

Time to care: tackling health inequalities through primary care

Michael Norbury^a, Stewart W Mercer^{b,*}, John Gillies^c, John Furler^d
and Graham C M Watt^b

^aQuality, Safety and Informatics Research Group, Clinical and Population Sciences and Education Division, University of Dundee, Mackenzie Building, Dundee DD2 4BF, UK, ^bAcademic Unit of General Practice & Primary Care, University of Glasgow, 1 Horselethill Road, Glasgow G12 9LX, UK, ^cRCGP Scotland, 25 Queen Street, Edinburgh EH2 1JX, UK and ^dPrimary Care Research Unit, Department of General Practice, University of Melbourne, 200 Berkeley Street, Carlton, Victoria 3053, Australia. *Correspondence to Stewart Mercer, Professor of Primary Care Research, Academic Unit of General Practice & Primary Care, University of Glasgow, 1 Horselethill Road, Glasgow G12 9LX, UK; E-mail: Stewart.Mercer@glasgow.ac.uk

Health inequalities are systematic, socially produced and unfair: systematic because the differences in health outcomes are not randomly distributed but rather show a consistent pattern across the socio-economic spectrum; socially produced because no Law of Nature decrees that the poor should endure greater ill health and premature mortality than the rich, and unfair because they are maintained by unjust social arrangements—arrangements which mean, for instance, that the chances of survival for many children are determined by the socio-economic position into which they are born.¹

A global issue

Life expectancy, health and health-related behaviours have greatly improved over the last 50 years in many countries, but progress among disadvantaged groups has been slower, so the overall gap in health between rich and poor continues to widen.^{2–6} The World Health Organization (WHO) established the Commission on Social Determinants of Health (CSDH) in 2005 to marshal evidence on what could be done to promote health equity, describing social justice as a ‘matter of life and death’.⁷ Critically, the Commission identified health inequities as an urgent problem for all countries (high, middle and low income). The Commission provided three overarching recommendations: (i) improve daily living conditions; (ii) tackle the inequitable distribution of power, money and resources and (iii) measure and understand the problem and assess the impact of action.⁷

The recent independent review of health inequalities in England concluded that premature illness and death affects everyone below the wealthiest tier of English society, causing productivity losses for England of £31–33 billion annually, lost taxes and higher welfare costs of £20–32 billion each year and additional costs for the National Health Service (NHS) in excess

of £5.5 billion per year.⁸ The review suggested that reducing health inequalities would require action on six fronts that included giving every child the best start in life, enabling all children to maximize their capabilities, creating fair employment and good work for all, ensuring a healthy standard of living, creating sustainable communities and strengthening the role of ill health prevention.⁸

Such high-level reports emphasize the importance of the social determinants of health, but they can also be criticized for offering little in the way of policy change that could affect health inequalities in the short term.⁹

The Inverse Care Law; policy failure and the potential of primary care

The 2008 WHO World Health Report, marking the 30th anniversary of the Declaration of Alma-Ata, ‘Primary Health Care, Now More than Ever’ emphasizes the importance of primary healthcare in addressing health inequalities.¹⁰ The report argues that strengthening primary healthcare is a key practical strategy for responding effectively to the needs of entire populations.¹⁰ Evidence shows that strong primary healthcare is associated with better health and a more equitable distribution of healthcare both cross-nationally and within nations.¹¹ In the UK, with >300 million consultations annually, representing >90% of all contact with healthcare professionals, the importance of General Practice is clear.¹²

While primary healthcare has the potential to help narrow health inequalities, the inverse care law, first described in 1971 by Tudor-Hart, still persists.^{13,14} In Scotland, the flat distribution of GPs across the population, despite levels of ill health in deprived areas that are 2- to 3-fold more than levels seen in affluent areas, results in high demand and unmet need. Patients in these deprived communities face poorer access to their

GP, have less time with the GP and are less enabled by the consultation compared with patients in more affluent areas, as well as GPs in these deprived areas experiencing higher levels of stress within encounters.^{15,16} Combined, these factors confound attempts to narrow health inequalities. The rhetoric on more resources for deprived areas continues but with little action.^{17,18} The report from the UK House of Commons Committee of Public Accounts further serves to underscore this point. The report was highly critical of the Department of Health (DOH) in England who took ‘nine years after it announced the importance of tackling health inequalities to establish this as an NHS priority’.¹⁹ The report was also critical of a missed opportunity by the DOH to use the revised GP contract in 2004 to ensure that more doctors worked in deprived areas or to focus attention on key interventions in deprived areas that would make a difference to inequalities.^{19–21} The potential for primary health care to play a key role in addressing health inequalities is made all the harder in the face of such policy failures. The opportunity to mitigate the health effects of social inequity becomes instead a health system that ‘perpetuates injustice and social stratification’.²²

