Irish College of General Practitioners

Irish General Practice: Working with Deprivation

AUTHOR

Dr Brian Osborne, ICGP Assistant Medical Director

The Irish College of General Practitioners

Acknowledgments

Dr Edel McGinnity, Dr Austin O'Carroll, Dr Hugh O'Faoláin, Dr Margaret O'Riordan and Professor Susan Smith are thanked for their contribution to this report. Ms Patricia Patton, ICGP Librarian, supported the literature review.

The ICGP Board and Professor Fergus O'Kelly, ICGP President, were very supportive of this initiative.

About the Irish College of General Practitioners

The Irish College General Practitioners (ICGP) is the professional body for education, training, research and standards in general practice.

College Activities

- Teaching, training and education at undergraduate and postgraduate levels
- Accreditation of specialist training programmes in general practice
- Operates a professional competence scheme under arrangement with the Medical Council
- Examining body for membership in general practice (MICGP)
- Continuing education and professional development
- Research
- Practice management support through training, advice and consultancy
- General practitioner health
- Public relations and media liaison on behalf of the profession
- General practice publications, guidelines and protocols
- Advice and support to members
- Advocacy on behalf of the profession with external agencies

Contact Us

Irish College of General Practitioners
4–5 Lincoln Place, Dublin 2
Tel: 01 676 3705, Fax: 01 676 5850
Email: info@icgp.ie
Web: www.icgp.ie

TABLE OF CONTENTS

Introduction

"In areas with most sickness and death, general practitioners have more work, larger lists, less hospital support and inherit more clinically ineffective traditions of consultation, than in the healthiest areas and hospital doctors shoulder heavier case loads with less staff and equipment, more obsolete buildings and suffer a current crisis in the availability of beds and replacement staff. These trends can be summed up in the inverse care law, that availability of good medical care tends to vary inversely with the need for the population served."[1]

" Rise up with me against the organisation of misery."[2]

The ICGP is committed to maintaining the highest standards of general practice for patients across all sectors of society. Health declines uniformly as income, class and education decrease.[3] Health inequalities, variances in morbidity, mortality and access to healthcare need to be at the forefront of the healthcare agenda.

This report is aimed at highlighting the spectrum of deprivation seen by all general practitioners on a daily basis in both rural and urban settings and to try and provide recommendations on reducing the effects of health inequalities and improving the overall service.

There has been chronic under funding of general practice in Ireland with many GPs struggling to meet the ever changing demands. Lack of investment in primary care has been shown to have a negative impact on population health.[4] This underinvestment has also led to posts being less attractive to newly qualified GPs with over 13% of GP trainees definitely planning on emigrating.[5]

General practice , with its unrivalled access to the heart of communities, has a central role in addressing both the causes and consequences of health inequalities. A fundamental solution to health inequalities is a strong well resourced general practice (and wider primary care) at the heart of the community.[6]

General practice and demand

Somewhere between 22% and 30% of practices in Ireland work with areas of deprivaton.[4] An Irish study showed that almost all services, apart from dental and optician services, were used more by those at the lower end of the income distribution but that this group also had the greatest need.[7] GP visiting patterns show that patients with medical cards visit 2.5 times more per annum than those without medical cards.[8] Health status is a very important driver of GP visits. Those with very good health had 1.7 visits on average in the last 12 months. This rose to over 15 for those with very poor health.[3]

Studies have shown that areas with greater levels of material deprivation possessed lower levels of primary care provision in both GP numbers and services, and they found that in primary care, GPs and pharmacists have a tendency to gravitate to areas of greater affluence.[9]

A study of consultation rates in the UK found that they were 42% higher in social classes 4 and 5 than in 1 and 2.[10]

Increasing socioeconomic deprivation is associated with a higher prevalence of psychological distress but shorter consultations.[11]

A higher propensity of GP burnout was found among GPs with a high share of deprived patients on their lists compared with GPs with a low share of deprived patients.[12]

Very often deprivation in rural areas is less visible to the general public but highly apparent to GPs. The specifics are often different from those seen in urban areas but equally as detrimental and under resourced. Geographic, financial and social isolation and the closure of once vital rural life including post offices, Garda stations, pubs, schools and GP surgeries has led to ever increasing difficulties in rural Ireland.

