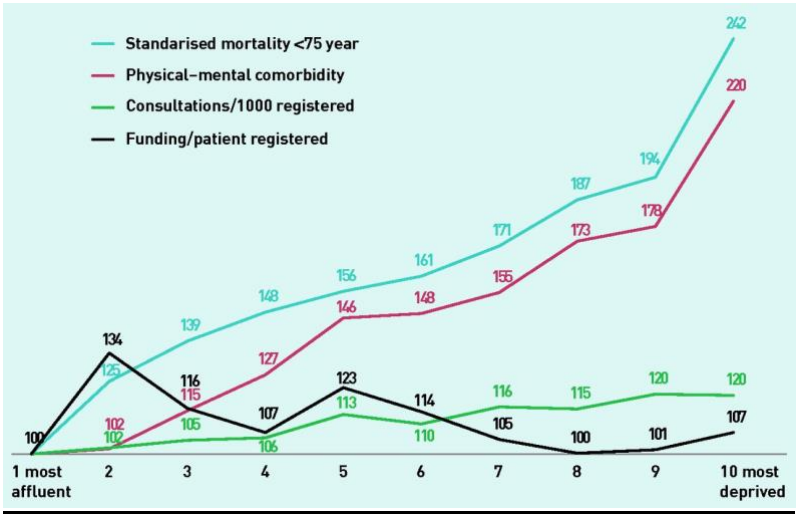
**Briefing Document: Deep End Ireland: Meeting with An Taoiseach, Dr Leo Varadkar**
Thursday 8th June 2023
Dr Edel McGinnity, Dublin 15
Prof Susan Smith, Dublin 8,
Dr Niamh Irving, Dublin 8.

Deep End Ireland is a group of GPs working in disadvantaged areas in Ireland – see www.deepend.ie.

**Health Inequalities**
People living in the most deprived areas have Lower life expectancy and higher mortality at all ages. They present later with cancer and are twice as likely to die from it. They have higher rates of chronic conditions with multimorbidity occurring 10-15 years earlier in the most disadvantaged groups compared to the most affluent and are twice as likely to have a combination of physical and mental health problems, with rates of 113/1000 patients compared to 52/1000 for practices working in the most affluent areas. Children in the most deprived areas have up to 4 times the rate of serious mental illness than the most affluent.
GPs working in the most disadvantaged areas tend to have approximately 40% more patients with multimorbidity and there is on average 2.5 days less GP time per month in practices in most deprived areas. The following Figure illustrates the challenges facing GPs working in the most deprived areas in Scotland with relatively flat funding allocation across practices but 20% higher consultation rates, despite the significantly higher health needs.

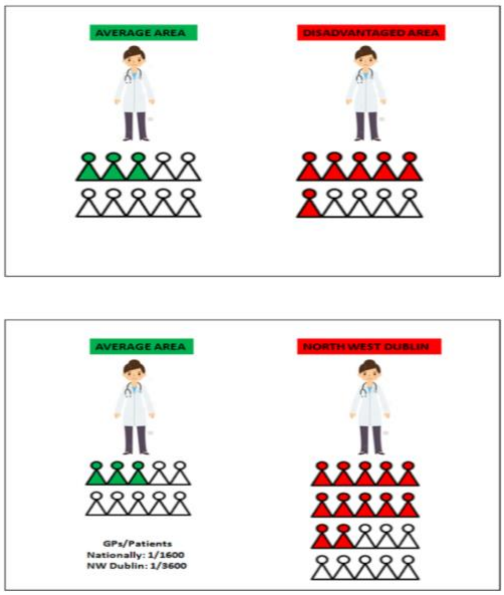



https://bjgp.org/content/65/641/e799

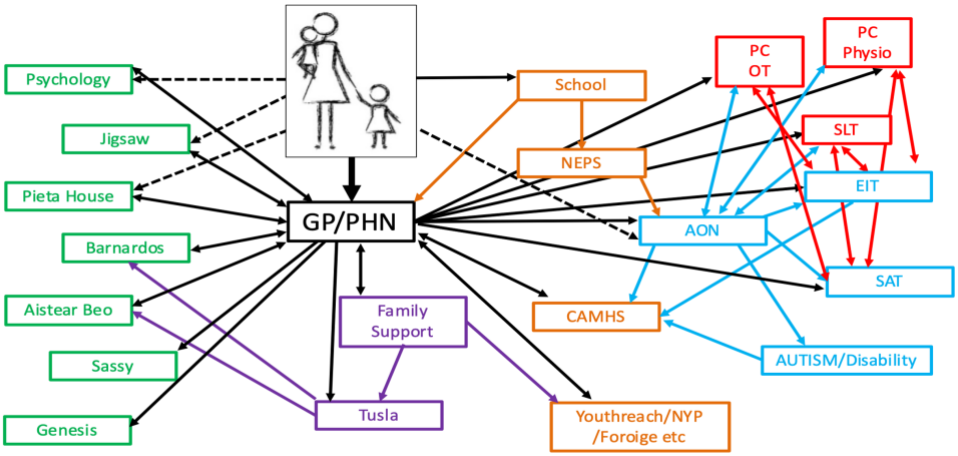
**Life-long Impact of Childhood Adversity on Health**
There is, as you and your colleagues are aware, an abundance of international literature highlighting both the long-term negative effects of adverse childhood experiences on physical and mental health. The most common causes of death and multimorbidity (cancer, diabetes, heart disease) have their genesis in metabolic changes which start in childhood. There is also

the value in intervening early to mitigate these effects in early childhood. A recent UK study estimates an annual cost to society of £16b relating to problems that could have been prevented with early childhood intervention. (https://centreforearlychildhood.org/research/) Much of the higher morbidity and death rates in areas of disadvantage have their genesis in poverty in childhood which is why it is so critical to address this issue.
While the root causes of health inequalities largely lie outside of health services, modern health care does have enormous potential to prevent the onset of illness and to delay its progression. Access to health care is itself a social determinant of health. As a result, inequitable access to effective health care is an inadvertent yet powerful driver of health inequalities.

