Health inequity – dealing with the silent killer

Patrick O'Donnell, Anne MacFarlane and Austin O'Carroll describe the work of the Partnership for Health Equity, which supports the provision of primary care for marginalised groups

MOST GPs HAVE ENCOUNTERED patients who are having difficulty paying the prescription charge and come seeking advice on 'the tablets I need the most'. We all deal with patients waiting months for secondary care appointments in public hospitals, when we know we could have them seen privately within the week. These reflect inequities in the healthcare system.

The WHO defines health inequities as 'avoidable inequalities in health between groups of people within and between countries'.[1] The stories of Simon and John *(see Cases 1 and 2)* are more extreme examples of health inequities in our country. In the UK the concept of health inequities pervades not just health policy but also local primary care initiatives. In Ireland, this is not the case. The term appears occasionally in health policy documents, but it does not yet have the same gravitas or ability to effect change as it does in the UK.

In 2012 Prof Anne MacFarlane of the University of Limerick Graduate Entry Medical School (UL GEMS) and Dr Austin O'Carroll of the North Dublin City GP (NDCGP) Training Scheme developed plans for a venture that would seek to create awareness of these health inequities, study them and ensure that future doctors would have an understanding of the inequities and their effects on the lives of their patients.

To achieve these goals it was decided to have both a research and educational focus for the initial work of the project and also to request funding and invite representation from the HSE to the group. The HSE Social Inclusion and Primary Care directorates, which plan and fund the relevant health services, then agreed to join the project. This led to the establishment of the Partnership for Health Equity (PHE). To date, the work has focused on a number of interrelated research, education and health service delivery projects. These include:

- Supporting the provision of primary care for marginalised groups
- Education initiatives for medical students at UL GEMS and GP registrars on the NDCGP Training Programme on providing healthcare to marginalised groups
- Researching access to primary care for marginalised groups
- Developing a web portal to provide resources for primary healthcare to marginalised groups.

Currently, there are five clinical and academic members of the PHE team, three based in Dublin: Dr Austin O'Carroll, Dr Fiona O'Reilly (assistant programme director NDCGP and research fellow UL GEMS), Suzanne Barror (research fellow NDCGP and UL GEMS) and two in Limerick: Prof Anne MacFarlane and Dr Patrick O'Donnell (clinical fellow in social inclusion, UL GEMS). They work in

Case 1: Simon, 30

Simon is 30 years old. He has been in Ireland for three years and he has been homeless for two of those years. He has no family or friends here. He is from Lithuania but does not qualify for any State supports. His English is very poor. He has no PPS number, no medical card and his passport has been stolen. He now has a fear of encountering 'official' services, as he worries he will be deported.

One night while sleeping rough he was arrested trying to find shelter in a city-centre car park. He was then imprisoned for two months. He said that was a blessing as he had a bed, warmth and medical care provided.

I met him three weeks after his release; he still had the same bandages on his legs that the prison nurse had applied the day before he was released. Simon had started injecting heroin one year before. He had exhausted all options for injecting in his arms and legs (which now had multiple chronic ulcers) and so he now resorts to injecting into his buttocks.

Is Simon a man that can be helped? What does he need? How does he fit in to the 'system' of healthcare and social services we have in our towns and cities?

partnership with Diane Nurse of the HSE Social Inclusion national office, Tony Quilty and Maurice Hoare of the HSE Social Inclusion Mid-West office and Alice McGinley of the HSE Primary Care Mid-West office. This article focuses on the development of a pilot low-threshold clinic in Limerick city, but first provides a summary of our other areas of work.

PHE work to date

Education

The educational work to date has involved the development of a curriculum on social medicine for the ICGP. This will aim to explain the differences and challenges in providing healthcare for marginalised groups. Further opportunities to work on curricula for migrant health and the care of patients with disabilities are being explored.

The NDCGP registrars have innovative special interest placements where they provide care in addiction treatment centres, homeless accommodation and other settings attended by marginalised groups. They work in these settings one day a week for four months. These posts are run in conjunction with Merchants Quay Ireland, DePaul, The Capuchins, Mountjoy and Dochas prisons, Crosscare and others in Dublin city.

Front-line service providers from addiction services and relevant NGOs also are involved in running discussions and debriefing sessions for the GP registrars. In this way, their clinical training is embedded in clinical settings serving people living in complex and socially disadvantaged situations.

Research

A research study examining the health and health care access of the homeless populations in Dublin and Limerick was conducted in 2014. NDCGP registrars were involved, giving them valuable experience of quantitative survey research. The results were presented at the International Street Medicine Symposium held in Dublin in October 2014. The study was covered widely in the Irish media and a report on its findings will formally be launched in early 2015.

We are also undertaking a Participatory Health Research project about access to primary care for marginalised groups in Limerick city. This research has provided opportunities for GP registrars from the Mid-West GP scheme to gain experience of large scale qualitative action research. The study sample includes include homeless people, migrants and refugees, Travellers and sex-workers. The purpose of this project is to provide these service users and patients an opportunity to identify their priorities for improving access to healthcare and develop communication channels with relevant HSE personnel to develop workable responses to the identified priorities.

Knowledge transfer

We are developing a web portal for service providers working in primary care with marginalised groups in Ireland (**www.healthequity.ie**). This will act as a repository of information on initiatives taking place throughout the country, events planned and relevant contact information.

Clinical work

The clinical fellow at UL GEMS works two sessions a week at the practice of Drs English and Lane in Limerick city. This practice cares for many patients from disadvantaged groups.

