Perspectives in NHS Management

Inequalities in health: can they be corrected?

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A major objective of the National Health Service at its inception was to provide readily accessible medical care to everyone, thus reducing inequalities in health. That objective remains. Given the substantial evidence on inequalities, however, it would be perverse to avoid the conclusion that the lowest social groups have relatively bigger health needs yet even now receive fewer and worse health services, particularly preventive and health promotion services.¹⁻⁷ Sadly, the NHS in its 36 year history seems to have made little impact on these figures, though no doubt they would have been even worse without it. Nevertheless, it is unacceptable to say to our poorest people that you will die sooner and while you live you will experience worse health and will have fewer health services, and that the health services you receive will be worse. What can the NHS do about it?

The idea of social class has some meaning for most people but it is limited at the level of social policy and inadequate for planning health programmes. A more important reason for not using class as a planning tool is that its use would hinder progress. The vocabulary of class and inequality is not a usual part of the conversations of professional people and is more likely to arouse hostility than support. Even worse, inventing yet another special case for more funds—Black style³—would add a weak bidder to the many competing interests for cash.

Instead of class, there is a need for accessible social information that health authorities could use in their planning. The case for an epidemiologically sound national morbidity survey, particularly at district level, is unanswerable and must surely come one day. The need for further information, however, is an inadequate alibi for continued inaction. Two proposals are made here that could be tried by any health professional interested in making progress in improving equity in health.

Geographical targeting

With the spread of information technology every health authority and family practitioner committee has at its disposal a wide range of detailed census data about its population. This includes a wide range of social indicators often accepted as good proxies for morbidity. The small area statistics provide information down to enumeration district and postcode level. Following Brotherston's suggestion, each health authority or family practitioner committee could take selected social indicators and identify the worst 5% of its enumeration districts.⁸ This could identify those small areas within the catchment

area with a relatively high incidence of, for example, unemployment, unmarried parents living alone, and overcrowding. This could be overlaid with such National Health Service indicators as perinatal deaths or failure to attend a clinic. This would enable each authority or practice to satisfy itself that care provided in those areas was of the right order within available resources. It seems likely that in any catchment area with substantial numbers of the lowest social groups then some redeployment of existing community services would be called for and possibly make a good case for additional resources.

Making a start

There are severe inequalities in health, and the NHS has so far done little or nothing to combat this. While many of the causes lie outside health institutions, leaders in the NHS have a responsibility to ensure that sufficient effort is applied towards achieving that founding objective of the NHS—equity. The type of programme outlined here is substantially untried, but it is easier to think of methodological objections and practical difficulties than to make a start. There is a genuine problem here, so let us make that start.

At risk registers

Something more accurate is still needed to identify specific patients or families. The household rather than the individual on the one hand or the parish on the other might be the most appropriate level. Registers of at risk households should be compiled. Putting resources where they will do most good is a familiar idea, as is an at risk register. Therefore there need not be any objections to compiling at risk registers to log those households actually or potentially experiencing health deprivation. The considerations to be taken into account are the variables to be used in compiling this register; management of the register; and the response once action is triggered.

COMPILING AN AT RISK REGISTER

Each group of professionals could determine which variables to use and how to weight them in their own circumstances. A housing waiting list approach is suggested—partly because this is a widely accepted mechanism for rationing public service and partly because it can tackle a range of complexities flexibly. The variables included could be tailored to suit local preference. Given controlled trials, it would be possible over time to

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identify those variables and weightings that were good predictors of successful interventions. Initially, there would have to be a mixture of professional judgment and trial and error. The box gives an example as an illustration.

This example includes both census social indicators and locally available data often thought to show an accumulation of deprivation. Practitioners will have their own preferences as to which variables could be excluded or added. The same is true of the weightings. Experience would suggest changes. Perhaps some variables will be so critical as to trigger action in themselves, and they would therefore need weighting at the appropriate level.

MANAGEMENT OF AN AT RISK REGISTER

Management of a register needs to be done from a convenient point such as the office of a director of community nursing services or a general practitioner's surgery. A split level register could be maintained with the first level regarded as provisional and the second level substantive. The provisional level could include entries scoring, say, five points or more and the second level would be where a response had been triggered in accordance with local policies, say at 15 points.

