



GPs at the Deep End

Addressing Health Inequalities: Deep End Ireland

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“The availability of good medical care tends to vary inversely with the need for it in the population served. This ... operates more completely where medical care is most exposed to market forces, and less so where such exposure is reduced.”

Julian Tudor Harte, 1971

The inverse care law and the potential of primary care in deprived areas



The inverse care law, whereby health care favours more assertive interests and in doing so compounds the disadvantage of patients and communities with the poorest health,¹ exists in most health systems. 50 years after Julian Tudor Hart's landmark paper in which he first described the inverse care law in England and Wales,¹ it is still going strong.^{2,3} In *The Lancet*, Richard Cookson and colleagues⁴ provide a global re-examination of the inverse care law.

Tudor Hart's main target was the role of commerce in health care, but he also showed that the maldistribution of the health workforce and other resources limits the ability of health professionals to address patients' needs. "Medical services are not the

health needs to discuss, especially related to psychosocial issues.¹¹ These consultations generally involve lower patient expectations of shared decision making, poorer health outcomes, and greater stress among health professionals than in wealthier areas.^{11,12} Patients who are socioeconomically disadvantaged generally make more use of emergency health services but less use of specialist and preventive care.¹³ COVID-19 is compounding these issues through social gradients in incidence and case-fatality rate, the mounting backlog of non-COVID-19-related clinical work, increases in psychological and financial stress, and the limitations of remote primary care consultations.¹⁴⁻¹⁶

Tudor Hart not only described the inverse care

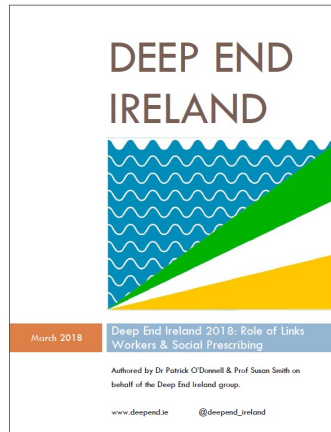
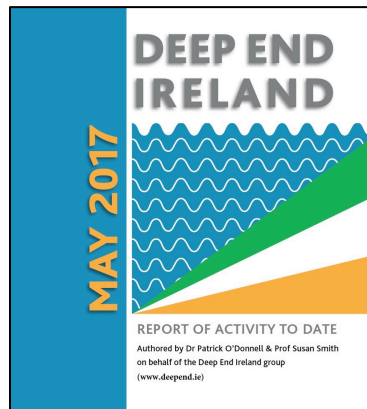
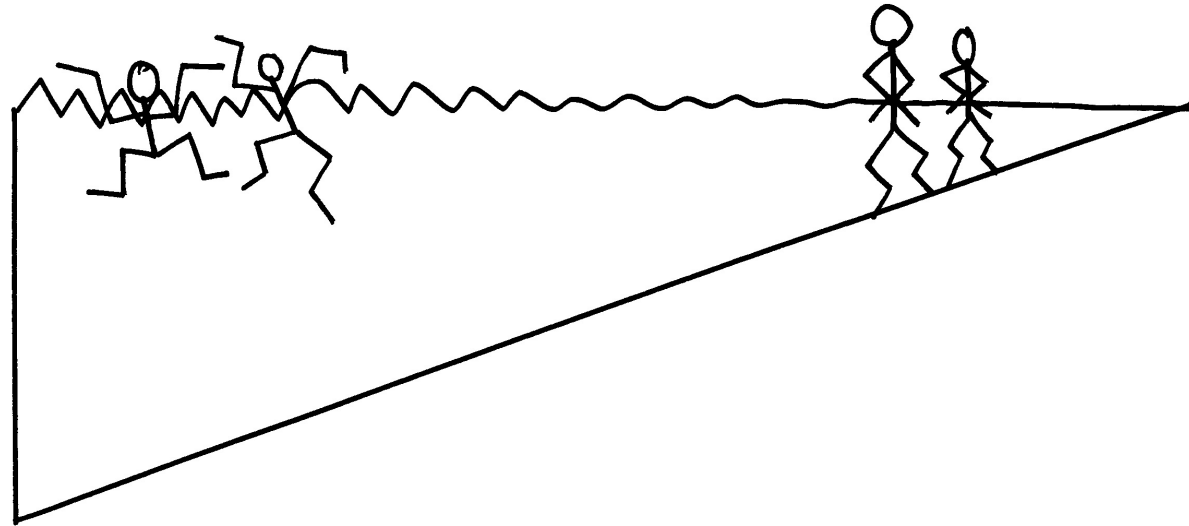


