Tissue viability and the inverse care law

Richard White

Regular readers may be anticipating some more thoughts on evidence in wound care and tissue viability, or on the case for silver dressings. However, more urgent matters demand consideration. First, the plight of our elderly population in care: much has already been written on this topic in other journals and in the national press. Very little of this has touched upon matters of tissue viability. I am concerned by the prospect of the plans to increase the role and responsibility of the general practitioner (GP) in the NHS. With specific focus on our collective interests, the 'failings' of the current system do not inspire any confidence that much more of the same will bring improvements. The 'failings' to which I refer are the standard of care of patients of all ages with tissue viability issues, and of the elderly with chronic conditions commonly associated with wounds. Precisely, sufferers with multiple sclerosis and similar at risk of, or suffering from pressure ulceration, those with diabetes with foot ulceration, elderly patients with leg ulcers, especially with co-existing lymphovenous oedema. There are more, but my attention is directed at these groups with particular emphasis on those in care, or being cared for, in their own homes in England.

The more I investigate and enquire, the more I see that GPs in general are largely ignorant of, and indifferent to, such patient groups. Ignorant, because of the woefully inadequate training in such pathologies. Indifferent, because of the time-consuming nature of the provision of adequate care. This latter point is compounded by the Quality and Outcomes Framework (QOF) system. This relies upon a points system depending on level of achievement for each of 146 clinical indicators. The criteria are grouped into domains of clinical, organisational, patient experience and additional services. The criteria are designed around best practice and have a number of points allocated for achievement. The formula includes the number of patients and, in particular, the numbers diagnosed with certain common chronic illnesses. QOF was designed to stop the 'haemorrhage' of GPs out of the NHS (Bradshaw, 2008). Tim Burr (2008) of the National Audit Office has said: 'There is no doubt that a new contract was needed and there are now 4,000 more GPs than five years ago'. However, having more GPs, more evenly spread throughout the country, does not necessarily make for better primary care.

The level of achievement recorded depends on the GP treating the patients with the relevant problem. In order for GPs not to lose points on account of circumstances that are 'outside their control', they can exclude those patients from counting towards their achievement by 'exception reporting' them. This is allowed for:

- Patients who refuse to attend
- Patients for whom chronic disease reporting is inappropriate (e.g. terminal illness, extreme frailty)
- Newly-diagnosed or recently registered patients
- Patients who do not show improvement;
- Patients for whom prescribing a medication is not clinically appropriate
- Patients not tolerating medication
- Patients refusing investigation or treatment (informed dissent)
- Patients with supervening conditions
- Cases where diagnostic/secondary care service is unavailable.

Those familiar with community tissue viability and 'chronic' wound care will immediately see that these criteria can (and do) include many such patients. Community tissue viability patients are often denied best clinical services but are rarely a subject of patient experience (PROMS) evidence. They are, in effect, disenfranchised in terms of primary care. Herein lies my main point, our patients in care (whether house-bound or in care homes) can readily be manipulated in residential care into meeting the criteria of exception reporting, thus abrogating the GP of the responsibility to deliver adequate care, an easy way out of a costly problem.

According to Hart (1971), the availability of good medical care tends to vary inversely with the need for it in the population served. This inverse care law operates more completely where medical care is most exposed to market forces. While this was first stated 40 years ago, it still applies in a fashion today and, I believe, nowhere more evidently than in the patient population that I have outlined above.

The responsibility for tissue viability services in primary care must be clearly established as a matter of urgency. GPs should be quite certain of their role in this respect. WUK

Richard White is Professor of Tissue Viability, Institute of Health and Society, University of Worcester

References

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