In the current system, it is difficult to recruit GPs to work in areas of deprivation. There is no incentivisation financially, professionally or personally for GPs to work in these areas.

Health inequalities

Ireland demonstrates one of the highest income inequalities amongst social democratic countries. Only Australia, the United Kingdom and most markedly the United States are worse.[13]

It has been estimated that 5,400 fewer people would die prematurely each year across the island of Ireland by tackling social deprivation and inequalities.[14]

CSO figures from 2010 show that in the poorest neighbourhoods, on average, males die 4.3 years earlier and females 2.7 years earlier than their counterparts living in the richest neighbourhoods.[15]

In Ireland, the cancer death rate in lower socioeconomic groups is more than double the rate compared with higher socioeconomic groups.[16]

For circulatory diseases, mortality is 120% higher in the lowest occupational class, respiratory disease 200% higher and injuries and poisoning over 150% higher.[17]

The All Ireland Traveller Health Study[18] showed that the life expectancy at birth for traveller males is 15.1 years lower than the general male population. Traveller infant mortality is 3.6 times higher than the general population.

Homeless people experience high rates of ill health and 40% of hostel dwellers have serious psychiatric illness.[19]

Homeless people have worse mortality and experience excessive rates of ill health. One in three have hepatitis C, one in 20 have HIV, one half have depression and one in three have attempted suicide.[20, 21]

From 2004–2011, there were 4,606 drug-related deaths in Ireland (2,745 due to poisoning).[22] There is increased mortality due to infection with HIV and the subsequent development of an AIDS-related illness, and the harmful effects (both short and long term) on the health of the drug user, such as the cardio-toxic effect of cocaine or drug related liver disease. Actions taken while under the influence of drugs, such as accidents caused by impaired judgement and psychiatric illness as a co-morbid condition, which places the individual at a greater risk of suicide, also increase morbidity and mortality.

People from lower socioeconomic groups are more likely to drink excess alcohol, smoke cigarettes, exercise less, and eat less fruit and vegetables than richer people. These lifestyle choices are limited by their economic and social circumstances.[19]

A wide range of factors – such as poverty, inequality, social exclusion, employment, income, education, housing conditions, transport access to healthcare, lifestyle and stress – impact significantly on an individual's health and wellbeing.[23]

In the UK, studies have shown the poorer the person is, the more likely they are to have a mental health problem. There is a strong correlation between lower social class and the diagnosis of schizophrenia.[24]

Significantly higher child mortality has been found for children with fathers in manual occupations than those in non-manual occupations.[25]

In 2010, the Marmot review[2] concluded that in England, people living in the poorest neighbourhoods will, on average, die seven years earlier than people living in the richest neighbourhoods and that the average difference in a disability free life is 17 years. Therefore, people from less deprived areas will live longer with fewer years of disability.

Health inequalities and deprivation in general need to be addressed on a governmental and societal basis but a properly resourced general practice service is essential to reduce health inequalities.

General Practitioners at the Deep End

In Scotland, general practitioners working in the 100 general practices serving the most socio-economically deprived population have formed a group called General Practitioners at the Deep End. These GPs were identified as providing care in areas of blanket deprivation, i.e. the majority of their patients are from the most deprived areas in Scotland. This was based on the proportion of patients on the practice list with postcodes in the most deprived 15% of Scottish datazones. Between 44% and 88% of Deep End practice patients are from the most deprived 15% of datazones.

