

MIND THE GAP

Do we mind the gap?

Hawkes describes how inequalities in health in the UK reflect inequities in society.¹ I disagree that “there’s not much that health care can do about that.”

Certain groups find it difficult to register with a GP, including people who exhibit challenging behaviour, move frequently with their work, are homeless or vulnerably housed, or are gypsies, travellers, migrants, refugees, or asylum seekers. GPs can register anyone for primary care whom they believe to be eligible, yet it has become common practice to require identification papers, proof of address, or other documentation to register. Where the impetus for introducing what is in effect a barrier to services has come from is unclear: the Department of Health has not issued guidance to this effect.

Access to health care depends on candidacy and permeability. The person must feel that they are a candidate for a certain health intervention, and the health professional to whom they present must concur. People with addictions, people who behave oddly or challengingly, people who do not speak good enough English, people with intellectual disabilities, people who sleep rough or who smell or who are old and possibly confused have treatment delayed or denied within our system to an extent that is shameful and largely unacknowledged.

As a new approach to improving access, the government invented the Choice Agenda, but

who is getting the choice? The very instruments of choice such as Choose and Book, walk in centres, and automated hospital switchboards reduce permeability and thus militate against the most vulnerable in society—elderly people, those reliant on public transport, those with complex and multiple needs, those without a landline phone.

Do we as health professionals mind the gap? If we do, what are we prepared to do about it?

Angela M Jones freelance general practitioner, Abingdon, Oxfordshire OX14 4PD
angela.jones@inclusivehealth.co.uk

Competing interests: AMJ is chair of the Health Inequalities Standing Group of the Royal College of General Practitioners. She is a partner in the Inclusive Health consultancy, run on social enterprise principles. The views expressed are her own.

1 Hawkes N. Mind the gap. *BMJ* 2009;338:b2604. (30 June.)
Cite this as: *BMJ* 2009;339:b2933

Reducing the gap

Hawkes emphasises the widening in health inequalities with the increasing inequality in absolute income.¹ People in the most deprived areas live in the poorest quality housing with poor insulation. Thus heating the house, even inadequately, takes a disproportionate percentage of an already low income. Poor insulation also leads to the development of mould, affecting health and economics.

In Easthall, a part of Easterhouse, a very deprived area of Glasgow, two blocks of flats (36 flats) were refurbished to a high standard, thanks to the determined efforts of residents.² Blood pressure fell from a mean of 142/85 mm Hg to 122/73 mm Hg.² This fall is greater than

that seen in studies showing the beneficial effects of lowering blood pressure.³⁻⁵ The incidence of respiratory disease also fell, three people with severe asthma being able to stop all drug treatment.

Reducing the temperature differential between the rooms rather than the absolute temperatures was important in improving health. Before the refurbishment, many families could afford to heat only one room: in winter they would have had to spend £60/week to achieve the recommended healthy temperatures throughout and to avoid the risk of condensation dampness. However the refurbished flats could be kept comfortably warm throughout for about £7/week, including plenty of hot water. The absence of damp and mould also meant not having to replace furnishings damaged by mould.

Thermal refurbishment of poor quality housing is an opportunity to decrease financial disparities and health inequalities.

Evan L Lloyd retired consultant anaesthetist, Edinburgh EH12 6NQ evlloyd@waitrose.com

Competing interests: None declared.

- 1 Hawkes N. Mind the gap. *BMJ* 2009;338:b2604. (30 June.)
- 2 Lloyd EL, McCormack C, McKeever M, Syme M. The effect of improving the thermal quality of cold housing on blood pressure and general health: a research note. *J Epidemiol Community Health* 2008;62:793-7.
- 3 He FJ, MacGregor GA. Cost of poor blood pressure control in the UK: 62,000 unnecessary deaths per year. *J Hum Hypertens* 2006;17:455-7.
- 4 Law M, Waki N, Morris J. Lowering blood pressure to prevent myocardial infarction and stroke: a new preventive strategy. *Health Technol Assess* 2003;7(31):1-94.
- 5 Tunstall-Pedoe H, Smith WCS, Crombie IK, et al. Coronary risk factors and lifestyle variation across Scotland: results from the Scottish Heart Health Study. *Scott Med J* 1989;34:556-60.