<i>Illustrative social factors for an at risk register</i>	
<i>Variable</i>	<i>Points awarded</i>
● Head of household unskilled manual and unemployed for over two months	10
● Single parent family living alone, head of household not working	10
● Household lacking running water and inside water closet	5
● More than one person per room	5
● Entry in at risk register for non-accidental injury to children	15
● Late attendance at antenatal clinic	5
● Living in furnished rented accommodation	1
● No fixed abode	5
● No private transport	1
● Person over 75 living alone	5
● Registered disabled	1
● Failure to attend antenatal clinic	2
● Incomplete vaccinal state	1
● Illiterate adult	1
● School defaulter	1
● Head of household unskilled manual with six or more children	5

While it would be better to keep such a register based only on health service information than not at all, there would be obvious advantages in including information from other sources—for example, voluntary organisations, social services, education and housing authorities. Reports could be fed in as spin offs from normal visits by staff from all those participating agencies. To this could be added reports from attendance at accident and emergency departments and child development or school health clinics. Though these sources of information will not be rigorously comprehensive, they will be able to provide a wide

coverage. It is unlikely that many households at risk will not be visited by one of the agencies suggested or pay a visit to a participating clinic or department or both. Ideally, these data sources should be supplemented by specific programmes for households with no fixed abode—for example, gypsies.

An option would be to add social indicator dimensions to general practice age and sex registers to carry out the functions of household at risk registers. This would have the advantage of building on existing practice systems and avoid relying on a wide range of disparate agencies. Naturally, the feasibility of this alternative depends on the enthusiasm and stamina of the participating general practitioners. Another possibility might be to combine both approaches.

Such registers would be obvious candidates for computerisation. The number of entries would not be massive and once established not subject to rapid change. This avoids the huge back filing problems associated with some other patient administration systems. It will be commonplace for community health departments to have access to microcomputers and this at risk register could be an additional system at little marginal cost.

TRIGGERING ACTION

The objective is to use the register to change the way in which services are provided in order to improve the health of individuals. There are two key operational questions in implementation. The first is at what cut off point will some kind of response be triggered? The variables and weightings can be changed easily to control the number of responses deemed feasible. It would be easy to define present and planned levels of response. In the above illustration the following standards could be set:

Minimum response: 15 points.

Planned level of response: 11 points.

Preferred long term policy aim for response: five points.

The response could also be triggered at the direct request of the appropriate doctor or nurse. Quite what the response should be would be determined locally by those providing the service and changed according to experience. The first response could be a home visit by an appropriate professional from the community health service who had local induction training into this specific programme. This might well be a health visitor—either an attached health visitor or one recruited specifically for this programme.

The initial visit would be for assessment and require extensive informal contact with at least one member of the household. Selection of the staff undertaking these visits would be crucial: they should be skilled in winning confidence and establishing communication in an unofficial, unauthoritarian way. The more sensitive these visits are to the lifestyles of the household being visited the better in order to avoid rejection. In the event of any such rejection, then the programme must withdraw contact. Some skill at generic assessment visiting in circumstances where they are not always welcome has been built up by community psychiatric nurses, particularly those working with the elderly who are severely mentally infirm. Experience can also be drawn from other intervention strategies that are slowly spreading into the NHS—for example, coronary disease primary prevention projects. These do not so much require additional resources as a closer working relationship between staff than is common in the health and social services.

The second operational question relates to determining the aspects of health under consideration and the choice of a health programme appropriate to the individual concerned. This is likely to take the form of referral to the general practitioner or other appropriate point for medical treatment of an active condition or to draw on appropriate health promotion activities or both. Programmes would be based on prearranged packages of medically agreed specific regimens for such activities as family planning, immunisation and vaccination, hygiene, nutrition, smoking, alcohol and drug abuse, baby and child

Survey of GPs' attitudes to out of hours cover

In a report on out of hours patient care prepared jointly by Air Call and the BMA's central advisory committee the results of a survey of general practitioners' opinions on deputising services are published. Air Call, a commercial company specialising in information and communications technology, runs 20 deputising services in conjunction with the BMA. The survey, carried out by Market and Opinion Research Institute International, showed that 79% of the 818 general practitioners interviewed in February and March 1984 believed that they should be allowed to use deputising services.