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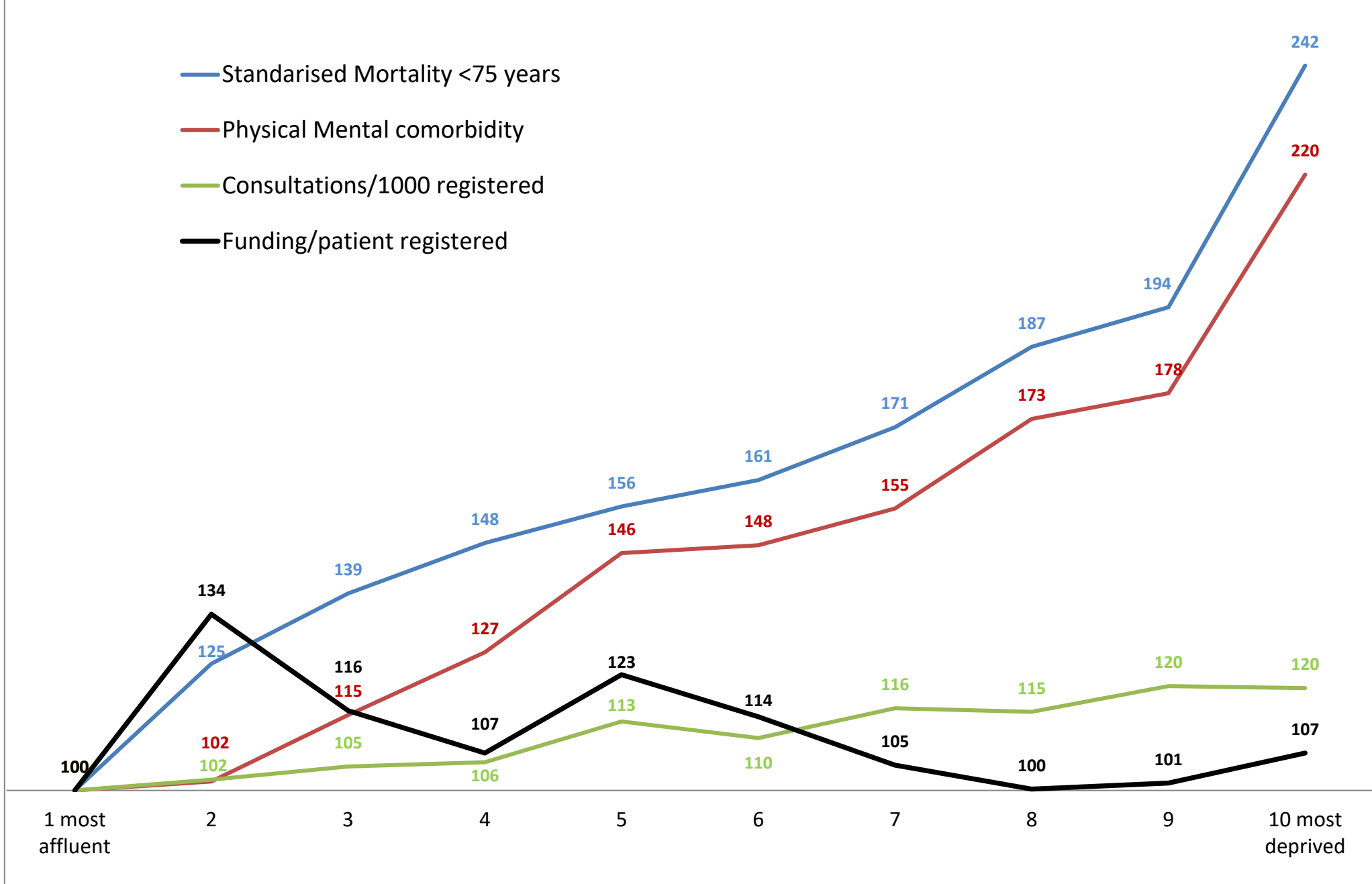
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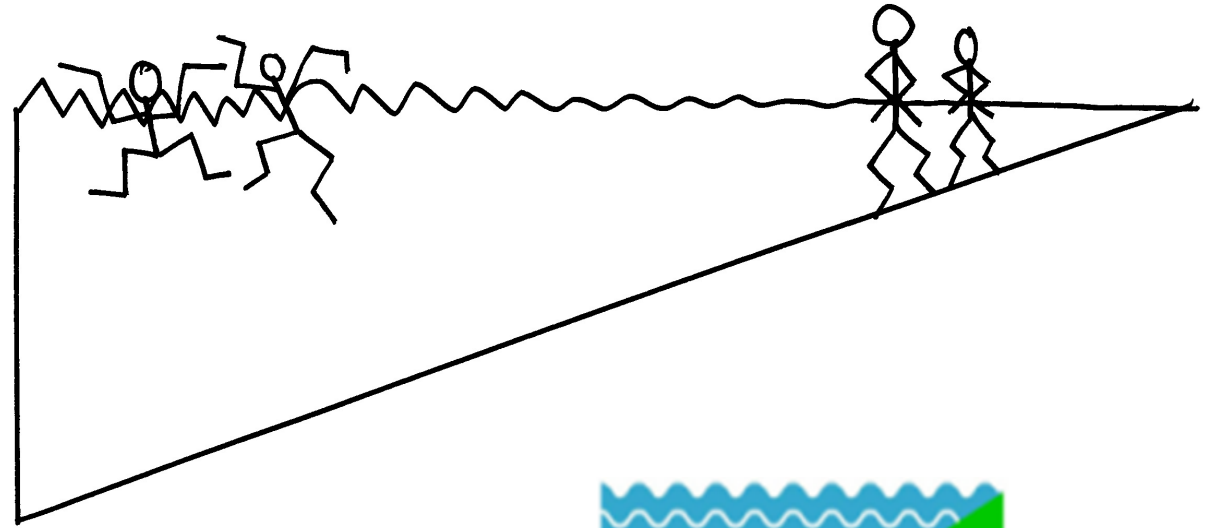