Cite this as: *BMJ* 2009;339:b2928

Regional inequalities and cancer

Hawkes highlights the health impact of the widening deprivation gap and the stark regional differences in income.¹ Deprivation is associated with increased cancer incidence and worse outcomes.^{2,3}

In the deprived regions of Yorkshire and Humber and the north east only 25-28% of patients with cancer received radiotherapy.⁴ By contrast, in the three regions of the south east access to radiotherapy was 49% and consistent with international norms. The reduced access to radiotherapy was strongly correlated ($r=-0.820$) with increasing deprivation.⁴



The links between deprivation and reduced cancer survival are complex.² However, patients with lung cancer whose first hospital attendance was at a radiotherapy centre were more likely to receive active treatment, with evidence of longer survival.³ Cancer pathways and barriers to specialist care seem critical.^{3,5}

Michael V Williams consultant clinical oncologist, Oncology Centre, Box 193, Addenbrooke's Hospital, Cambridge University Hospital NHS Trust, Cambridge CB2 0QQ
michael.williams@addenbrookes.nhs.uk

Competing interests: None declared.

- 1 Hawkes N. Mind the gap. *BMJ* 2009;338:b2604. (30 June.)
- 2 Munro AJ. Deprivation and survival in patients with cancer: we know so much, but do so little. *Lancet Oncol* 2005;6:912-3.
- 3 Jack RH, Gulliford MC, Ferguson J, Moller H. Geographical inequalities in lung cancer management and survival in south east England: evidence of variation in access to oncology services? *Br J Cancer* 2003;88:1025-31.
- 4 Williams MV, Drinkwater KJ. Geographical variation in radiotherapy services across the UK in 2007 and the impact of deprivation. *Clin Oncol* (in press)
- 5 Department of Health. *Cancer reform strategy*. London: DH, 2007.

Cite this as: *BMJ* 2009;339:b2927

HEALTH AS A WEAPON OF WAR?

A misrepresentation of reality

The misrepresentative article by a Tamil national with a highly biased point of view that favours the propaganda of the Liberation Tigers of Tamil Eelam (LTTE) seems to have the objective of tarnishing the image of Sri Lanka among *BMJ* readers worldwide.¹

Its accusation that "successive governments have used access to medicines as a weapon of war against the Tamils" is false and factually wrong. Sri Lanka's free government sponsored healthcare system operated unabated in every part of Sri Lanka, including the areas controlled by the LTTE. The regional directors of health services in the north and east ensured that each hospital and government dispensary functioned properly. The government provided medicine, staff, and funding for the continuation of the system. The LTTE also benefited from this system so it allowed it to operate as usual.

It is cynical to say, "Since 2006 the Sri Lankan government and its armed forces have systematically blocked the provision of water, shelter, food, and medicine by civil organisations as well as local and international non-governmental organisations." All these criminal acts were committed by the LTTE against innocent civilians.

In 2006 the LTTE deprived thousands of hectares of paddy fields of irrigation water by blocking the sluice gates of Mavil Aru in eastern province. Then they chased the Tamil civilians away from their homes. Food and medicine sent to these areas by the UN World Food Programme and the government were taken by the LTTE. The security forces found incontrovertible evidence of

rice sacks being used for building LTTE bunkers, and high nutrition biscuits from the UN meant for undernourished children were found in the sacks of dead LTTE cadres.

The argument that Tamil doctors were "refused access" to serve displaced people is false. In April 2009 the government appointed 232 additional doctors, irrespective of whether they were Sinhalese or Tamil, additional nurses, and other support staff to the hospitals in the region and the welfare villages.

Nihal Jayasinghe high commissioner, Sri Lanka High Commission, London W2 2LU mail@slhc-london.co.uk

Competing interests: The rapid response from which this letter is derived was prepared by the Ministry of Foreign Affairs of Sri Lanka based on approved information given by the Ministry of Health, 9 June 2009.

- 1 Suntharalingam S. Sri Lanka: health as a weapon of war? *BMJ* 2009;338:b2304. (8 June.)

Cite this as: *BMJ* 2009;339:b2941

Confirmation of my experience

I worked in the north east of Sri Lanka and witnessed the government's discrimination.¹ Ultrasound and computed tomography machines donated by the international community were held at Colombo docks for months to rust before being transported to the north east. Equipment sent to Colombo for repair was returned untouched. This forced us to work in an extremely challenging environment, with minimal or no functioning equipment. I participated in operations, including limb amputations, without anaesthetics and adequate monitoring equipment. Drugs, including analgesics and antibiotics, were past their expiry dates. Many of our patients did not survive even the most basic disease.