**The Inverse Care law**




The Inverse Care Law is having a particular impact on access to other vital clinical and social care support services including Child and Adolescent Mental Health Services, Child Psychology, Speech and Language Therapy and Child Protection social workers. The lack of resourcing according to need means that the relative underfunding of services in disadvantaged areas leads to much longer waiting times for the children who need the services most, with wait times up six years for Disability services in some areas. This is greatly aggravated by multiple overlapping services, who deal with lack of capacity often by dysfunctional responses to demand, such as closing waiting lists and declaring referrals unsuitable. This diagram below illustrates how things are in Dublin 15.




**Case History (anonymised)**

Sarah (35) has 2 boys, Alex (3) and Daniel (8). Sarah had a lot of trauma in her life and suffers from anxiety, she finds it difficult to cope especially as both boys have problems. Daniel has ADHD. It took a long time (and many letters) to get CAMHS to accept his referral, and he was started on medication when he was seen. He wouldn't take the medication initially. His behaviour was very difficult to manage.

Alex, age 3, likely has autism and possibly ADHD as well resulting in the creche reducing his hours and threatening to exclude him. He was referred for Assessment of Need (AON) in 2021 but the referral was lost. After multiple phone calls and letters he has been reinstated on the AON list and is still waiting. He is also on the Community Disability Network Team (CDNT) waiting list. CAMHS declined to see him as he is waiting for Assessment of Need. His behaviour can be very scary at times and poses a risk to his brother.

Sarah gets understandably overwhelmed and presents often in crisis feeling she can't cope. The GP supports her as much as possible with her mental health. The referrals to services took much longer than they should because she couldn't manage the forms, and eventually the GP filled them all in with her while she attended when one of the boys was sick. Six months ago the family's medical card lapsed and the GP staff spent many weeks getting them reinstated. Sarah's phone doesn't work regularly and she misses a lot of calls. CAMHS sent a letter of discharge about Daniel last July but the GP challenged this and secured another appointment. The GP made multiple calls and reminders to make sure he attended. Since starting again on meds for ADHD he has improved. Meanwhile, Alex is causing havoc regularly. Sarah was offered a Family Support Worker but is very fearful of Tusla and declined their involvement (Family Support is a Tusla agency). She was also offered a parenting course for ADHD but only attended one session, she felt she had nothing in common with the other parents.

The GP is critical for the continued involvement of these children in the services they have been able to get, and in supporting their mother to manage as best she can. It has been exceptionally time consuming to make sure Daniel stayed in CAMHS and Alex gets his AON assessment. The GP has also been liaising with CDNT to try and get him seen sooner.

These patients are often called **'hard to reach'** – for example the uptake of cervical screening is lower in these areas - but actually they have frequent contact with the practice so we are ideal to catch them. Acute health and social problems act as serious barriers to chronic disease management, cancer screening and prevention. The GP is a really central resource for vulnerable families because our service is low threshold and much easier to access than any other. GPs are by far the best professionals to coordinate other services because they will have holistic knowledge of the whole family, and also many more opportunities to catch children when they present for other reasons like acute illness. They can help to rearrange appointments and also pick up problems early at these visits.

We welcome the Taoiseach's commitment to addressing Child Poverty. As the health professionals with most contact with families in crisis, it is fundamental that the voice of General Practice is heard in any forum wishing to improve the response to vulnerable children.

The illustration of services above represents a top down approach and demonstrates very well the absence of front line service providers in designing services.

**Addressing Health Inequalities**

There is an overarching need to target resources where needs are highest. Within this context we want to highlight key areas for action:

- Inclusion of Deep End GPs in Child Poverty Unit working groups
- Strong primary care infrastructure in deprived areas that can act as local hubs and facilitate linkage with community services and forums, with staffing levels in primary care teams based on patient and community needs.
- GP supports including more consultation time to address complex health needs. Deep End Ireland GPs have welcomed the new Social Deprivation Practice grant but it is very widely dispersed and provides very modest additional resource to practices (max €16,000 annually). More effective resourcing could be facilitated through deprivation weighted capitation payments for patients living in the most disadvantaged communities and other options such as salaried GPs (working within GMS practices) and additional practice nurses, administrative staff and other multidisciplinary primary care team members such as link workers and financial advisors. There is evidence from the Care Plus study in Scotland that longer consultations for patients with complex problems in deprived areas are associated with better outcomes after 12 months and that it is cost effective (£12,224 per QALY).
- Another innovation we propose is the use of Focused Care Workers to support families that are in particular stress with very high health and social care needs. We have connections through Deep End with Dr John Patterson who leads this work in Manchester (https://focusedcare.org.uk/ )
- We would like to emphasise our commitment to the focus of Sláintecare Healthy Communities. We note that some of the populations covered are very large – up to 40,000 people. There may be a need to target specific vulnerable groups within these areas to achieve maximum benefit.
- Deep End Ireland has no external sources of support and relies on volunteering and academic input. In Scotland, there has been government funding to support its activity and maximise its impact. Similar support in Ireland would significantly improve our ability to support policy and practice in addressing Health Inequalities to realise the full potential of general practice in disadvantaged areas, as well as advise on how to maximise the impact of all the other services so critical to the most vulnerable. We would welcome the opportunity to submit a Business Case for funding.