"Compared with patients in least deprived areas, patients in the most deprived areas have a greater number of psychological problems, more long-term illness, more multimorbidity, and more chronic health problems. Access to care generally takes longer, and satisfaction with access is significantly lower in the most deprived areas. Patients in the most deprived areas have more problems to discuss (especially psychosocial), yet clinical encounter length is generally shorter. GP stress is higher and patient enablement is lower in encounters dealing with psychosocial problems in the most deprived areas. Variation in patient enablement between GPs is related to both GP empathy and severity of deprivation."[26]

In 2015, a focus group meeting of GPs at the Deep End[27] identified the CPD needs of GPs working in areas of high deprivation. These included addressing low engagement and health literacy, maintaining therapeutic optimism, the effective use of evidence-based medicine in the context of high levels of multi-morbidity and social complexity, and meeting the needs of migrants.

The Deep End project has only begun in Ireland. A process is taking place to map out 100 practices serving the most deprived socio-economic populations. It is important to note that while all GPs deal with some level of deprivation, referred to as "pocket deprivation", GPs at the Deep End deal with blanket deprivation as the majority of their patients have great health and social care needs. This can lead lead to greater levels of stress, burnout and low morale. These GPs have different needs – including

financial, personal , professional and educational – than GPs working in less deprived areas and specific measures will need to be introduced to support them.

Access to healthcare

The ICGP is committed to universality, access to good quality care and equity. No person should be barred from access to healthcare and there should be equal access on the basis of need.

More deprived areas generally have fewer GPs which can make it more difficult for patients to access services. Nationally, there is one GP per 1,600 of population. In North Dublin, there is one GP per 2,500 population. In addition, there have been increased A/E charges, long stay charges and prescription charges, meaning that in 2013, every person in Ireland was on average paying about €100 in additional costs for accessing care and prescribed drugs.[28] The Spirit Level shows that countries with the biggest income inequality do worse according to almost every quality of life indicator. The more unequal a society, the unhealthier it is.[29]

Patients with learning disabilities and mental health problems, and patients from minority groups can find it difficult to access healthcare.[30]

The American Medical Association found that a lower socio-economic position was associated with having fewer cervical smear tests, mammograms, childhood and influenza vaccinations, and diabetic eye exams.[31]

UK studies have shown large local variations in mortality from coronary heart disease. Socio-economic deprivation is associated with a significantly reduced likelihood of angiography and coronary artery by-pass grafting.[32]

Furthermore, GPs in Ireland are constrained from providing the service they are trained to deliver due to lack of access to diagnostics in the public hospital system. In the public hospital system, 20% of GPs have no access to ultrasound. Where access is available, public patients have an average 14 week waiting period but this varies from one day to 42 weeks depending on geographical location. A total of 80% of GPs have no access to CT and 90% have no access to MRI. Where CT is available, there are significant waiting times varying from less than one week to 48 weeks. This contrasts with the private system where there is near universal access within a short time frame. In the public hospital system, there is direct access to colonoscopy for 57% of patients. This contrasts with 85% direct access in the private system. Where available, there is on average a 12 week wait compared with 12 days in the private system.[33] Delayed access to diagnostics leads to delayed diagnoses and worse outcomes.

Marginalised groups have particularly poor access to primary care. Homeless people have been shown to have poor access to medical cards, and even when they do have medical cards they often cannot avail due to barriers such as distance, difficulty making appointments, etc.[21]

Several studies have found that mainstream services do not provide adequate care for homeless people and are poorly designed for their needs.[34–37]

Travellers also have been shown to have poor access to primary health care practitioners.[18] Undocumented migrants are known not to have entitlement to primary healthcare.

Potential solutions

Health inequalities, deprivation, inequitable access and underinvestment in general practice and primary care are international problems. There is no one easy solution and general practice is only part of the solution.

