SOUTH EAST WALES REGIONAL COMMITTEE

HEALTH INEQUALITIES: THE COMMUNITY HEALTH COUNCIL PERSPECTIVE

While we accept that there are a whole range of issues which contribute to Health Inequalities including:-

- incidence of illness and industrial legacy
- poor employment opportunities
- poor housing
- poor transport links
- poor school attainment levels
- unhealthy lifestyles
- distribution of Local Authority funding
- distribution of NHS funding

to name but a few, we would like to concentrate on one aspect which we consider to be at the centre of these issues.

We are referring to the numbers of single-handed doctor practices, particularly in those areas which are identified as areas of ill health and deprivation.

We have picked on this subject because the problems associated with single-handed GP practices are likely to become more acute in the next few years. The problems we are referring to are:-

- problems of replacing them when they retire
- lack of peer-group interaction when working alone
- problems when the GP is ill or on holiday
- difficulties for patients who do not hit it off with the doctor; they may need to change practices
- problems of clinical governance
- problems with overworked GPs
- problems with engaging single-handed GPs in the activities of Local Health Groups
- a general lack of female doctors in these areas

All of these issues will impact upon the quality of service experienced by patients and with the emphasis which the government is placing on developing the role of primary care, this will make progress much more difficult, ironically in areas where deprivation is already identified as

a clear problem.

In Gwent the deprived areas are largely focused on Blaenau Gwent and Caerphilly. The number of single-handed practices in Gwent is as follows:-

Blaenau Gwent	12
Caerphilly	13
Monmouthshire	3
Newport	5
Torfaen	2

This clearly demonstrates the problem.

Similarly, in Bro Taf the picture is as follows:

Merthyr Tydfil	6
Rhondda/Cynon Taff	8
Cardiff	3
Vale of Glamorgan	2

Some members may be aware of Dr Julian Tudor Hart's paper, Going for Gold, which strongly advocates the encouragement of salaried GPs, paid by the Health Authority, as a means of dealing with the time-bomb in primary care, particularly in the valleys areas. We support his concerns and we think his solution is worth supporting as well, but maybe as part of a package of measures.

As CHCs dealing with patients who are dissatisfied with the services they receive, we have more than our share of complaints about GPs in single-handed practices. Such complaints will almost inevitably lead to the patient either leaving the practice or being struck off and this has an impact on the continuity of care. Anecdotally we see many examples of patients who have poor health associated with no regular employment, no personal transport and generally poor circumstances. To the GP some of these people are difficult patients and it is also significant that more patients get struck off the GPs lists in Blaenau Gwent than in Monmouthshire for example.

We are also aware that GPs in deprived areas attract extra payments but very often do not provide the service for which this is meant to pay.

We believe that Local Health Groups are capable of being a major force for good in the reduction of inequalities and the improvement of health. They bring together a wide spectrum of partners to deal with these problems. In those areas where group practices exist the early signs are that the LHG gets off to a better start and its problems of working corporately and communicating well are very much less than in areas where single-handed practice is a major player. Thus, once again, the gap in health standards is likely to increase between the deprived areas and the more prosperous ones, despite the best intentions of the strategists.

We believe most strongly that this problem must be addressed, and if the Going for Gold blueprint is not favoured, then some other way must be found to bring the majority of single-handed practices together if health inequalities are to be addressed in the areas which need it most. We are aware that this problem is known to Health Authorities and Local Health Groups, but we are very concerned about it

That is our main submission to you, but individual CHCs also wish to flag up the following points:-

1. You will know that CHCs represent the public in NHS issues and we have a statutory role to do so. In the course of our work we pick up a mass of anecdotal evidence and this can often be used to act as a hypothesis which can then be tested by research. We are keen to collaborate with Health Authorities and Trusts in such work. In particular, we are very keen to work with the NHS on public involvement issues.

2. We support the position of the Health Authorities that priority should be given to the re-vamping of the Resource Allocation Formula as the current Formula does not recognise deprivation. We are also aware that Gwent is a net importer of patients who live in England but are served by Welsh GP practices.

3. The waiting times for cardiac surgery in South Wales are of considerable concern. The specialised Health Service Commission for Wales and Health Authorities are to be commended for the work they have undertaken to identify patients who can be "fast tracked" to England for surgery, but this does not resolve the problem of inadequate provision of cardiac services in Morriston and the University Hospital of Wales.

4. Public consultation involving the Local Health Groups in the Bridgend area has identified major concern that patients with drug and alcohol related problems are treated on an acute psychiatric assessment ward. Complaints have been received from relatives of both categories. Additional concerns have been expressed that unnecessary strains and stresses are placed on both categories of patient. Public opinion favours a dedicated Drug and Alcohol Treatment Unit as well as Iechyd

Morgannwg Health's proposal for a community based rehabilitation programme.

5. The lack of NHS dentists with open lists is a cause of public concern. The current system pressures the public into joining private dental schemes in order to receive dental treatment because there are virtually no NHS dentists left in some areas.

6. Research carried out by Iechyd Morgannwg Health Authority in the Bridgend area has highlighted that locally there is a higher mortality rate due to end stage renal failure than the Welsh average, and the number of GP referrals to the existing dialysis service does not reflect this. Consequently GPs are not diagnosing this problem and unless there is an increase in the service locally by the provision of local renal centres, the mortality trends will escalate.

7. Cardiff and District Community Trust manage two community mental health teams in the Vale of Glamorgan. These are based in the Sealock Centre in Butetown and the Amy Evans Centre in Barry. The former team provides services in Grangetown and Butetown and demand is such that little cover can be provided to the Penarth, Dinas Powys and Wenvoe areas. Not only would a CMHT based in Penarth address the present inequity in services, but it would allow the Team based in the Sealock Centre to concentrate on Grangetown and Butetown. The Trust has recognised deficiencies in the Vale and the need for improvements in order to bring it to even the Cardiff level which itself is considered inadequate.

There are little alternatives in the Vale to hospital care - very limited rehabilitation facilities to refer to and community residential facilities are scarce, particularly supported housing. This results in beds being taken up at Sully Hospital by people with accommodation requirements that cannot be met in the community. "Bed blocking" is not confined to acute hospitals.

One must hope that mental health services and community services, do not have a lower priority when the new all-specialty Trust comes into being on the 1 April 2000.