absolute material standards?

Richard G Wilkinson

See editorial by Haines and Smith and pp 541, 547, 553, 558

This is the first in a series of eight articles examining factors that affect the relation between deprivation and health

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That mortality in developed countries is affected more by relative than absolute living standards is shown by three pieces of evidence. Firstly, mortality is related more closely to relative income within countries than to differences in absolute income between them. Secondly, national mortality rates tend to be lowest in countries that have smaller income differences and thus have lower levels of relative deprivation. Thirdly, most of the long term rise in life expectancy seems unrelated to long term economic growth rates. Although both material and social influences contribute to inequalities in health, the importance of relative standards implies that psychosocial pathways may be particularly influential. During the 1980s income differences widened more rapidly in Britain than in other countries; almost a quarter of the population now lives in relative poverty. The effects of higher levels of relative deprivation and lower social cohesion may already be visible in mortality trends among young adults.

The existence of wide—and widening—socioeconomic differences in health shows how extraordinarily sensitive health remains to socioeconomic circumstances. Twofold, threefold, or even fourfold differences in mortality have been reported within Britain, depending largely on the social classification used.[1-3] This series will illustrate some of the most important mechanisms involved in the generation of these differences.

Fundamental to understanding the causes of these differences in health is the distinction between the effects of relative and absolute living standards. Socioeconomic gradients in health are simultaneously an association with social position and with different material circumstances, both of which have implications for health—but which is more important in terms of causality? Is the health disadvantage of the least well off part of the population mainly a reflection of the direct physiological effects of lower absolute material standards (of bad housing, poor diets, inadequate heating, and air pollution), or is it more a matter of the direct and indirect effects of differences in psychosocial circumstances associated with social position—of where you stand in relation to others? The indirect effects of psychosocial circumstances here include increased exposure to behavioural risks resulting from psychosocial stress, including any stress related smoking, drinking, eating "for comfort," etc; most of the direct effects are likely to centre on the physiological effects of chronic mental and emotional stress.

Evidence from three sources suggests that the psychosocial effects of social position account for the larger part of health inequalities. If valid, this perspective would have fundamental implications for public policy and for our understanding of the pathways through which socioeconomic differences have an impact on human biology.

Income within and between societies

Despite the difficulty of disentangling material from social influences on health, it is possible to look at the relation between income and health in population groups where income differences are, and are not, associated with social status. Social stratification exists within rather than between societies. Therefore, while income differences among groups within the developed societies are associated with social status, the differences in average per capita incomes between developed societies are not. We may therefore

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A "feel bad" factor in the health divide?

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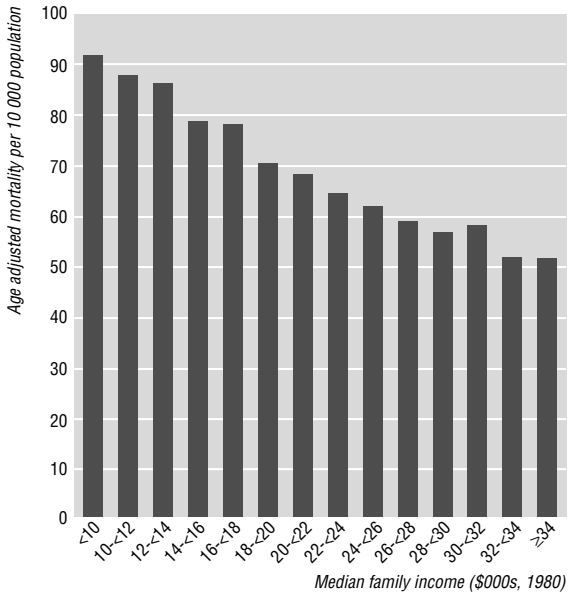

Fig 1 Age adjusted mortality of 300 685 white American men by median family income of zip code areas in the United States[4]

compare the association of income and health within and between societies.