The recruitment and retention of general practitioners to work in underserved areas need to be addressed. Health professionals respond to incentives; but financial incentives alone are not enough to improve recruitment and retention. Single interventions have limited effect over time. Policy responses need to be multifaceted.[38] Higher wages seem to have a positive influence on job satisfaction initially, however, there is evidence that the effectiveness of financial incentives on retention declines after 5 years, compared to other factors such as a positive work environment.[39, 40] A recent OECD paper recommends that policy makers consider complementary strategies to attract and retain doctors in underserved areas: "adapted selection and education of students; incentive systems and regulatory measures to influence physicians' location choices and service redesign or configuration solutions."[41]

In the UK, the Marmot Review in 2010[2] concluded that reducing health inequalities would require action on six policy objectives:

1. Give every child the best start in life.
2. Enable all children, young people and adults to maximise their capabilities and have control over their lives.
3. Create fair employment and good work for all.
4. Ensure a healthy standard of living for all.
5. Create and develop healthy and sustainable places and communities.
6. Strengthen the role and impact of ill health provision.

In 2015, the RCGP[6] stated that without measures to end the current resource and workforce pressures facing GP services across the UK, health inequalities will continue to worsen. The RCGP believes that action is needed in the following six areas:

7. Place incentives to attract more GPs to currently underdoctored areas.
8. Direct more funding into GP and wider primary care services in those areas where health inequalities are currently worst.
9. Ensure that new models of care tackle rather than exacerbate problems.
10. Create a supportive environment for GPs and their teams to take a more proactive approach to preventing ill health.
11. Incentivise ways of working that promote the continuity of care in areas where patients would benefit most.
12. Fund outreach programmes to often excluded groups such as those with mental health problems and learning disabilities, and the homeless to access general practice.

In the UK, the Future of Primary Care Report[42] advised that specialised services should be developed where there were large homeless populations.

Recommendations in the 2005 report Health Inequalities and Irish General Practice in Areas of Deprivation[4] include:

For the health service and others:

- A deprivation weighting in future capitation payments to be linked to the development of specific quality initiatives.
- Monitor primary and secondary care access for equity on the basis of social class and ethnicity.
- Action on social and economic issues facing patients suffering health inequalities.
- Improve primary/secondary care communication and introduce a single hospital waiting list for all.

For the ICGP:

- Seek further funding to develop project work in this area.
- Consider developing a network of GPs and nurses working in deprived areas.
- Further develop the role of the college as an advocate for patients living in poverty.
- Advocate for expanding GMS access to people on low incomes.

Recommendations in the 2012 IMO position paper on health inequalities[20] include:

- A model for the allocation of resources to primary care is needed which takes into account patterns of co- and multi-morbidities and GP utilisation in areas of deprivation.
- The government must ensure that vulnerable rural and deprived urban communities have adequate GP cover.
- Ensure equity of access to healthcare service based on medical need and not ability to pay or any other criteria including age, gender, place of residence or cultural identity.

Recommendations

The literature is clear. There is robust evidence for the association between socio-economic deprivation and poor health. Lack of investment in primary care has a negative impact on population health. The literature also highlights the increased demand for general practitioner services in areas of deprivation and the difficulty in recruiting and retaining doctors to work in these areas. The problems are multifactorial and the solutions need to be multifaceted.

1. Investment in general practice and primary care

A total of 95% of patients seen are managed solely in general practice with only a 5% referral rate.[43,44] Despite this, general practice receives just 2% of the health budget. This compares with 8% in England (and the RCGP is campaigning for this to increase). This chronic underfunding has been exacerbated under the FEMPI cuts and had led to many practices not being viable. There were 21 GMS vacancies as of May 2015. Unless there is investment in primary care, the crisis that is occuring in general practice in Ireland will worsen. Areas of deprivation specifically need investment because of the increased workload, greater degree of psychological problems and social complexity, and more long term health problems.

2. Financial incentives to attract doctors to work in underserved areas

A deprivation weighting should be considered to encourage establishing GPs to set up in areas of deprivation and make practices viable in these areas.

A deprivation practice allowance similar to the rural practice allowance should be considered.

