

# Provision of health promotion clinics in relation to population need: another example of the inverse care law?

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**SUMMARY.** *The new contract encourages health promotion in general practice. The aim of this study was to explore the pattern of provision of health promotion clinics across one family health services authority and to relate this to possible indicators of health need in the practice population. Single-handed practices were less likely to be running health promotion clinics. The proportion of practices running clinics increased with increasing numbers of partners. Practices located in wards where the standardized mortality ratio was greater than 100, and practices receiving deprivation payments were less likely to be offering health promotion clinics. This was explained by the presence of most single-handed practitioners in deprived, historically unhealthy wards. If effective, health promotion clinics will have tended to benefit populations in Bedfordshire at lower risk of ill-health. Other shortcomings of the clinic-based health promotion model are discussed.*

**Keywords:** *GP clinics; health promotion; GP services; health status; inequalities in health.*

## Introduction

THE 1990 general practitioner contract contained a number of specific measures to encourage health promotion.<sup>1</sup> These included payments for the following activities: health checks for specific groups, the achievement of target rates for the uptake of cervical smears and immunization, and health promotion clinics. Well person screening, anti-smoking groups, clinics for the management of stress, diabetes, hypertension and asthma are among the activities encouraged. The importance of general practice for delivering health promotion and the success of pioneering work in this field is implicitly acknowledged.<sup>2,3</sup> However, these contractual initiatives raise several questions.

First, is health promotion effective? There is evidence to support screening for smoking, hypertension and cervical cancer.<sup>4</sup> The relative benefits of anti-smoking clinics, stress management and many other screening activities remain contentious.<sup>5</sup> Psychological distress may be caused by routine health checks.<sup>6,7</sup>

Secondly, is such a clinic-oriented approach appropriate? In failing to reward opportunistic health promotion, general practitioners may be discouraged from recording risk factors and giving advice within ordinary consultations. In addition, a population-based approach to disease prevention may be more effective than an approach based on disease prevention for those

individuals at high risk.<sup>8</sup> Effective health promotion requires alliances between many different agencies including health authorities, social services and the voluntary sector.<sup>9</sup> However, collaborative approaches are not facilitated under the present system.<sup>10</sup>

Thirdly, do health promotion clinics reach those in most need? More deprived practice populations are likely to have greater health needs. Evidence suggests that Tudor Hart's inverse care law<sup>11</sup> also applies to invitations for health checks. Within practices, patients at greater risk of ill health, for example those in social classes 4 and 5, are less easily persuaded to attend for health checks.<sup>12-14</sup>

The aim of this study was to explore the pattern of provision of health promotion clinics across one family health services authority. Provision was then related to measures of health need of the practice population.

## Method

The Bedfordshire family health services authority is coterminous with two health authorities. In addition to sparsely populated rural wards, the area covered by the family health services authority includes deprived wards in Luton, Dunstable and Bedford.

Health promotion payments made by the family health services authority to practices in Bedfordshire over the three-month period ending 31 December 1990 were analysed. Border practices receiving most of their health promotion payments from another family health services authority were excluded from the analysis, as were practices which had undergone internal reorganization during the study period. The number of health promotion clinic sessions performed per practice was correlated with various practice features including the number of practice partners, list size, cervical cytology payments and immunization payments.

Each practice was ascribed two measures of putative need. First, the all-cause standardized mortality ratio to age 75 years of the ward in which the practice lies was calculated from Office of Population Censuses and Surveys data aggregated for the years 1981 to 1985. Secondly, the number of practices receiving deprivation payments was determined.

Data were analysed using the *Epi Info* package.

## Results

Nine practices were excluded from analysis because either they were receiving most of their health promotion payments from other family health services authorities or because they had undergone internal reorganization. Of 80 practices studied, 55 were receiving health promotion payments from Bedfordshire family health services authority. The mean number of health promotion clinics performed for which practices received payment over the study period was 20, range one to 117. Single-handed practitioners were less likely to be operating health promotion clinics (10/21 versus 45/59, chi square = 5.80,  $P < 0.05$ ).

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The percentage of practices receiving health promotion payments increased with increasing number of partners (test for trend, chi square = 8.94,  $P < 0.01$ ) (Table 1).

Payments per head of the practice population for cervical cytology and immunization were positively correlated ( $r = 0.49$ , 95% confidence interval (CI) 0.30 to 0.64). Payments per head for health promotion clinics correlated strongly with immunization payments ( $r = 0.51$ , 95% CI 0.35 to 0.67) but poorly with cervical cytology payments ( $r = 0.27$ , 95% CI 0.05 to 0.46).