Within countries there is a close relation between most measures of health and socioeconomic circumstances. As an example, figure 1 uses data from 300 685 white American men in the multiple risk factor intervention trial to show the relation between mortality and the median family income in the postcode areas in which they lived.[4] Among black men in the trial, larger mortality differences are spread over a smaller income range.[5] In Britain, there are similar gradients in mortality and sickness absence among men and women.[6 7]

The regular gradients between income and mortality within countries contrast sharply with the much weaker relation found in the differences between rich developed societies. Figure 2 shows the cross sectional relation between life expectancy and gross domestic product per capita for 23 members of the Organisation of Economic Cooperation and Development (OECD) in 1993. Using data from the OECD countries reduces the influence of extraneous cultural differences by restricting the comparison to developed, democratic countries with market economies. Currencies have been converted at "purchasing power parities" to reflect real differences in spending in each country. The correlation coefficient of 0.08 shows that life expectancy and gross national product per capita are not related in this cross sectional data. Excluding government expenditure makes little difference: the correlation with private consumer's expenditure per capita is only 0.10.

Data on changes over time between countries show a weak but non-significant relation. During 1970-93 the correlation between increases in life expectancy and percentage increases in gross domestic product per capita among OECD countries was 0.30, suggesting that less than 10% of the increases in life expectancy were related to economic performance. Though the recent rise in national mortality in eastern Europe suggests that time lags may be short, the period used here allows for the possibility of longer lags.[8]

As figure 2 uses data for whole countries, the contrast between it and the strong relation shown in figure 1 cannot arise from sampling error. A strong international relation is unlikely to be masked by cultural factors: not only are the international comparisons confined to OECD countries, but the picture is supported by comparisons among the 50 states of the United States, where cultural differences are smaller. The correlation reported between age adjusted mortality and median incomes in the states was −0.28.[9] As with the international comparisons, social stratification mainly occurs within rather than between American states.

Income and mortality are so strongly related within societies that this relation cannot be assumed to exist between developed societies but has somehow become hidden. Its robustness within societies shows not merely in mortality data but in measures as diverse as medically certified sickness absence among civil servants and prescription items issued per head of population in relation to local rates of unemployment.[7 10] However, the contrast in the strength of the relation within and between societies would make sense if mortality in rich countries were influenced more by relative income than by absolute material standards.

Income distribution

A second source of evidence that relative income has a powerful influence on health comes from analyses of the relation between measures of income inequality and mortality both among developed countries[11] and among the 50 states of the United States.[12] Cross sectional data and data covering changes over time both show that mortality tends to be lower in societies where income differences are smaller, even after average incomes, absolute poverty, and a number of

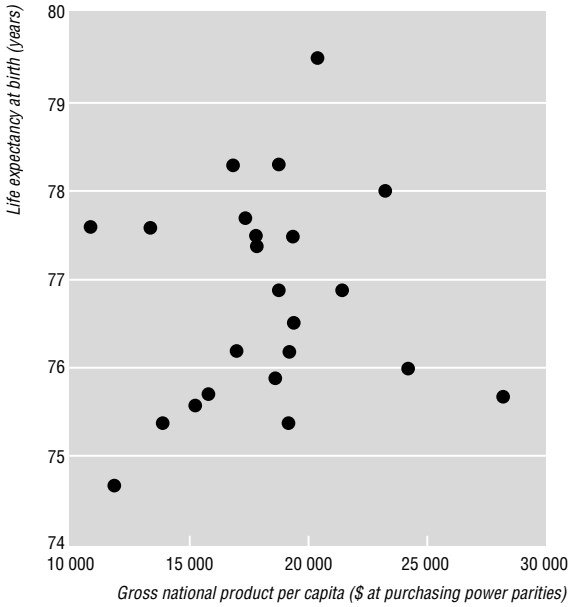

Fig 2 Relation of life expectancy and gross national product per capita in OECD countries, 1993 (based on data from OECD national accounts 1995 and World Bank's world tables 1996)

other socioeconomic factors have been controlled for. This relation has now been shown independently on over a dozen different datasets and has been reported absent only once.[11] The most plausible explanation is that mortality is lower in more egalitarian societies because the burden of relative deprivation is reduced.

The weak association between mortality and median (absolute) incomes of the 50 American states disappears when the distribution of income within each state is controlled for.[9] The correlation coefficient drops from -0.28 to -0.06, suggesting that absolute income is unrelated to mortality in the United States. Unfortunately, further exploration of the international relation between income distribution and mortality will depend on taking account of the differences in response to income surveys in different countries. Response rates vary by more than 30%, and as non-responders are concentrated particularly among the rich and poor, high non-response leads to smaller reported income differences.[13 14]

Epidemiological transition

The third reason for thinking that health is influenced more by relative than absolute income centres on the epidemiological transition. Although absolute material standards remain important in less developed countries, there are indications that the epidemiological transition represents a stage in economic development after which further improvements in material standards have less influence on health. Not only do the infectious diseases of poor countries give way to degenerative diseases as the main causes of death, but the transition also coincides with a flattening of the curve relating life expectancy to gross domestic product per capita.[11 15] In addition, several of the so called "diseases of affluence" (including coronary heart disease, stroke, hypertension, obesity, and duodenal ulcers) reverse their social distribution to become more common among poor people in affluent societies, reflecting that the majority of the population has risen above a minimum threshold level of living.[11 16] When those who are less well off cease to be thin, obesity ceases to be associated with social status.