3. Education

General practice training schemes should be delivered at local level in areas of deprivation. This would promote the retention of doctors working in these areas. An example of this is the North Dublin City GP Training Scheme established in 2010 where trainees spend time training in the areas of addiction, homelessness and community service.

Any future expansion of GP training places should start with placing of trainees in areas of deprivation in both rural and urban areas which are underserved at present.

4. Infrastructural support

Practice premises should be subsidised or provided free of charge – if owned by the government – as practices in areas of deprivation do not have an equivalent private income compared to more affluent areas.

Practice allowances for IT and equipment such as ECG/ABPM should be made available. These services are routinely available in practices in more affluent areas and this would reduce inequitable access to these basic investigations.

The design of new models of care should be aimed at reducing health inequalities. Equal access to diagnostics for public patients, based on need, should be urgently addressed.

Deep End doctors have indicated that longer consultation times would enhance their ability to effectively manage multimorbidity and social complexity. First and foremost, increased numbers of GPs will be needed.The core general practice team of GP, practice nurse and practice secretary should be the starting point for planning purposes. Innovative approaches such as providing subsidies to employ GP assistants and/or nurse practitioners in areas of deprivation could also be considered.

Access to healthcare for marginalised groups can be addressed through several measures. It has been shown that keyworkers can improve access to medical cards for homeless people and drug misusers. Specialised Services (as provided by Safetynet) has been shown to be effective in improving access for marginalised groups such as homeless people and migrants.[20] Patients with challenging health and social care needs (such as homeless people and substance abusers) may need "one-stop" healthcare hubs where people can receive multiple services in one place.[45, 46]

This may be addressed by practices established specifically to provide care for vulnerable groups or through conventional practices with on-site access to a multi-disciplinary team that includes social workers and drug and alcohol teams.[42]

Conclusion

General practice in Ireland, if properly resourced, is capable of providing high standard, quality patient-centred care to all sectors of society. There needs to be a whole system approach in order to properly address the causes and effects of health inequalities[2] but general practice and primary care can be part of the solution. The issues of investment, recruitment and infrastructural support and the solutions outlined in this report need to be addressed by the government without delay.

References

1. Hart, J.T. (1971). "The Inverse Care Law". *Lancet*. 1: 405–12.
2. Marmot Review. (2010) *Fair Society, Healthy Lives: Strategic Review of Health Inequalities in England Post 2010*. London: Marmot Review.
3. Layte, R., Nolan, A., and Nolan, B. (2007) *Poor Prescriptions: Poverty and Access to Community Health Services*. Dublin: Combat Poverty Agency.
4. Crowley, P. (2005) *Health Inequalities and Irish General Practice in areas of deprivation.* Dublin: Irish College of General Practitioners.
5. Mansfield, G., Collins, C., O'Riordan, M., and Ryan, K. (2015) *Bridging the gap- How GP Trainees and recent graduates identify themselves as the future Irish general practice workforce* Dublin: Irish College of General Practitioners.
6. Baker, M., Mawby, R., and Ware, J. (2015) *Health Inequalities.* London: Royal College of General Practitioners.
7. Layte, R. and Nolan, B. (2004) Equity in the Utilisation of Healthcare in Ireland. *Economic and Social Review,* 35 (2): 111–134.
8. Nolan, B. (ed). (2007) *The Provision and Use of Health Services, Health Inequalities and Health and Social Gain.* Dublin: ESRI.
9. Reeves D, and Baker D. (2004) Investigating relationships between health need, primary care and social care using routine statistics. *Health Place*. Jun; 10(2):129–40.
10. Martin, R.M., Sterne, J., Mangtani, P., and Majeed, A. (2001) *Social and economic variation in general practice consultation rates amongst men aged 16–39*. *Health Statistics Quarterly*, 9: 29–36.
11. Stirling A.M., Wilson P., and McConnachie A. (2001) Deprivation, psychological distress, and consultation length in general practice. *British Journal of General Practice.* 2001 Jun; 51(467): 456–60.
12. Pedersen AF, and Vedsted P. (2014) Understanding the inverse care law: a register and survey-based study of patient deprivation and burnout in general practice. *International Journal for Equity in Health.* Dec 12; 13(1): 121. doi: 10.1186/s12939-014-0121-3.
13. Coburn D. (2004) Beyond the income inequality hypothesis: class, neo-liberalism, and health inequalities. *Social Science and Medicine.* Jan; 58(1):41–56.
14. Department of Health, Social Services and Public Safety (2002) *Investing for Health,* Belfast: DHSSPS.
15. Central Statistics Office (2010) *Mortality Differentials in Ireland*. Dublin; CSO.