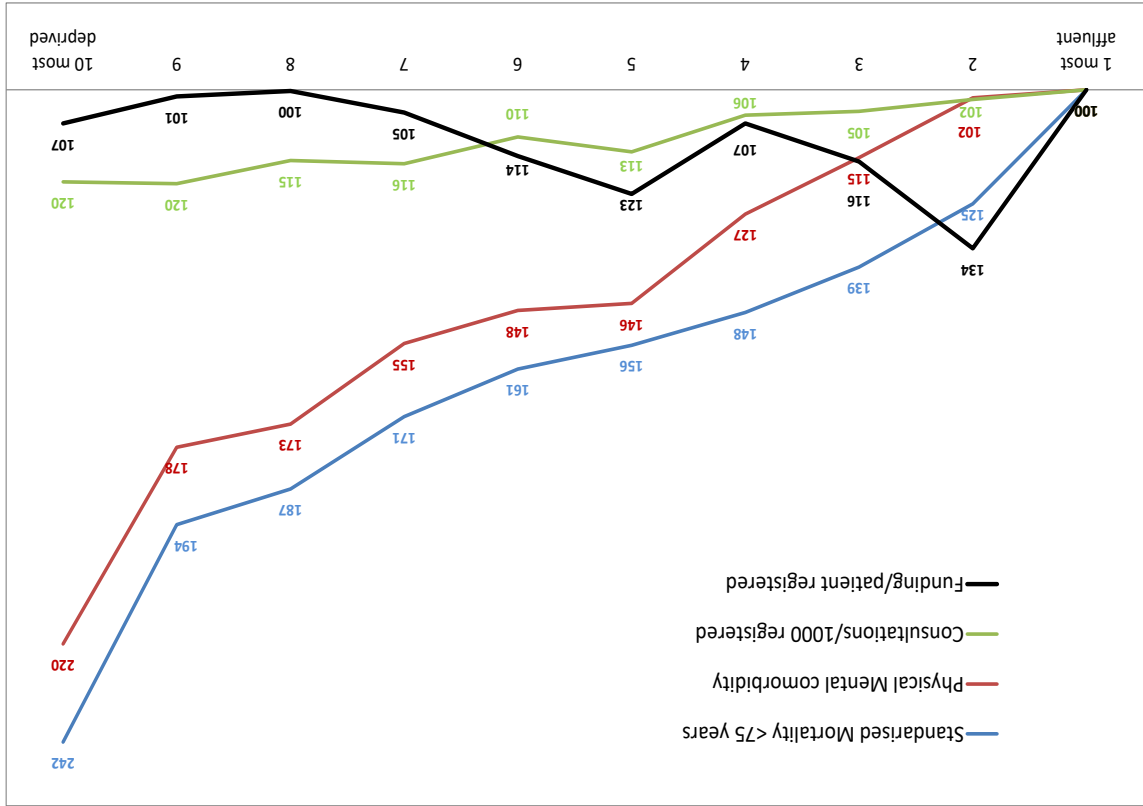
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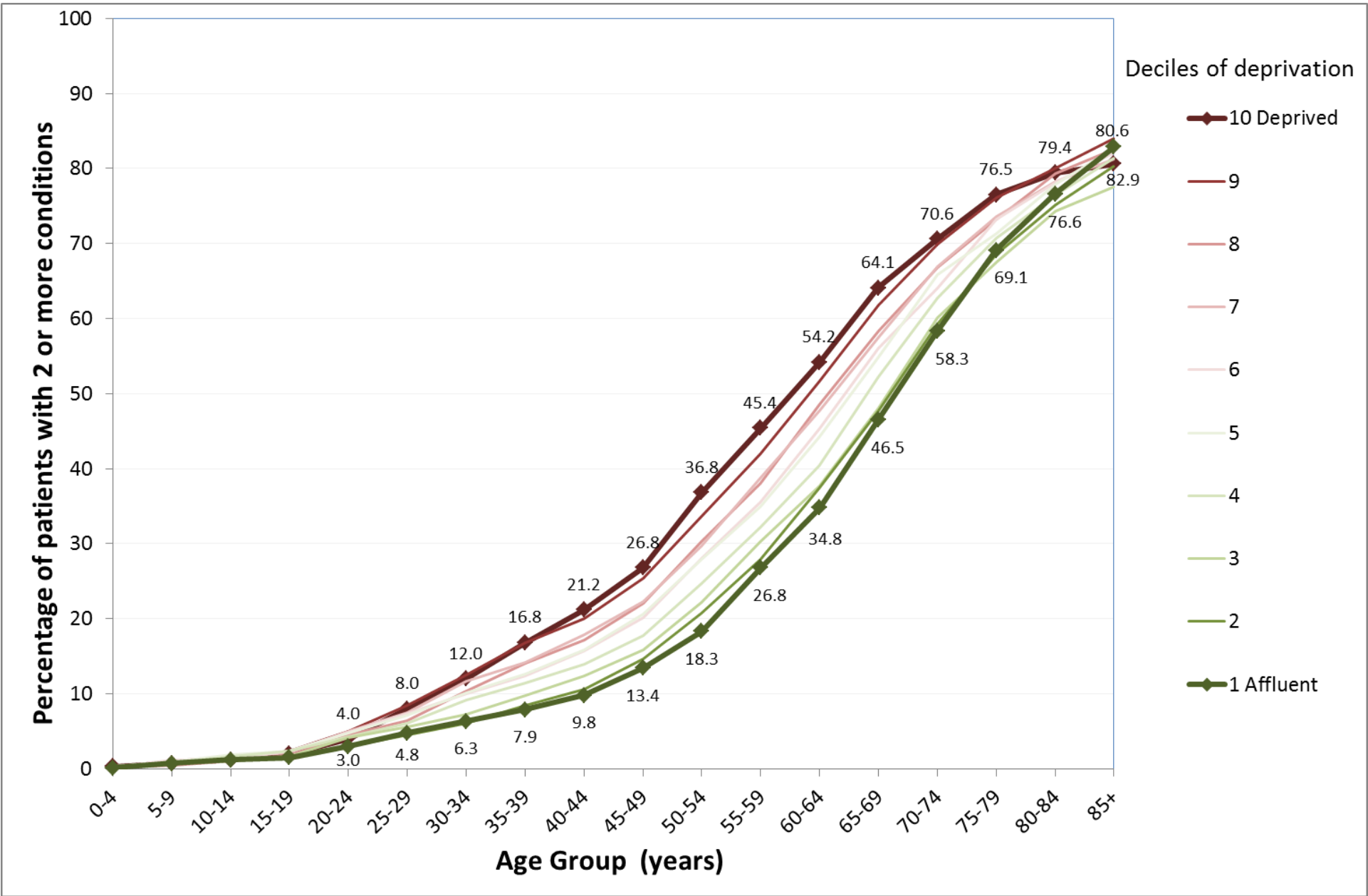
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McLean G, Guthrie B, Mercer SW, Watt GC. **General practice funding underpins the persistence of the inverse care law: cross-sectional study in Scotland?** BJGP 2015; 65(641): 799-805.