A theory of health and social position?

If the association between health and socioeconomic status within societies—at least in the developed world—is not primarily the direct effect of material standards, then some might think it resulted simply from differential social mobility between healthy people and unhealthy people. However, many research reports show that this is not the major part of the picture,[17-20] and social selection is entirely unable to account for the relation between national mortality rates and income distribution.

This pushes us—inexorably though perhaps reluctantly—towards the view that socioeconomic differences in health within countries result primarily from differences in people's position in the socioeconomic hierarchy relative to others, leaving a less powerful role to the undoubted direct effects of absolute material standards. If health inequality had been a residual problem of absolute poverty it might have been expected to have diminished under the impact of postwar economic growth, and it would tend to distinguish primarily between the poor and the rest of the population—rather than running across society, making even the higher echelons less healthy than those above them (see figure 1).

Need for a theory

A theory is needed which unifies the causes of the health inequalities related to social hierarchy with the effects of income inequality on national mortality rates. At its centre are likely to be factors affecting how hierarchical the hierarchy is, the depths of material insecurity and social exclusion which societies tolerate, and the direct and indirect psychosocial effects of social stratification.[21]

One reason why greater income equality is associated with better health seems to be that it tends to improve social cohesion and reduce the social divisions.[11] Qualitative and quantitative evidence suggests that more egalitarian societies are more cohesive. In their study of Italian regions, Putnam *et al* report a strong correlation (0.81) between income equality and their index of the strength of local community life.[22] They say, "Equality is an essential feature of the civic community." Kawachi *et al* have shown that measures of "social trust" provide a statistical link between income distribution and mortality in the United States.[23] Better integration into a network of social relations is known to benefit health.[24 25] This accords with the emphasis placed on relative poverty as a form of social exclusion, and with the evidence that racial discrimination has direct health effects.[26] However, social wellbeing is not simply a matter of stronger social networks. Low control, insecurity, and loss of self esteem are among the psychosocial risk factors known to mediate between health and socioeconomic circumstances. Indeed, integration in the economic life of society, reduced unemployment, material security, and narrower income differences provide the material base for a more cohesive society. Usually the effects of chronic stress will be closely related to the many direct effects of material deprivation, simply because material insecurity is always worrying. However, as Hogarth's *Gin Lane* shows, even absolute poverty has often killed through psychosocial and behavioural pathways.

Pathways

In terms of the pathways involved in the transition from social to biological processes, there is increasing interest in the physiological effects of chronic stress. Social status differences in physiological risk factors among several species of non-human primates have been identified. Animals lower in the social hierarchy hypersecreted cortisol, had higher blood pressure, had suppressed immune function, more commonly had central obesity, and had less good ratios of high density lipoproteins to low density lipoproteins—even when they were fed the same diet and social status was manipulated experimentally.[27 28] Among humans, lower social status has also been associated with lower ratios of high to low density lipoproteins, central obesity, and higher fibrinogen concentrations.[29] In experiments in which social status was manipulated, subordinate monkeys "received more aggression, engaged in less affiliation, and spent more time alone than dominants ... they spent more time fearfully scan-

Gin Lane—desperation strengthens the link between poverty and death

ning the social environment and displayed more behavioral depression than dominants." [30] Loss of social status resulting from being rehoused with more dominant animals was associated with fivefold increases in coronary artery atherosclerosis.[31]

Although research has shown that psychosocial factors are related to both morbidity and mortality, differences in reporting make international comparisons of morbidity unreliable. Nevertheless, because patterns even of self reported morbidity are predictive of mortality rates, we can probably assume that mortality differences indicate differences in objectively defined morbidity.[32 33] Although no obvious patterns have emerged from attempts to assess international differences in the extent of inequalities in self reported morbidity when people are classified by education or social class, across countries there is a close relation between the extent of inequalities in income and in self reported morbidity.[34 35]