16. Centre for Health Geoinformatics, NUI Maynooth. *An Atlas of Health Inequalities in Ireland 2006–2011.*

17. Balanda, K. and Wilde, J. (2001) *Inequalities in Mortality 1989–1998: A Report on All-Ireland Mortality Data*. Dublin/Belfast: Institute of Public Health in Ireland.

18. All Ireland Traveller Health Study Team; School of Public Health, Physiotherapy and Population Science, University College Dublin. (2010) *All-Ireland Traveller Health Study summary of findings.* Dublin: Department of Health and Children.

19. Burke, S., Quirke, B., O'Donovan, D., and Keenaghan, C. (2003) *Health in Ireland: an unequal state.* Dublin: Public Health Alliance of Ireland.

20. O'Reilly, Fiona and Barror, Suzanne and Hannigan, Ailish and Scriver, Stacey and Ruane, Lynn and McFarlane, Anne and O'Carroll, Austin (2015) *Homelessness: an unhealthy state. Health status, risk behaviours and service utilisation among homeless people in two Irish cities.* Dublin: The Partnership for Health Equality.

21. O'Carroll A, O'Reilly F. (2008) Health of the homeless in Dublin: has anything changed in the context of Ireland's economic boom? *European Journal of Public Health*. Oct;18(5):448–53. doi: 10.1093/eurpub/ckn038. Epub 2008 Jun 25.

22. Health Research Board (2014) *Drug related deaths and deaths among drug users in Ireland: 2011 figures from the National Drug –related Death Index*. Dublin: Health Research Board.

23. IMO (2012) *IMO Position Paper on Health Inequalities.* Dublin: Irish Medical Organisation.

24. Pilgram, D. (2004) Social Class and Mental Health, Personal Communication.

25. Chawla R. (2004) Risk factors for death in infancy persist into older age groups in England and Wales. *BMJ.* Nov 20; 329(7476): 1204.

26. Mercer SW, Watt GC. (2007) The inverse care law: clinical primary care encounters in deprived and affluent areas of Scotland. *Annals of Family Medicine*. Nov–Dec; 5(6):503–10.

27. MacVicar, R, Williamson, A, Cunningham, D.E., and Watt, G. (2015) What are the CPD needs of GPs working in areas of high deprivation? Report of a focus group meeting of 'GPs at the Deep End'. *Education for Primary Care*. May; 26 (3):139–145.

28. Barry , S., Burke, S., Thomas, S. (2014)The Irish health-care system and austerity: sharing the pain. *The Lancet*. 383 (9928): 1545–1546.

29. Pickett, K and Wilkinson, R. (2009) *The Spirit Level: Why More Equal Societies Almost Always Do Better.* London: Allan Lane.

30. Ware, J. and Mawby, R. (2015) *Patient access to general practice: ideas and challenges from the front line.* London: Royal College of General Practitioners.

31. Fiscella K, Franks P, Gold MR, Clancy CM. (2000) Inequality in quality: addressing socioeconomic, racial, and ethnic disparities in health care. *JAMA.* May 17;283(19):2579–84.