GPs at the Deep End



Barnett et al, Lancet 2012

Wider social determinants of health (life course)

- Income inequality
- Education and environment (green spaces; diet)
- Adverse Childhood experiences

Structural societal issues vs individual responsibility (blame)

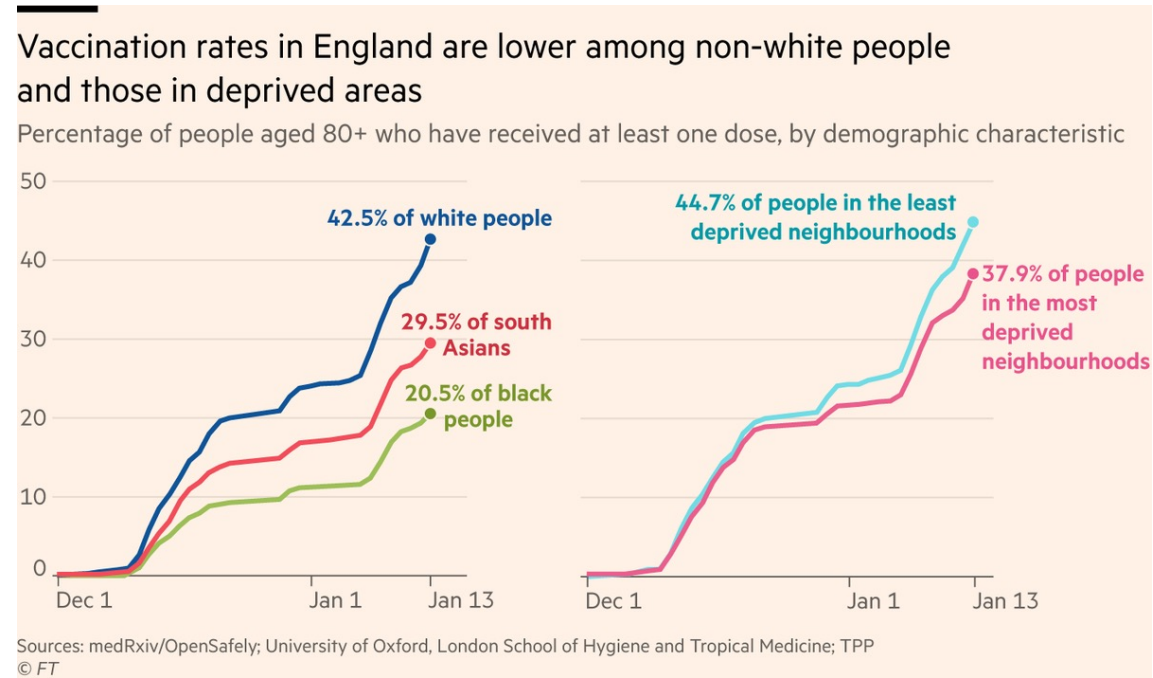
COVID-19: All in this together??