Relative poverty and mortality

Although Britain had a greater increase in inequality during the 1980s than other developed market economies,[36] the proportion of the population living in relative poverty (below half the average income) may—for the first time in two decades—have decreased slightly during the early 1990s. It now stands at almost one in four of the whole population (incomes after deducting housing costs).[37] Among children the proportion is almost one in three. Particularly worrying is the likely increase in the proportion of children emotionally scarred by the tensions and conflicts of family life aggravated by living in relative poverty. During 1982-92 there were no improvements in national mortality rates among young men (aged 20-40) and smaller improvements among younger women (aged 15-24) than at most other ages.[38] Socioeconomic differences in mortality are at their maximum at these ages, and the national trends are likely to be partly a reflection of the increased burden of relative deprivation. Among young men, deaths from suicide, AIDS, violence, and cirrhosis increased. These causes suggest that the psychosocial effects of relative deprivation are unlikely to be confined to health. As in the international data, where death rates from accidents, violence, and alcohol related causes seem to be particularly closely related to wider income inequalities, the predominance of behavioural causes may reflect changes in social cohesion.[9 13]

The papers in this series are intended to illustrate some of the processes which give rise to the relation between relative deprivation and health. What comes out of several of them may not have been so different had the subject been crime, drug misuse, or poor educational performance. Important aspects of the evidence suggest that the rest of society cannot long remain insulated from the effects of high levels of relative deprivation.

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Primary care: opportunities and threats

Distributing primary care fairly

Mike Pringle, Iona Heath

In this pair of articles two general practitioners give their opposing views on the government's plans for reorganising primary care. In particular, they consider the problems of providing primary care in deprived areas. Mike Pringle argues that there are systematic problems with the current system of delivering primary care, particularly in deprived inner city areas, and that these problems may not be solved through new ways of designing and delivering services. Iona Heath, on the other hand, argues that existing primary care services strive for and often achieve equity. Thus they should be supported and strengthened rather than opposed or replaced.

An opportunity to improve primary care

Mike Pringle

The new legislation based on *Primary Care: The Future. Choice and Opportunity*[1] offers flexibility in the methods used to provide primary care services in England and Wales. Providers perceive more threats than opportunities. Though no changes are without pain, the greatest threat may well be to general practitioners' complacent assumption that all will be well if they are left alone to continue as they are. This article argues that there are systematic problems with the current system of delivering primary care which may be addressed through new ways of designing and delivering services.

"It ain't broke, so don't fix it"

There is a contention that primary care is doing just fine and there is no need to change it. In particular, there is no reason to destabilise it with innovations in service delivery, even those that have been evaluated. Such complacency runs counter to the reality of primary care experienced by patients and health service managers throughout Britain.

There are still practices which provide poor quality clinical care—such that general practitioners would not recommend them to patients who are moving. There are still practices that offer an inadequate range of services—no screening, prevention, family planning, and minor surgery—while the doctors pursue a strategy of high list size and high personal income. And there are practices where health service resources are wasted through high referral rates,[2] poor prescribing,[3-5] and inappropriate investigations[6] or through inefficient catchment areas.[7 8] Provided such practices comply with their conditions of service, the health service has neither the will nor the way to stop contracting with them.

And then there are the restrictions that prevent other practices from enhancing their quality of care—for example, the inability to move resources with patient care; the limitations on changing skill mix (such as replacing a retiring partner with a part time partner and two nurses) to meet the requirements of patient care[9]; the failure to institute effective postgraduate education; the weakness in exploiting commissioning models (fundholding,[10] locality commissioning, and purchasing[11]) to improve value for money from the secondary care sector; problems in integrating social care with medical care—all these relative inadequacies, and more, argue for change, not for stasis.

To convert the rhetoric of a primary care led NHS into better patient care, general practitioners need to explore new ways of delivering services and of acting as the champions of their patients in the bewildering labyrinth of the NHS.

Different contracts for different locations

Some general practitioners believe that the great strength of primary care lies in the single national contract which applies throughout Britain. Though some special interests are already recognised within that contract—the London Initiative Zone workforce flexibilities, the rural milage payments, etc—most of its provisions apply nationwide.

This is the third part of a series of articles discussing the imminent reforms in primary care

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The absurdity of this approach is perhaps best illustrated by two features. The standard practice income tariffs, including the reimbursement of average practice expenses, make no allowance for practices in high cost areas; and the application of the cost rent scheme takes no account of land or building costs, thus aggravating the problems of primary care provision in inner city areas, especially in London.