Ways forward

Nevertheless, it is possible to make progress. An analysis of 34 Quality and Outcome Framework (QOF) clinical indicator scores following the implementation of the new UK GP contract in 2004 revealed a significant narrowing of the scores between deprived and affluent areas in the first 3 years of QOF, although it is not yet clear if these will actually result in more equitable health outcomes.^{12,23} The impact of financial incentives on inequalities is likely to vary by the care targeted and some kinds of care may require more focussed activity.²⁴ Primary care resources could be targeted more directly to the disadvantaged at various levels, for example, to the lowest income patients within each GP practice, or the most deprived GP practices within primary care organizations.²⁵

In terms of tackling health inequalities more broadly, a recent evidence review supports the importance of generalism, patient advocacy and community and population level healthcare by General Practice.¹² GPs and primary care teams can play a crucial role in improving the health of those in the most deprived areas, although they have been criticized for failing to focus sufficient attention on their more deprived patients and ignoring the political call to tackle inequalities.^{19,21} However, the capacity of a strong primary care/GP sector to act as a positive social determinant of health in a community by practicing in a way that sustains levels of trust, security and sense of caring

and well-being is hampered if it is so overwhelmed by the burden of disease care it must perform.²² Until action is taken by governments to directly reverse the inverse care law, the latter will persist. Indeed, in identifying characteristics of policies that are likely to be effective in reducing health inequalities, Macintyre highlights that both prioritizing disadvantaged groups and offering intensive support are of key importance.²⁶

Decisive leadership and evidence of effectiveness are key priorities for the future if health inequalities are to be reduced despite the current economic climate. High-level policy recommendations such as those recently made by the Royal College of Physicians in the UK which call for a change in doctors’ perspectives, a change in systems, and a change in the education of doctors, while important, are in themselves insufficient.²⁷ The Royal College of General Practitioners (RCGP) in the UK has also published a guide for GPs on addressing health inequalities. The Health Inequalities Standing Group of the RCGP and the Health Inequalities Unit at the DOH in England identified six key areas in which GPs can exert their influence to help reduce health inequalities: GPs as individuals, GPs and the primary care team, practice-based commissioning, engagement with Primary Care Trusts, working in partnership with other organizations and influencing the national agenda.²⁸

Subsequent to the publication of the English report, RCGP Scotland recently completed their own assessment of the situation in Scotland.²⁹ This differed substantially from the approach taken in England, by bringing together GPs working in the 100 most deprived areas of Scotland (coined ‘GPs at the Deep End’) for a unique meeting to gather views and make recommendations—the first time in the history of the NHS (and perhaps in the world) that such a meeting has taken place.³⁰ GPs in remote and rural areas were also included and a review of deprivation in remote and rural areas was commissioned. The report concluded that the only route by which practices in severely deprived areas can improve patient’s health and narrow health inequalities is by increasing the volume and quality of the care they provide but that practitioners lack time in consultations to address the multiple morbidity, social complexity and reduced expectations that are typical of patients living in severe socio-economic deprivation. As such, opportunities for anticipatory care are often fleeting and may be lost if there is not the opportunity to connect quickly with other disciplines and services that are closely linked to the practice. Specific proposals included (i) additional time for consultations with patients in very deprived circumstances, addressing directly the fundamental cause and operation of the inverse care law; (ii) enhancement of multi-professional practice teams via the attachment of staff with specific skills/

expertise; (iii) improved joint working between general practices and other local services, e.g. child health, care of the elderly, mental health and addiction, health improvement and (iv) recognition of the principle that additional activity should not be expected of practices without commensurate resources.^{29,30}

In conclusion, general practices provide contact, coverage, continuity, flexibility and coordination of care and need to be recognized and supported as the hubs around which other services operate.³¹ Support and development of practices in areas of high deprivation as multidisciplinary, learning organizations, committed and supported to sharing experience, information, evidence, activity and education are essential if progress is to be made on reducing health inequalities through primary care. This includes the need for recognition, training, support and reward for the leadership required to co-ordinate integrated local services. Policy makers need the moral imagination to understand that the lives of the poor have as much value as those of the rich³² but also need to demonstrate the courage to distribute limited resources where they are most needed. The time to care is now.

Declaration

Funding: none.

Ethical approval: none.

Conflict of interest: none.