Other findings from the survey were:

- 94% of those interviewed who only used a commercial deputising service for out of hours cover were satisfied with the standards of medical care provided.
- Nearly one fifth of the general practitioners in the survey worked more than 90 hours a week; 61% worked over 60 hours a week.
- 67% of the sample believed that patient care would suffer if they were to spend more time working or on call.
- In urban and metropolitan areas 85% of the general practitioners interviewed believed they should be allowed to delegate to commercial deputising services. In rural areas, where deputising services generally do not operate, 64% believed that doctors should be allowed to delegate.
- The most common form of arrangement which general practitioners made for providing out of hours patient care was an internal arrangement within their own partnership or group (69%). One third used a commercial deputising service at least some of the time, while 13% use only a commercial deputising service.
- Over one quarter of general practitioners were on call for their own patients at least

three times a week on Monday to Friday evenings (between 7 pm and 11 pm). Most (87%) were on call for their own patients at least once a week at this time.

- 63% of the doctors interviewed were on call for their own patients at least one weekend a month. Around half were on call for their own patients at least one weekend a month and at least once a week on weekdays from 7 pm to 11 pm and at least once a week on weekdays from 11 pm to 7 am.

- Over half (56%) of general practitioners who used an outside arrangement said they were "very satisfied" with the standard of medical care which their patients had received; a further 26% said they were "fairly satisfied." Only 2% of GPs said they are "not very satisfied" with the standard of medical care provided, and only one GP (less than half a per cent) said he was "not at all satisfied."

- Of the general practitioners interviewed who use only a commercial deputising service and do not use any other form of out of hours cover, 94% were satisfied with the standard of medical care provided—66% "very satisfied," and 28% "fairly satisfied."

- 79% of GPs believed that general practitioners should be allowed to delegate their night-time and weekend duty to professionally approved and monitored commercial deputising services; 14% believed that they should not, and 7% did not know.

- Two thirds (67%) of general practitioners believed that patient care would deteriorate if they were to spend more time working, or being on call outside normal working hours.

Few complaints

At the press conference at BMA House on 21 May when the survey was announced the medical director of Air Call, Dr Peter Gregory, said that the standing and experience of deputies had been questioned. "In the services we operate," he continued, "the profile of the average deputy is that he is 44 years old and has been qualified for some 18 years, some 9.6 years have been spent in general practice. None are approved unless they have a minimum of six months' general practice experience. Over 75% are general practice principals.

But what of patient satisfaction? The only facts are known complaints to medical services committees and those that are investigated by our professional medical advisory committees. In 1981 and 1982 there were 11 complaints to medical service committees out of a total of 1 487 000 visits. During the same period I understand that there were 1659 medical services cases against all general practitioners. Of the complaints to our professional advisory committees there were 146, the vast majority of which resulted in no disciplinary action or breach of service by the service."

Dispensing doctors: discount inquiry leads to abatement of reimbursed costs

The Department of Health and Social Security and the British Medical Association have been studying dispensing doctors' drug costs. Mr Kenneth Clarke, Minister for Health, announced the results of the inquiry to parliament on 17 May. He reported that the majority of dispensing doctors obtained discounts, which amounted on average to about 5% of the cost of all drugs dispensed. His statement continued:

"The government and the profession are agreed that, as a matter of principle, the reimbursement of drug costs should as nearly as possible match the amounts actually paid by doctors to their suppliers. Having considered the results of the discount inquiry, they have agreed that the amounts reimbursed to doctors in respect of the costs of drugs and appliances should be abated to reflect the discount received. We will protect the position of doctors with small or remote practices who cannot obtain discounts.

"We will be introducing an interim scale from 1 July 1984 at a rate designed to offset over the course of a full year approximately two thirds of the full amount of the discount found from the inquiry. We will introduce a scale to offset discount at the full annual rate in 1985-6.

"In practice, the introduction of a discount

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care, school and play groups, money management, and social security. The potential list is endless, and the literature abounds with suggestions for both subject matter and programmes.

Can we afford it?

This programme is affordable if the motivation is there. There is a relatively small number of people at risk—perhaps 4000 in the average health district. No other similar high risk group would be so ignored. Most health authorities can afford to redeploy resources if they stop spraying them about and start using them selectively. This means at risk strategies in other services too. The onus of proof should be on those who argue that redeployment is impossible.

Quite modest numbers of staff are needed to deal with the minimal level of response suggested here. The employment of additional community health staff for these purposes would be an excellent use of joint funding that is still increasing. The experience of other programmes—for example, in relation to the

elderly severely mentally infirm—suggests that around six to 12 people could provide the minimum service. This cost is substantial but manageable, especially when compared with the running costs of new hospitals, additional consultant posts, and the other more conventional growth areas still attracting money.

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