Flexibility is obviously needed in both the drafting and application of contracts to enable high quality general practice to flourish in all settings. If such contracts are negotiated centrally, the negotiations start from a false understanding of what "good general practice" is.

Many general practitioners, including their leaders, perceive a well organised training group practice in good premises with a full primary healthcare team as the model to deliver highest quality of care, and this is supported to an extent by the literature.[13-15] This vision has been given substance over the past 30 years through allowances and vocational training payments. Yet patients registered with smaller, non-training practices consistently express more satisfaction with their care.[16-19] Bigger practices erode one of our core values: continuity of care.[20]

A system in which a national contract specified the minimum quality of care—standards of care, range of services, accessibility, and availability—supplemented by local contracts that offered incentives to develop better services locally (as defined by healthcare professionals, managers, and patients) would be the exact reverse of the current system but would correct its shortcomings. Local contracts would be awarded to those most able to deliver primary care, which would usually be the current practices. In two specific situations, however—inner London and remote rural areas—alternatives are likely to be viable.

Problems of inner London

Although London is the example used here, these conclusions are broadly true of other inner city areas. London is voracious of resources: 20% of NHS expenditure is applied to the health needs of the 15% of the population resident in London,[21] and London has been showered with special reports,[21-24] deprivation payments, and now the London Initiative Zone scheme, which developed out of the Tomlinson report.[24]

The increased resources are, in part, justified by London's poor standardised mortality rates (including over half the cases of AIDS in Britain),[24 25] the population's mobility (30-40% annually in some parts of the city[24]), the high proportion of people for whom English is not a first language, and substantial levels of homelessness, substance abuse, and poverty.[24] Yet 45% of practice premises in London are below minimum standards[24]; a high proportion of general practitioners are aged over 65 (130% of English average) and have large lists; the rate of single handed practices is twice the national rate (although that is not necessarily to the detriment of patient care); staffing levels are low; recruitment[26-28] and morale are problematic; and computerisation is delayed.[14 29] These structural problems have resulted in poor achievement of contractual targets and levels of service provision—for example, 40% of general practitioners are on the minor surgery list compared with 72% nationally.[30]

Money will not be the only answer to these problems; even worse, if the London Initiative Zone scheme were to finish, resources might decrease. New insights into the organisation of primary care will be required. One option that received much media attention on the publication of the white paper[1] was for primary care surgeries in supermarkets: commerce entering into health care; privatisation by stealth.

A primary care centre in a densely populated area which offers 24 hour facilities with shifts of anonymous doctors might suit some people. After all, accident and emergency departments are flooded with patients, many of whom are there inappropriately and who seem to prefer a wait of hours rather than immediate access to general practice cover.[31 32] The reason is, of course, that general practice (with the historical exception of deputising services) offers a filter which controls patient demand: a general practitioner may offer advice and an appointment at a time appropriate to the problem but less convenient to the patient.

Primary care centres will, like accident and emergency departments, have to accept unfiltered demand and will largely rely on temporary residents to be economically viable (and even then a profit is doubtful). This will make them an expensive option for primary health care delivery and one which dispenses with the virtues that general practitioners and patients believe are fundamental to good care—the doctor-patient consultation and continuity of care. Society—not its doctors—has, however, to decide whether an extra cost would be worth paying for a service that may be technically better but which lacks human values.

Much more likely is the advent of primary care organisations managed by community (or possibly hospital) trusts or by consortiums of general practitioners (as I recently saw working effectively in Christchurch, New Zealand[33]). While allowing good doctors to continue to deliver clinical care in their practices just as now, such an organisation would offer practice management, financial control, information technology, and clinical audit systems. Doctors would be employed as independent contractors, as now, if they wished, or they might opt for any number of permutations of contract. This flexibility of employment

contract may help some doctors who are not currently working to return to their profession.[34]

However, the real innovation would be that the NHS's contract for the delivery of primary care services would be with the organisation, not the individual general practitioner. This would make the organisation—in one variant a consortium of all its general practitioners—collectively responsible for the standards of care delivered by each and all of its members. This model is being explored with locality commissioning groups[12] and out of hours consortiums,[35] and it would seem to be culturally acceptable. It would once and for all remove the current absolution that says that another general practitioner's poor care is someone else's problem.