- Higher risk of getting COVID19 in most SE deprived group: 2.79 (2.00–3.90)¹ and higher risk mortality
- Greater challenges following public health guidance

“COVID-19 is experienced as a **syndemic**—a co-occurring, synergistic pandemic that interacts with and exacerbates their existing NCDs and social conditions”¹

¹<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7298201/>

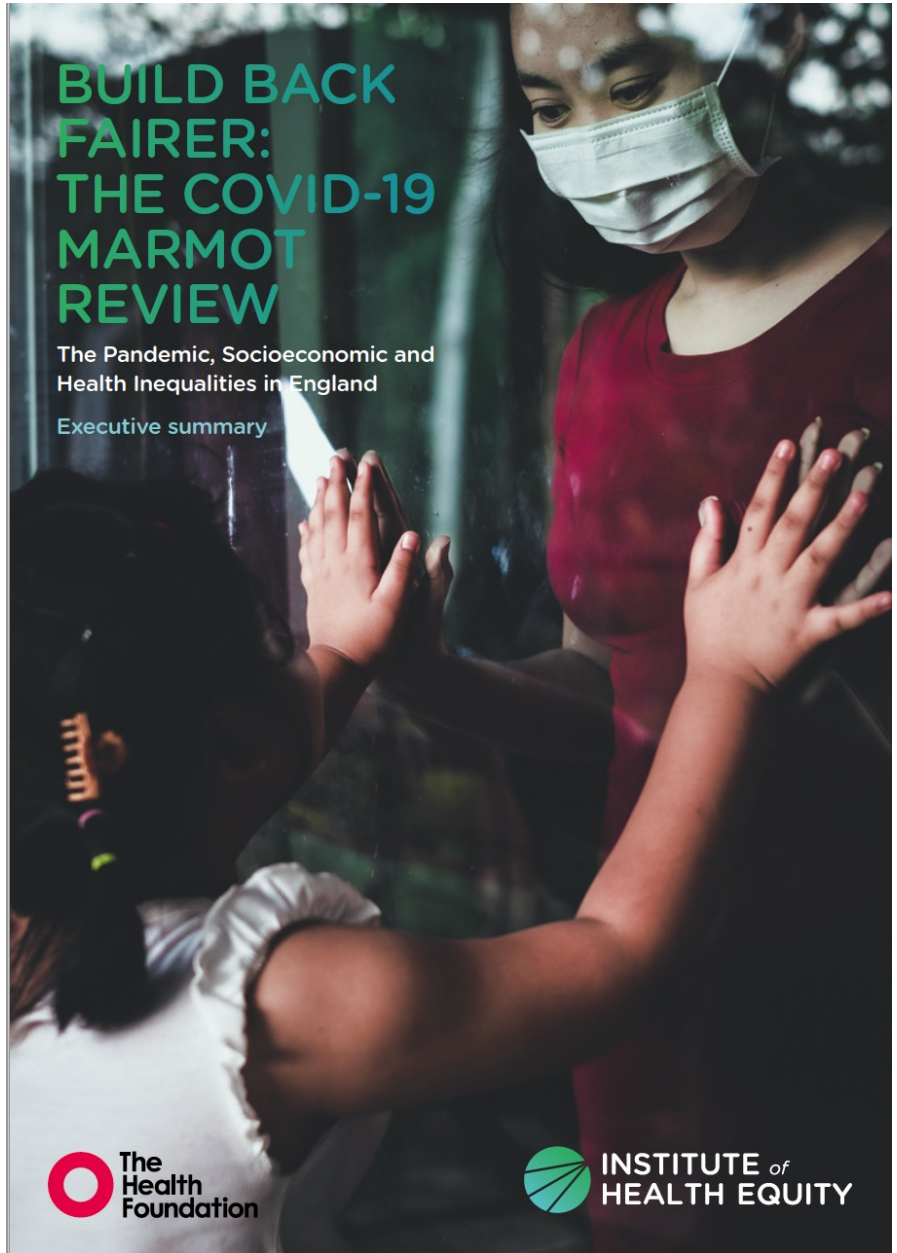
COVID-19 Vaccines



Global perspective:

<https://globalhealth.ie/doctors-for-vaccine-equity/>





BUILD BACK FAIRER: THE COVID-19 MARMOT REVIEW

The Pandemic, Socioeconomic and Health Inequalities in England

Executive summary



Deep End Successes

- Deprivation payment in revised GP contract: 2020
- Linkworkers for social prescribing
- Focussed care workers
- HSE GP Fellow 2021

Key lessons

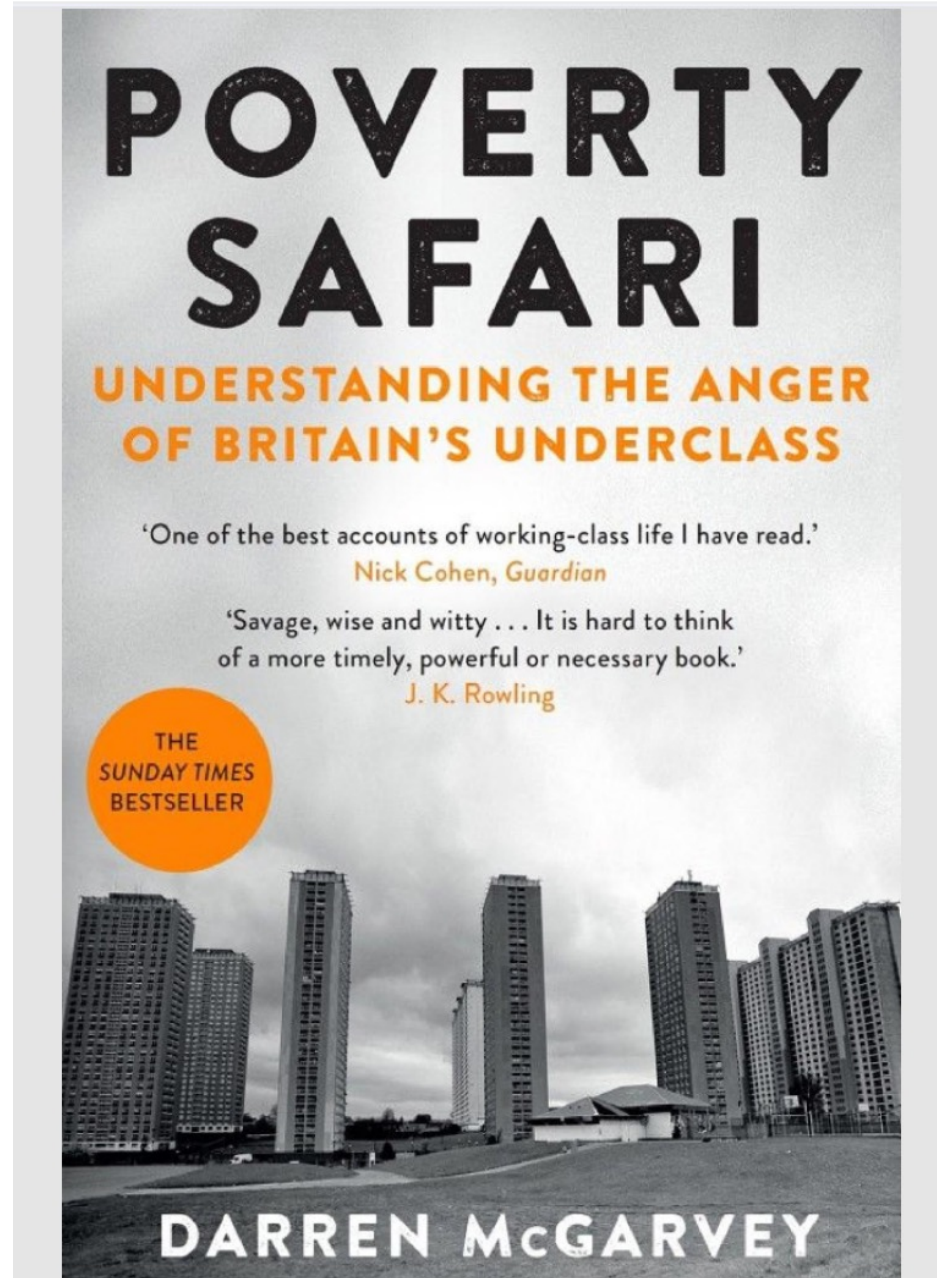
- Clinical and academic partnership is crucial
- Ongoing advocacy, branding, incrementalism



