Deprivation and primary care:
a time to revisit

INTRODUCTION

The negative effect of socioeconomic deprivation on health has been an important theme for primary care for several decades. Efforts to draw attention to this problem and redress inequalities have been actively supported by the RCGP, and have led to much good work.[1] However, I believe that the role of deprivation in both service planning and medical education requires review.

The NHS was founded in 1948 on an expressed egalitarian ethos. However, within a few years of its inception, health professionals began voicing concern that despite overall rising prosperity and improving population health, poorer people were still disadvantaged in accessing this resource. In 1971 Julian Tudor Hart published his influential paper 'The Inverse Care Law' in which he argued that, even within the NHS, market forces that disadvantaged the poor existed.[2] Another milestone occurred in 1983 when Brian Jarman published a scoring system for identifying areas of deprivation that had an adverse impact on GPs workload,[3] giving the topic further impetus.

REDISTRIBUTION — A FLAWED STRATEGY

The medical profession, and the wider community, has a moral duty to look after less fortunate citizens,[4] and a degree of wealth redistribution appears a reasonable strategy. Indeed, for many years and under successive governments, healthcare funding has been preferentially diverted towards areas of deprivation, and is a stated aim of the current government.[5] For example, from 1990 until the start of the GMS2 contract, GPs working in deprived areas were given extra payments under the said Jarman index, and not conditionally to demonstrating improved outcomes. Yet inequalities of income and health have continued to grow,[6] and Britain's health and wealth maps mirror each other precisely. A study showing premature mortality within parliamentary constituencies showed 12 of the 13 healthiest areas to be in Southern England.[7] In contrast, the Glasgow area had all the nine least healthy areas, while North Bermondsey and Southwark was the only southern constituency in the bottom 15.[7] It is recognised that the cause of this runs beyond what health services can influence, either clinically or politically.[8,9] The pursuit of a free-market economy by successive governments since 1979 has probably been the most significant factor in widening income inequalities,[9] which have a linear relationship with health inequalities.[6] However, proponents argue that this is a small price to pay for the increasing overall prosperity that the free market has brought. The electoral success of Margaret Thatcher and latterly Tony Blair, suggests that the free market has wide public support, and that even the less well off have placed their faith in it. Redistribution has probably been necessary to ameliorate even wider inequalities, but there is no groundswell of support for old-school socialism within the electorate, a point that altruistic health professionals ought to bear in mind.

PROSPERITY AS A SOURCE OF DEMAND

If judged in macro-economic terms the free market has indeed been a success. In the last two decades factors such as globalisation, financial deregulation and the information technology and property booms have combined to make Britain more prosperous, and many people very wealthy. With the virtual eradication of real poverty thanks to the welfare state, deprivation as applied to the UK lacks a precise definition, although social marginalisation is a fairer indicator than material poverty.[10] It is, after all, a rich nation's luxury that among its deprived are individuals who may still possess a mobile phone, satellite TV and car. This affluence has increased the pressure on health services in a way not as readily appreciated, or as politically easy to sell as the deprivation-led demand. A less deferential population has refashioned its relationship with the health service, and expectations have risen not only for sickness-service healthcare, but also for screening and lifestyle-related themes; a focus on 'wellness' as much as illness.

As a registrar I can recall sitting with colleagues in our Balint group, reflecting on challenging experiences with patients. The words 'middle class' and 'demanding' were oft-used adjectives, and it occurred to me that while we learned the literature on deprivation, there was little to help us with the patients we were most often coming across. One factor is that our notion of upward mobility exacts a price in stress and social fragmentation. Regions of the country coveted by the socially aspiring, such as the commuter towns of the Home Counties and many a rural idyll, serve as case studies. You know when the urban middle classes (I use the term in an economic and not educational context) have moved in: up come the electric gates, and the gleaming 4x4s have mudless mudguards. The irony that they have brought with them the stressors that they sought to leave behind is lost on the newcomers, although not on the locals. Often distanced from families and former social networks, with frequently poorer civic amenities and above all surrounded by similar arrivistes, a competitive materialism becomes their *modus vivendi*. Its ultimate folly is to leave people no happier than before.[11] Furthermore, the vogue for borrowing heavily to support an ostentatious lifestyle above one's real means, a market-driven phenomenon quite recent in historical terms, further suggests that wealth, and indeed its pursuit, has not bought contentment. Health, like deprivation, is not a one-dimensional concept, and moderate stress suffered by a large number of people has its effect on the health economy. It would be an impossible, and

inappropriate, form of social engineering to try and differentiate between deserving 'need' and undeserving 'demand', as both occur across the social spectrum. Each of us has, after all, acquiesced to a demand for a sick certificate for someone whose reason for not working has little to do with illness. They all beat a path toward our door.

Other demographic trends have increased the pressure on primary care in affluent areas. The ageing population has made nursing and care homes a lucrative business, and developers favour building on green field sites in prosperous suburbs. My small Hertfordshire village has four such complexes with plans approved for another, and such projects have taken place without any consultation with local healthcare providers, whose practices have, literally overnight, been asked to cope with dozens of new dependent elderly patients. It is an example of the Inverse Care Law in its modern guise, and not the way Tudor Hart intended: the wealthy commercial sector presents a stretched public service with a *fait accompli*. The residents live to a great age, a positive health indicator belying the significant use of primary care resources typically seen during the last third of life.

This is the crux of my argument. Methods of evaluating health and resource allocation rely on morbidity, mortality and census data that are easy to measure. However, these under-estimate the call on resources from demographic trends over-represented in prosperous areas, such as population ageing. Britain is also very culturally diverse, with the emergence of communities that defy the conventional relationship between ethnicity, wealth and health. For example, the East African–Asian community is among the richest in the country, but still suffers high morbidity from diabetes and coronary heart disease.[12]

SUMMARY

The seminal work on the impact of deprivation in primary care was done when Britain was much less economically sophisticated and socially diverse than today. The deleterious effects of deprivation persist, but simultaneously there exist pressures on healthcare intertwined with prosperity. Britain presents its healthcare professionals with one of the most socioeconomically and educationally diverse populations in Europe, a challenge that is particularly relevant to primary care, as most practices will look after patients from across the spectrum. Vocational training schemes in general practice must ensure that its graduates are adept at doing so.

Edin Lakasing

Competing interests

The author has stated that there are none.

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