With this would have to come a recognition that higher standards would earn higher investment and that investment would be funnelled not just into general practitioners' income but also into patient care and facilities. While some extra resources will come from gaining more value for money, it needs to be explicit that primary care organisations would be a means of investing to get better value for money.

Of course, population density and the special problems of inner city general practice make conurbations particularly suitable for this model. But wherever cost effectiveness is poor—where standards are low or costs of care are especially high—the primary care organisation may be superior to the current system.[36 37]

Problems of rural areas

General practice in rural areas faces other problems. Keeping personal development and continuing education going when distances are large and professionals are isolated is never easy; when locums are hard to find and out of hours cover is still a major commitment the difficulties are compounded.[38 39] As the rural general practitioners' perennial financial prop of doing their own dispensing is removed, the problems of underinvestment and deteriorating morale will hit these practices as they now hit inner city practices.

One solution may be to consider a primary care organisation where a professional grouping has responsibility for ensuring that standards are maintained and developed and for supplying the cover, support, and education to make that possible. Again, some resources could be released through better deployment of current resources. In addition, the NHS would have more confidence in investing in primary care that offered consistent quality of care.

Building on strengths

Where general practice is good it should not regard new organisations as a threat. Good general practices offer high quality personal continuing clinical care with optimal use of resources. Such practices and primary care teams will survive and will be enhanced by having improved options to which they can be compared.

When general practice is suboptimal because of the locality, the history of investment, or the nature of the general practitioners, then other models should be tried. If such a model can enhance standards and bring in extra investment, then it should be welcomed.

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Threat to social justice

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The speed of change in the NHS since 1990 has been furious and, with the recent spate of three white papers[1-3] and a bill,[4] there is no let up in sight. It is essential to continue to ask whether this change has been, and will be, for the better. This does not imply a facile assumption that all is well.[5] We need always to be striving for improvement, and yet in the laudable desire to improve it is easy to lose sight of the fundamental aims of the health service and of its purpose within society. It is time to take stock of the current changes and analyse how far they take Britain towards the NHS to which it aspires.

Health as a social goal

At its inception the NHS was designed to provide personal health care as a publicly organised service. It was to include all citizens and was a deliberate move towards social justice.[6] Despite all the recent changes the NHS remains explicitly committed to equity.[7] However, it is now expected to operate in the context of a wider society which apparently has no such commitment. Increasing socioeconomic polarisation has let the rich become richer and more complacent and the poor become poorer and more marginalised. Homelessness, unemployment, and the prison population have all risen.[8] Poverty, marginalisation, loss of autonomy, unemployment, and homelessness are all destructive of health and so make the task of the NHS more difficult. During the 1980s social divisions in Britain accelerated at a rate not matched for a sustained period by any other rich industrialised country.[9] Yet responsibility for health has been shifted from society to the individual[10] and we seem to have lost any notion of the pursuit of health as a social goal.

The greatest contemporary challenge facing the discipline of general practice is to rediscover the social dimension of health and to find an adequate response to the malign effect of poverty on the health of patients.

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This is the context within which general practitioners must judge the proposed changes, especially as the changes are seen as a solution to the perceived problems of general practitioner care in inner cities, where the effects of socioeconomic deprivation are greatest.

Protecting patients' interests

Probably the greatest strength of British general practice is the positioning of general practitioner care close to the patient and at a distance from any institutional interest. This ensures accessibility and encourages trust. Patient and doctor need time and space to work together, to negotiate trust, and then to negotiate the complex interactions between life stresses and illness and the dangerous interface between illness and disease.[11] Only if enormous and impartial care is taken can the patient benefit from the achievements of scientific medicine while being protected from its dangers, and only if this is achieved will the gatekeeping role of the general practitioner be cost effective. All citizens in the United Kingdom are entitled to this pattern of service, and this entitlement should not be undermined by a specious commitment to local flexibility.

The new proposals threaten to undermine the trust between patient and doctor. Part I of the 1977 NHS Act enables health authorities to contract with a range of hospitals for the provision of secondary care. In contrast, under part II of the act general medical services can be provided by general practitioners only as independent contractors. With the proposed shift of general medical services to part I, NHS trusts and commercial organisations are to be encouraged to tender for the provision of general practitioner services. This is likely to be done through the provision of salaried general practitioners. The obvious dangers are that the details of the contracts offered to general practitioners will allow the interests of the patients to be overridden by the interests of the employing organisation. An example of this might be the gagging clauses which have already impinged on the work of specialists employed by trusts. Contracts could also drastically curtail the ability of the general practitioner to act as an advocate for the patient and complain publicly about the effects of the underprovision of various services, particularly those provided by the employing trust. In the case of community trusts this would undermine the ability of general practitioners to complain about the level of provision of district nurses or health visitors, or the standards of care on psychiatric wards. Other restrictions might dictate the use of a limited formulary or confine referral rights to a limited range of secondary care providers. These kinds of developments are already familiar in health maintenance organisations in the United States, and they will be encouraged by the proposed changes.