What can I do?

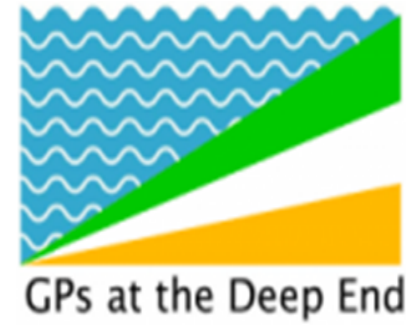
Clinical work

Advocacy

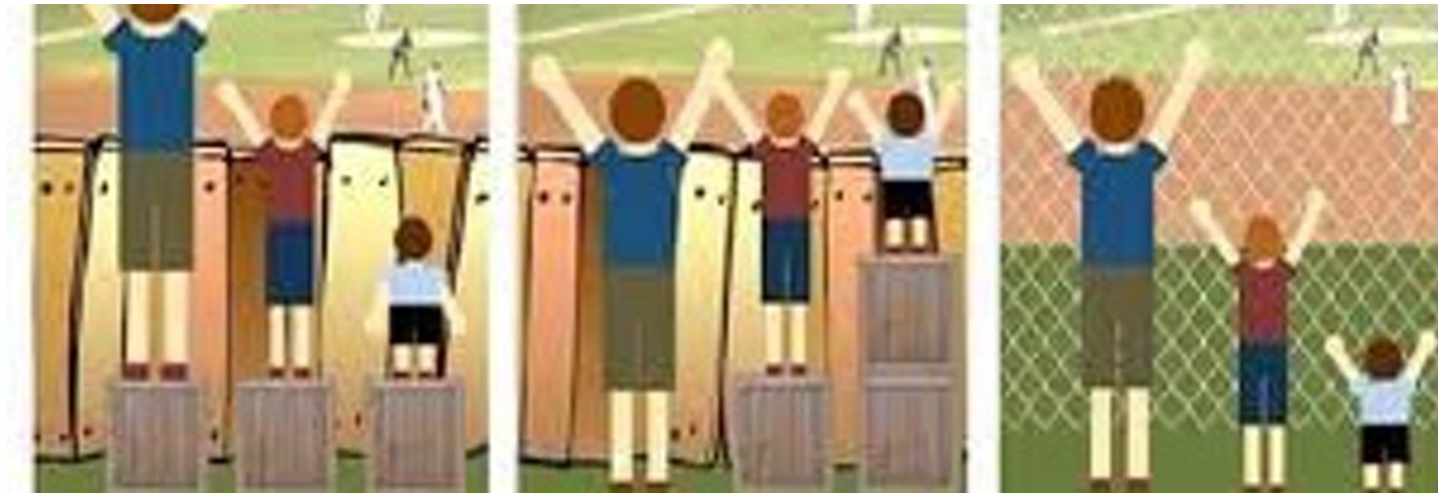


Conclusions

Impact of poverty on health, intergenerational effects



Resource allocation based on need and an inter-departmental approach to wider determinants of health



Questions?