Health Inequalities and General Practice in deprived areas

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With thanks to Niamh Killeen, Gillian Doran, Dr Claire Collins & Terri Jones

Origins of project

- Previous college AGMs called for action on health inequalities
- Small college working group proposed a review of the literature and a survey of GPs
- First phase now completed and presented today
- Supported by grant from ICGP Research and Education Foundation

The literature on health inequalities

- Mortality rates twice as high in social class 4/5 as social class 1

- Socio-economic deprivation associated with much higher morbidity, mental illness, chronic illness and disability

The literature on practice in deprived areas

- Higher rates of demand for GP services in deprived areas associated with higher illness rates
- More home visits and out of hours demand, more use of A+E
- Rural practices – more demand for on-call and wider range of services

The role of general practice in creating inequalities?

- GPs No.s higher in wealthier areas
- Some evidence internationally for lower referral rates to hospital for poorer patients, women and ethnic minorities
- Better resourced practices in wealthy areas hit targets and bonuses more easily

The role of general practice in tackling inequalities

- Investment in primary care improves population health
- Deprivation weighted payments can enhance services
- GPs should be vocal advocates for change
- Tackle access to own services esp for minority groups, disabled etc.

A survey of 2419 GPs

- 718 responses – a rate of 29.6%
- 25% aged over 55
- Practices with average 2.6 partners
- 30% single-handed
- 31% are female
- 23% rural, 38% urban and 39% mixed

How many practice in deprived areas?

- 40% felt they practised in deprived areas
- Comparing deprivation and %GMS correlation is strongest at over 60% GMS and stronger still at 70%
- >60% GMS includes 30% of practices
- >70% GMS includes 22% of practices

Morale in Irish General Practice

- Only 9.6% felt morale poor/very poor
- 27% felt it was average. 63% good/very good

- Lower morale associated with male GPs, older GPs, single handed GPs and those in deprived areas or high GMS%

Difficulties in providing quality care in deprived areas

- Lack of access to hospital and community services for patients - 59%
- Social and psychological problems in patients - 54%
- Lack of time to deliver care - 44%
- Need to work harder in deprived areas to earn same income - 38%

Positive aspects of working in a poor community

- Good relationships with patients - 84%
- ‘Real need’ for their service - 82%
- Potential for greater impact - 64%

Obstacles facing patients accessing services 1

- Lack of GMS card for poor patients accessing GP - 84%
- Self exclusion by patients accessing GP – 49 %
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- Long waiting lists for community services - 94%
- Lack of community services - 76%

Obstacles facing patients accessing services 2

- Bureaucracy hindering access to community services - 59%
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- Long waiting times for hospital services - 59%
- 2-tier access to hospitals - 52%
- Bureaucracy in hospital services - 46%

GP priorities for action

- Additional deprivation payment
- Increase the medical card income threshold
- Develop multi-disciplinary teams and fund ancillary staff
- GPs and ICGP to become advocates for tackling health inequalities
- Cut hospital waiting lists and tackle 2-tier access

Other GP priorities for action

- Health education for patients
- Train and employ more doctors for deprived areas
- Develop counseling and social supports
- Improve rural access/transport
- Direct access to hospital tests
- Tackle health inequality

Conclusions

- Significant health inequalities
- General practice key to tackling them
- 2 tier access to hospital services a major problem
- Need more GMS cards
- Positive aspects of working in deprived areas
- Need to target resources to areas of deprivation and develop teams

Recommendations for the ICGP

- Seek funding for project work on health inequalities and general practice
- Primary care networks for deprived areas
- Encourage links between primary care and community organisations
- Increase the College's advocacy role on health inequalities and medical card access
- Develop work on rural general practice
- GPs ensure minority group access to GP

Recommendations for the health service and others

- Devise deprivation allowance for service development + invest in primary care
- Ensure multi-disciplinary teams in deprived areas
- GMS access and 2 tier hospital access must be improved
- Improve primary/secondary care links
- Monitor secondary care access for deprived areas and by ethnicity