

# 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,<sup>1</sup> we have experienced that the inverse care law<sup>2</sup> 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*,<sup>1</sup> 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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## Entering general practice

Congratulations on publishing Daniel Furmedge's telling short paper.<sup>1</sup> Full marks for his insight and interpretation. He reminded me of my first Claire Wand Fund Prize on 'Postgraduate education for the newly qualified doctor in preparation for entry into general practice.'

That was more than half a century ago. Returning from my 6-year sabbatical in the Army, I was seriously worried that none of my clinical teachers had any personal experience of general practice, and that no mention of the subject was made.

The stigma was real, enormously encouraged by the arrogance of Lord Moran, who had publicly declared that the GP was 'the doctor who had fallen off the ladder of success.'

On one point I disagree with Daniel Furmedge. The GP is essentially a generalist — not a specialist. The specialist is the one who has chosen to wear Lord Moran's blinkers.

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- Furmedge D. General practice stigma at medical school and beyond — do we need to take action? *Br J Gen Pract* 2008; **58**(553): 581.

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## Osteoarthritis

We read with interest the recent 'Top tips in 2 minutes: Osteoarthritis of the knee',

which was published in the May issue of the *BJGP*.<sup>1</sup> Although written in an engaging style it is baffling that such an article should appear just 2 months after the published NICE osteoarthritis guidelines and yet contain no reference to them.

While certain pieces of advice contained in the article are consistent with the NICE osteoarthritis guidelines (notably 'don't leave surgery too late'), it also substantially diverges in many places:

- Core treatment is information and advice about the condition; weight loss; exercise (both aerobic and strengthening have been shown to be effective — there is no basis for the emphasis on 'non-impact').
- Glucosamine is not recommended for use within the NHS. While 1500 mg glucosamine sulphate has demonstrated a small benefit over placebo for knee osteoarthritis guidelines, this product does not currently have an EU licence.
- Topical NSAIDs are recommended.
- Neither viscosupplementation nor debridement are recommended ('when symptoms worse than X-ray' is relatively meaningless).
- X-rays not recommended to confirm a clinical diagnosis of knee osteoarthritis guidelines; indicated only in the presence of giving way/locking.
- MRI not currently recommended for diagnosis, even in early osteoarthritis guidelines.

We would encourage readers of *BJGP* seeking Top Tips in 2 minutes on this subject should consult the NICE osteoarthritis guidelines 2-page summary and the accompanying version for members of the public.

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*Top Tips in 2 Minutes for the May issue was compiled in January 2008, a month before the NICE guidelines were published. A correction was published in the June issue with reference to the latest NICE guidance. DOI: 10.3399/bjgp08X302907.*

## Tooke report

Professor Field commented on the Tooke report in the April Journal.<sup>1</sup> He suggests it is good news for general practice because it emphasises excellence and recommends an extension of GP training to 5 years.

Am I the only GP who qualified in the late seventies or early eighties who is slightly bemused by this?

We were trained by the age old 'rote-regurgitation' system (learn by rote, regurgitate in exams). Most of us attended half-day release in our post-graduate years — only if ward work allowed (quite right too!). There was often little or no departmental teaching. By modern educational standards a poor system.

So why do we need 5 years of training? It must be because we are not good doctors, patients do not value the service we give, and we have not coped with change.

Yet, we are the generation who learnt maths on slide rules (I still have mine!). We have seen massive changes in the practice of medicine, in general practice, including the arrival of practice nurses, computers, contract changes, clinics, and the devolving of clinical work from hospital to general practice. We still have the respect