This clinical work is complemented by the development of the PHE clinic to which we now turn.

Case 2: John, 58

John is 58 years old and from Clare. He describes himself as a problem drinker and a benzodiazepine addict. In March 2014 he was admitted to hospital following a stroke. While an inpatient, his medical card expired and he lost his rented accommodation. He was now homeless for the first time in his life.

He was discharged with a prescription for many cardiovascular and respiratory medications that he could not afford. He missed his medical outpatient clinic and community rehabilitation (physiotherapy, OT, psychology, SLT, social work) appointments as the letters must have gone to his old address. He was discharged from both services.

His drinking had worsened and he was becoming depressed about his physical deficits following the stroke. What are his options now that he has no address and no medical card? What are the priorities for action in his case?

The PHE pilot clinic

To inform the establishment of the planned clinic, a formal stakeholder analysis was conducted in Limerick city. The purpose of this exercise was to consult with all key stakeholders about gaps in existing services provided to marginalised groups. This consultation process took place from October to December 2013. This involved speaking to many people from marginalised groups, their families and the voluntary and statutory agencies in the city.

We found that many vulnerable people in Limerick city have poor access to basic medical care; some do not have medical cards and others who do have medical cards face many barriers to utilising their cards in existing services. The clinic operates with a low-threshold approach to care, meaning that as few people as possible are denied access to the clinic; no matter how chaotic their situation is.

Information from the stakeholder analysis helped to inform the decision on where to locate the pilot clinic. Two locations were chosen with the intention of reaching a wide range of marginalised groups in the city. The first was with the Ana Liffey Drug Project Mid-West Service (on the outskirts of the city) and the second was at the St Vincent dePaul Drop-in Centre (centrally located). The GP spends one afternoon a week at each site.

Both of these organisations have a history of advocacy and case working for vulnerable clients nationally, and in the Limerick area. The drop-in centre provides hot meals, washing facilities and advice on social and housing issues to many clients on a daily basis. The Ana Liffey Drug Project works closely with drug users in the city using the principles of harm reduction to assist them to access drug treatment services and stabilise their lives. The work of the clinic complements each of these services and seeks to address some of the wider social determinants of health for these marginalised patients.

The pilot clinic also relies on close working relationships with a number of key local statutory agencies and NGOs also concerned with health and wellbeing of marginalised groups in the city. Collaboration with a variety of agencies

Pictured at the launch of the partnership for Health Equity Pilot Clinic in April 2014 were (l-r): Dr Patrick O'Donnell, UL GEMS; Diane Nurse, HSE Social Inclusion; Prof Anne MacFarlane, UL GEMS; councillor Kathleen Leddin, Mayor of Limerick; and Tony Quilty, HSE Social Inclusion

and disciplines is necessary to try and address the complex social and healthcare needs of the clients using the clinic. These services include the local Homeless Action Team, the HSE Drug and Alcohol Service, McGarry House homeless hostel, the Ana Liffey Drug Project, the St Vincent dePaul drop-in centre, GOSHH (HIV/AIDS support service), Doras Luimni (migrant and refugee support) and Saoirse addiction treatment centre, among others.

Importantly, the pilot clinic was developed with the support of the Safetynet Primary Care Network for Homeless Health Services (**www.primarycaresafetynet.ie**). This charity provides a networking organisation for doctors, nurses and voluntary agencies that deliver primary health care to homeless people and other marginalised groups. Safetynet has an online patient record system that means patient records for previous visits to affiliated services in Dublin or Cork are available at the time of consultation.

Spreading the word

In the first nine months of operation the pilot clinics have been attended by over 160 patients for over 300 consultations. The most common issues presenting are linked to intravenous drug use, benzodiazepine addiction and mental health problems. Blood-borne virus testing, STI testing, hepatitis A, B and influenza vaccination are all available.

Many local services are now referring patients to the clinic and, most importantly, many patients are attending having heard of the work from other patients. There is also flexibility around the clinic work in that it allows the GP to make calls to homeless hostels in the city if needed. Every effort is made to encourage the patients seen to apply for a medical card with a GP in the city, and this highlights the role of the pilot clinic in supporting mainstream primary care. The figure below highlights many of the values that we try to reflect in the work of the clinic.

Principles of service provision

What of the two cases presented overleaf? Both seemed relatively hopeless. Is there anything that can be done? The answer is yes, simple actions have made a difference in both cases. Neither is 'cured', but they both have a better quality of life according to themselves.

Simon has been linked in with the HSE Homeless Action Team and he now is in hostel accommodation as part of the Winter Initiative. He is engaging with the Ana Liffey team around harm-reduction in his heroin-injecting practices. He has been vaccinated against influenza, hepatitis A and B. He has been tested for HIV and hepatitis. With careful dressing and treatment of infection, his leg ulcers have cleared up. He is on a waiting list for methadone and wants to eventually come off all opiates. His outlook is much improved and he can now start to plan the next steps in his recovery.

John is living in a homeless hostel in the city. His appointments were rearranged, but he has decided he does not want any more rehabilitation work for the time being. He successfully applied for a medical card and has attended the new GP for prescription of his medications. He is seeking to start addressing his alcohol problems and has regained some of his self-confidence.

For both cases, there is a long way to go, but progress has been made. Our vision for the PHE is that by researching and raising awareness of these issues, by educating the healthcare professionals of the future and by influencing relevant health policies, we can ensure the balance in healthcare that Tudor-Hart spoke of is tipped in favour of those least able to move it.

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