Eight weeks after the end of the shelling, international non-governmental organisations and the media had not been allowed into either the conflict zone or the detention camps. Aid workers remaining in Sri Lanka have been forced to leave the country.² A ship from Britain carrying 900 tonnes of food and medical aid for the displaced people was intercepted by the Sri Lankan navy and not allowed to unload its cargo.³ The Human Rights Leadership Coalition recently wrote to President Obama urging that he intervene.⁴

Bobby Sundaralingam radiologist/nuclear medicine physician, Eastern Health, Melbourne, VIC 3128, Australia
absunda@hotmail.com

Competing interests: None declared.

- 1 Suntharalingam S. Sri Lanka: health as a weapon of war? *BMJ* 2009;338:b2304. (8 June.)
- 2 Page J, Hodge A. Aid staff expelled over "Tamil Tiger links". www.theaustralian.news.com.au/story/0,25197,25582873-25837,00.html
- 3 Henderson B. Sri Lanka navy seizes British Tamil aid ship on "mercy mission". www.telegraph.co.uk/news/worldnews/asia/srilanka/5453350/Sri-Lanka-navy-seizes-British-Tamil-aid-ship-on-mercy-mission.html
- 4 Letter to President Obama, 18 June 2009. <http://physiciansforhumanrights.org/library/documents/letters/to-pres-obama-re-sri-lanka.pdf>

Cite this as: *BMJ* 2009;339:b2952

BREAST SCREENING

Breast screening saves lives

Godlee concludes incorrectly that our silence implies assent to Gøtzsche and colleagues' views on the magnitude of the effect of mammographic screening in reducing breast cancer mortality.¹⁻⁴

In 1993 a meta-analysis of randomised trials showed a 24% reduction in breast cancer mortality among all women aged 50-74 invited for screening,⁵ a result that has been generally accepted. This intention to treat analysis avoids selection bias, but at the cost of diluting the true estimate of the reduction in breast cancer mortality in screened women because about 22% of women declined screening but were included in the analysis. The true "on treatment" effect of screening must therefore be greater than 24% and would have been 31% assuming no selection bias. In the absence of evidence of strong selection bias, the effect is likely to be about 30%.

Without screening about 5% of women die from breast cancer. Screening performed over about 20 years from the age of 50 will have its impact in reducing breast cancer mortality a few years later, between the ages of about 55 and 74. Before systematic screening was introduced, about 60% of all breast cancer deaths occurred in the age group 55-74, so in this age group about 3% of women died from breast cancer (60% of 5%). Screening will reduce this 3% by 30% to about 2%—that is, an absolute risk reduction of 1%. The key element from research is the 30% reduction in breast cancer mortality in women who are screened; the rest of the calculation uses national data.

In summary, whatever the costs (human and financial), breast cancer screening saves lives. In 100 women aged about 50, three would die from breast cancer in the next 20 years if they were not screened, but with screening two would die and one would be saved, a risk reduction of about 30%.

Nicholas J Wald professor. n.j.wald@qmul.ac.uk

Malcolm R Law professor.

Stephen W Duffy professor, Wolfson Institute of Preventive Medicine, Barts and the London School of Medicine and Dentistry, London EC1M 6BQ

Competing interests: None declared.

- 1 Godlee F. Less medicine is more. *BMJ* 2009;338:b2561. (30 June.)
- 2 Gøtzsche P, Hartling OJ, Nielsen M, Brodersen J, Jørgensen KJ. Breast screening: the facts—or maybe not. *BMJ* 2009;338:b86. (27 January.)
- 3 Gøtzsche P, Hartling OJ, Nielsen M, Brodersen J, Jørgensen KJ. Electronic response. www.bmj.com/cgi/eletters/338/jan27_2/b86#209896
- 4 Gøtzsche P, Jørgensen KJ. Electronic response. www.bmj.com/cgi/eletters/338/jan27_2/b86#212985
- 5 Wald NJ, Chamberlain J, Hackshaw A, on behalf of the Evaluation Committee. Report of the European Society for Mastology Breast Cancer Screening Evaluation Committee. *The Breast* 1993;2:209-16.

Cite this as: *BMJ* 2009;339:b2922