32. Payne N, and Saul C. (1997) Variations in use of cardiology services in a health authority: comparison of coronary artery revascularisation rates with prevalence of angina and coronary mortality. *BMJ.* Jan 25;314(7076):257–61.

33. O'Riordan, M., Collins, C., and Doran, G. (2013) *Access to diagnostics: A key enabler for a primary care led health service.* Dublin: Irish College of General Practitioners.

34. Gelberg L, Gallagher TC, Andersen RM, Koegel P. (1997) Competing priorities as a barrier to medical care among homeless adults in Los Angeles. *American Journal of Public Health.* Feb;87(2):217–20.

35. Baggett TP, O'Connell JJ, Singer DE, Rigotti NA. (2010) The unmet health care needs of homeless adults: a national study. *American Journal of Public Health.* Jul;100(7):1326–33. doi: 10.2105/AJPH.2009.180109. Epub 2010 May 13.

36. Lebrun-Harris LA, Baggett TP, Jenkins DM, Sripipatana A, Sharma R, Hayashi AS, Daly CA, Ngo-Metzger Q. (2013) Health status and health care experiences among homeless patients in federally supported health centers: findings from the 2009 patient survey. *Health Services Research.* Jun;48(3):992–1017. doi: 10.1111/1475-6773.12009. Epub 2012 Nov 7.

37. Gelberg L, Andersen RM, Leake BD. (2000) The Behavioral Model for Vulnerable Populations: application to medical care use and outcomes for homeless people. *Health Services Research.* Feb;34(6):1273–302.

38. Barriball L, Bremner J, Buchan J, Craveiro I, Dieleman M, Dix O, Dussault G, Jansen C, Kroezen M, Rafferty AM, and Sermeus W. (2015) *Recruitment and Retention of the Health Workforce in Europe.* Brussels; European Commission.

39. Bärnighausen, T., and Bloom, D. E. (2009). Financial incentives for return of service in underserved areas: a systematic review. *BMC Health Services Research*, 9:86.

40. Misfeldt, R., Linder, J., Lait, J., Hepp, S., Armitage, G., Jackson, K., and Suter, E. (2014). Incentives for improving human resource outcomes in health care: overview of reviews. *Journal of Health Services Research & Policy*, 19(1), 52–61.

41. Ono, T., M. Schoenstein and J. Buchan (2014) Geographic Imbalances in Doctor Supply and Policy Responses. *OECD Health Working Papers*, No. 69. OECD Publishing.

42. The Nuffield Trust (2015) *The future of primary care: Creating teams for tomorrow: Report by the Primary Care Workforce Commission.* Leeds: NHS, Health Education England.

43. Comber, H. (1992) *The First National Study of Workload in General Practice.* Dublin; Irish College of General Practitioners.

44. RCGP (1992) The European Study of Referrals from Primary to Secondary Care. *RCGP Occasional Paper, No. 56*. London; Royal College of General Practitioners.

45. Hewett N, Hiley A, Gray J. (2011) Morbidity trends in the population of a specialised homeless primary care service. *British Journal of General Practice.* Mar;61(584):200–2. doi: 10.3399/bjgp11X561203.

46. Whittaker D, Hart G, Mercey D, Penny N, Johnson A. (1996) *Satellite clinics and delivery of sexual health services to the "hard to reach": an evaluation: final report to North Thames Regional Health Authority.* London; University College London, Academic Department of Sexually Transmitted Diseases.

The Irish College of General Practitioners (ICGP) is the professional body for general practice in Ireland. The College was founded in 1984 and is based in Lincoln Place, Dublin 2. The College's primary aim is to serve the patient and the general practitioner by encouraging and maintaining the highest standards of general medical practice. It is the representative organisation on education, training and standards in general practice.

The Irish College of General Practitioners, 4/5 Lincoln Place, Dublin 2
Tel: 01-676 3705, Fax: 01-676 5850, Email: info@icgp.ie, Web: www.icgp.ie