**Table 1.** Number of practices receiving health promotion payments according to number of practice partners.

No. of practice partners	No. of practices	No. (%) receiving health promotion payments
1	21	10 (47.6)
2	17	10 (58.8)
3	10	8 (80.0)
4	16	13 (81.3)
5	16	14 (87.5)

There was no direct correlation between the number of health promotion clinic sessions run and the measures of need. However, practices in wards where the standardized mortality ratio was greater than 100 and practices receiving deprivation payments were less likely to be offering health promotion clinics (Table 2). A lower proportion of the population of practices in wards where the standardized mortality ratio was greater than 100 were being offered clinic-based health promotion as compared with the population in practices in wards where the standardized mortality ratio was less than 100 ( $z = 20.11$ ,  $P < 0.001$ ). Similarly, a lower proportion of the population of practices receiving deprivation payments were being offered clinic-based health promotion as compared with the rest of the population ( $z = 76.98$ ,  $P < 0.001$ ). These differences were reduced or reversed if single-handed practices were excluded from the analysis (Table 2).

## Discussion

A number of methodological limitations to this study should be noted. The assignment of measures of putative need to individual practices is problematic.<sup>15</sup> Ward standardized mortality ratios do not necessarily reflect the current health of a practice population. While more precise means of ascribing underprivileged area scores to practices are becoming available,<sup>16</sup> the

validity of the Jarman index as a measure of deprivation has been questioned.<sup>17</sup> The level of deprivation payments based on the Jarman index may not accurately reflect social and economic conditions.<sup>18</sup>

However, this simple descriptive study does suggest that the establishment of health promotion clinics, if these are assumed to be effective, will have benefited populations at lower risk of ill health within the county of Bedfordshire. Furthermore, if within practices those at less risk attend,<sup>14</sup> the differences described underestimate these benefits.

Many doctors are openly sceptical of the value of health promotion clinics and suggest that the main reason for establishing them is monetary gain.<sup>19</sup> However, attainment of high coverage rates for cervical cytology and immunizations can reasonably be regarded as reflecting good practice organization and a commitment to disease prevention as well as financial incentives. That payments per head of the practice population for cervical cytology, immunization and health promotion clinics are poorly correlated does suggest that a different balance of motives may underlie the establishment of health promotion clinics.

The less extensive coverage of supposedly more needy practice populations may largely be explained by the siting of single-handed practices in the same areas. Single-handed practices have been slower to establish health promotion clinics. Personal approaches to doctors concerned suggest that lack of time and lack of support staff, both clerical and nursing, are the main reasons for this. They also have more difficulty attracting the requisite 10 patients per session.<sup>20</sup>

Allowing the accumulation of health promotion clinics will help smaller practices and address the unequal provision identified in this study. However, more radical changes have been proposed.<sup>21,22</sup> General practitioners have expressed understandable dissatisfaction at the inconsistent application of approval criteria for health promotion across the country, but family health services authorities need to exercise some discretion if worthwhile health promotion is to be encouraged in all practices in their area. One suggestion is for two levels of approval for health promotion.<sup>22</sup> The first level would involve registration as a 'health promotion approved practice'. An allowance would be paid on submission of a plan to include an assessment of the practice population's health needs, a range of methods to meet those needs, measures for quality control and practice protocols. A second level of reimbursement would be offered in return for health promotion clinics.

Fundamental doubts remain. By discouraging opportunistic health promotion, the new arrangements may actually diminish the amount of effective health promotion activity performed in general practice. By placing responsibility for health promo-

**Table 2.** Distribution of health promotion clinics in relation to measures of need in the practice population.

	No. (%) of practices offering health promotion clinics		No. (%) of total practice population offered health promotion clinics	
	All practices	Excluding single-handed practices	All practices	Excluding single-handed practices
SMR $\geq$ 100	27 (64.3)	20 (76.9)	179 770 (75.8)	156 941 (80.6)
SMR < 100	28 (73.7)	25 (75.8)	186 307 (78.5)	187 640 (80.0)
Deprivation payments				
Yes	28 (63.6)	21 (75.0)	160 216 (72.1)	145 196 (76.4)
No	27 (75.0)	24 (77.4)	205 661 (81.5)	199 385 (83.2)

SMR = standardized mortality ratio of ward in which practice located.

tion with general practitioners, the government may be abrogating wider responsibilities in the field of disease prevention.<sup>23,24</sup> Should public health initiatives be based on screening whereby those at 'higher risk' are identified and appropriate interventions made when general population interventions are likely to be more effective?<sup>25</sup>

Bedfordshire family health services authority was aiming to spend around £300 000 on health promotion payments during the financial year 1990-91 (Hunt S, personal communication). Further research into the cost effectiveness of different approaches to health promotion is required to justify spending on this scale.

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