In the original bill commercial organisations were also to be allowed to tender for contracts and provide primary care services. In the face of sustained criticism from the profession and from the opposition parties, however, the health secretary seemed to make consid-

erable concessions at the committee stage. The bill is to be amended to restrict primary care contracts to those made between health authorities and "members of the NHS family."[12] Yet the possibility of trusts subcontracting the provision of general practice services to commercial organisations remains.

The clear and overriding responsibility of such organisations is to generate profit for their shareholders. The patient's interest must come second to this. If the commercial organisation is a private health provider or a pharmaceutical company or high street pharmaceutical chain, then the scope for restrictive contracts which are financially advantageous to the employing company is yet more obvious. All would be well positioned to exploit a direct route to patients. For the first time, general practitioner services will be organised to generate private profit. How can this possibly be a means of promoting social justice?

Thus we see the spectre of a general practitioner service, the costs of which are rigorously controlled by market imperatives and the imposition of restrictive contracts. The freedom to act as an advocate for patients will be seriously undermined and the trust of patients will be eroded as a result. It will not be long before the cost effectiveness of general practice is similarly undermined. Impartial advocacy is most needed in deprived inner city areas, and yet these are the very areas most vulnerable to the proposed changes. These areas face the prospect of the complete destabilisation of general practice.

Needs in inner cities

There is already a serious recruitment crisis,[13] and many general practitioners in deprived inner city areas are due to retire within the next few years. Under the proposed changes, health authorities will be free to define job descriptions for the vacancies which arise, and the new requirement that applicants should be able to meet the standards set out will probably ensure that most of these remain vacant. Patients will be left without general practitioners, and pilot schemes will be ready to fill the gap. Contracts offered within pilots are likely to be initially and superficially attractive, offering protection from the open ended commitment which comes with conventional practice. Young and inexperienced doctors and those coming from overseas may not realise the dangers of the detail of their contracts until too late. Existing practices of whatever quality will have to compete for the limited number of young doctors[14] and will face ever greater recruitment problems. This will increase the pressure on the existing partners of these practices, threatening the survival of practices and the destabilisation of the whole pattern of care.

There is also a danger that some pilot schemes will seek to recruit younger and more healthy patients and discourage those with complex or intractable health care needs. This would further increase stresses on existing practices, especially those that strive to keep their lists open.

The potential inequities of the proposals go further. It seems highly likely that the majority of pilots in the more affluent parts of Britain will be practice based, building on the initiatives of the most innovative fundholders.[15] Pilots involving NHS trusts (and perhaps commercial organisations) are much more likely in deprived areas. These are the schemes which risk significant conflicts of interest working to the ultimate disadvantage of patients. The whole experience of the changes could be quite different in different parts of the country, exacerbating the inverse care law[16] and further undermining social cohesion.

What should be done

This divisiveness could be minimised by amending the legislation to ensure that all the pilots are based on existing practices. Many innovative schemes in the London Initiative Zone and in other deprived urban areas show what can be done to support and improve standards in existing practices while minimising disruption to the continuity of patient care.[17]

Each pilot is supposed to be properly evaluated before being implemented more widely, but there is no indication that funds have been identified for this purpose and there is no obligation on health authorities to involve general practitioners or academic departments of general practice in the evaluation. There must be a risk that there will be only token evaluation before far reaching change, driven by commercial and institutional interest, accelerates.

The government's recent series of white papers present both opportunities and threats. General practitioners would be naive to allow their enthusiasm and optimism in relation to the opportunities to blind them to the threats. The opportunities relate to local flexibility; the threats relate to cohesion and equity within a national service. In the context of a socially divided society, the need for the latter outweighs the as yet unproved benefits of the former.[18] This gloomy prognosis may be viewed as unduly alarmist, but the reality is that there are no safeguards in the primary care bill which would ensure a more optimistic future.

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