References

- Whitehead M, Dahlgren G. *Concepts and Principles for Tackling Social Inequalities in Health: Levelling up Part 1*. Copenhagen, Denmark: WHO, 2007.
- Macintyre S. *Briefing Paper on Health Inequalities*. Glasgow, UK: MRC Social & Public Health Sciences Unit, 2007.
- The Scottish Government. *Equally Well. Report of the Ministerial Task Force on Health Inequalities*. Edinburgh, UK: The Scottish Government, 2008.
- The Scottish Government. *Long-term Monitoring of Health Inequalities. Headline Indicators - October 2010*. Edinburgh, UK: The Scottish Government, 2010.
- Murray CJ, Kulkarni SC, Michaud C *et al*. Eight Americas: investigating mortality disparities across races, counties, and race-counties in the United States. *PLoS Med* 2006; **3**: e260.
- Draper G, Turrell G, Oldenburg BF. Health Inequalities in Australia: Mortality. Health Inequalities Monitoring Series No. 1. Canberra, Australia: Queensland University of Technology and the Australian Institute of Health and Welfare, 2004.
- Commission on Social Determinants of Health. *Closing the Gap in a Generation. Health Equity Through Action on the Social Determinants of Health*. Geneva, Switzerland: World Health Organisation, 2008.
- Marmot M, Atkinson T, Bell J *et al*. *Fair Society, Healthy Lives. The Marmot Review. Strategic Review of Health Inequalities in England post-2010*. London, UK: University College London, 2010.
- The Economist* (editorial). The price of being well. 2008. <http://www.economist.com/node/12009974> (accessed on 5 December 2010).
- World Health Organization. *The World Health Report 2008: Primary Healthcare, Now More Than Ever*. Geneva, Switzerland: WHO, 2008.
- Starfield B, Shi L, Mackinko J. Contribution of primary care to health systems and health. *Milbank Q* 2005; **83**: 457–502.
- Hutt P, Gilmour S. *Tackling Inequalities in General Practice*. London, UK: The King's Fund, 2010.
- Hart JT. The inverse care law. *Lancet* 1971; **297**: 405–12.
- Watt G. The inverse care law today. *Lancet* 2002; **360**: 252–4.
- Mercer S, Watt G. The inverse care law: clinical primary care encounters in deprived and affluent areas of Scotland. *Ann Fam Med* 2007; **5**: 503–10.
- Watt G. The NHS at 60: time to end the fairy tale. *Br J Gen Pract* 2008; **58**: 459–60.
- The Scottish Parliament Health & Sports Committee (press release). *More GPs Required in Deprived Areas*. 2008. <http://www.scottish.parliament.uk/nmCentre/news/news-08/pa08-037.htm> (accessed on 5 December 2010).
- BMA Scotland. *General Practice in Scotland: The Way Ahead - Final Report*. Edinburgh, UK: British Medical Association, 2010.
- House of Commons Committee of Public Accounts. *Tackling Inequalities in Life Expectancy in Areas with the Worst Health and Deprivation*. London, UK: House of Commons, 2010.
- National Institute for Health and Clinical Excellence (public health guidance 15). *Reducing the Rate of Premature Deaths from Cardiovascular Disease and Other Smoking-Related Diseases: Finding and Supporting Those Most at Risk and Improving Access to Services*. London, UK: NICE, 2008.
- The Lancet* (editorial). “Claptrap” from the UK’s Department of Health. *Lancet* 2010; **376**: 1617.
- Gilson L, Doherty J, Loewenson R, Francis V. *Challenging Inequity Through Health Systems: Final Report of the Knowledge Network on Health Systems*. Geneva, Switzerland: WHO, 2007.p. 8.
- Doran T, Fullwood C, Kontopantelis E, Reeves D. Effect of financial incentives on inequalities in the delivery of primary clinical care in England: analysis of clinical activity indicators for the quality and outcomes framework. *Lancet* 2008; **372**: 728–36.
- Norbury M, Fawkes N, Guthrie B. The GP contract, influenza immunisation and inequalities: a retrospective population database analysis. *Br J Gen Pract* (in press) 2010.
- Epstein D, Jimenez-Rubio D, Smith PC, Suhrcke M. An Economic Framework for Analysing the Social Determinants of Health and Health Inequalities. Research Paper 52. York, UK: Centre for Health Economics, The University of York, 2009.
- Macintyre S. Inequalities in Health in Scotland: What are They and What Can We Do About Them? Occasional Paper No. 17. Glasgow, UK: MRC Social & Public Health Sciences Unit, 2007.
- Royal College of Physicians. *How Doctors can Close the Gap*. London, UK: Royal College of Physicians, 2010.
- Ali A, Wright N, Rae M. *Addressing Health Inequalities: A Guide for General Practitioners*. London, UK: RCGP, 2008.
- RCGP Scotland Health Inequalities Short-Life Working Group. Time to Care: Health Inequalities, Deprivation and General Practice in Scotland. (in press). Edinburgh, UK: RCGP Scotland, 2010. http://www.rcgp.org.uk/college_locations/rcgp-scotland/initiatives/health_inequalities/time_to_care_report.aspx
- Watt G. General practitioners at the deep end. *Br J Gen Pract* (in press), 2011.
- Gillies J, Mercer SW, Lyon A, Scott M, Watt GCM. Distilling the essence of General Practice: a learning journey in progress. *Br J Gen Pract* 2009; **59**: 167–76.
- Benatar SR. Moral imagination: the missing component in global health. *PLoS Med* 2005; **2**: e400.