Letters

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The NHS at 60

In support of Watt's editorial calling for measures to correct health inequalities in deprived areas,[1] we have experienced that the inverse care law[2] is alive and flourishing.

Two years ago we were awarded an Alternative Provider Medical Services contract by Heart of Birmingham Teaching Primary Care Trust (HOBtPCT), to provide care to the patients of a retiring GP in Nechells, Birmingham. This inner-city suburb has operated for decades as a conduit for ingress into the city by progressive waves of immigrants. Hence, we serve a variety of patients including Irish, Pakistani, African–Caribbean (including significant numbers of refugees) and Eastern European, many of whose primary language is not English.

In our other practice, through a PMS contract 4 miles away in the Edgbaston Locality, South Birmingham PCT, we serve a comparatively mid-range socioeconomic population where nearly all the patients speak English.

In Nechells we crudely estimate the workload required to achieve similar quality of service to be about 130% of that in Edgbaston. However, our income per patient in Nechells in the first year was 55% of that in Edgbaston, taking into account basic contract, Quality and Outcomes Framework (QOF) and additional services. After 1 year we negotiated an uplift to 85%.

This letter is not a side swipe at HOBtPCT, who are responsible for provision of NHS services in a difficult area, but an illustration of the inequities that can exist invisibly, becoming apparent when people cross out of their usual divide, as we have. Financially, our winning the Nechells contract has been challenging (to say the least).

Professionally, it has been a revelation. We started with the intent of replicating a model of care from our Edgbaston practice to find that, not only were we regarded as over-idealistic by our new local colleagues, but that the patients were wrong-footed by our more patient-centred approach, and sometimes antagonistic to our insistence on, for example, face-to-face medication review.

We are proud of how far we have come on a shoe string. The shutters now go up and the doors open for the duration of our contractually agreed hours. Prescribing, QOF scores, and other quality indicators have improved, although we are disappointed by the limitations of existing measures in discriminating true quality. And, although we are improving primary care in Nechells, we remain frustrated by our sense of how much more we could achieve, were resources fairly allocated to where the need is greater.

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1. Watt G. The NHS at 60: time to end the fairy tale. *Br J Gen Pract* 2008; **58(552):** 459–460.
2. Hart JG. The inverse care law. *Lancet* 1971; **1(7697):** 405–412.

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Cardiovascular disease risk of homeless patients

In response to the article by Holt *et al*,[1] in the July issue, the use of practice-based software would increase our efficiency in identifying individuals at risk of cardiovascular disease (CVD). This study focuses on the older age group of 50–74 years. A recent study done by the Stockport PCT examining the CVD risk factor screening in the homeless population demonstrates that only a small number of homeless individuals fell within the age range of screening (35–70 years), but all of them were successfully screened to some degree. It also shows that they had more risk factors, the age of the individuals attending was younger, and they had more high-risk lifestyle behaviours. Even though only a small number was taken into account in this study, it emphasised why this group of individuals needs to be targeted for future health care. A proposed GP-led health centre by Lord Darzi in the area providing 0800–2000 hours care daily would allow them to be registered with a GP and therefore provide these patients with supportive and accessible health care. More upstream health prevention and health promotion could be offered in this centre as well as drug and alcohol treatment services.

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