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## EDITORIALS

## Multimorbidity and the inverse care law in primary care

Inequalities set to rise as criteria for funding change in the UK

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Multimorbidity, usually defined as the coexistence of two or more long term conditions within an individual, is rapidly becoming the norm among people with chronic disease. Although often seen as a problem of elderly people, it affects large numbers of younger people too. Multimorbidity is not simply a problem of chronological ageing, but neither is it randomly distributed.<sup>1</sup> In a recent Scottish study of almost 1.8 million people, more people with multimorbidity were aged below 65 years than above,<sup>2</sup> and similar findings have been reported outside the United Kingdom.<sup>3</sup> The level of deprivation influences not just the amount but also the type of multimorbidity that people experience. Multimorbidity is more common and occurs 10-15 years earlier in the most deprived areas than in the most affluent ones.<sup>2,4</sup> A greater mix of mental and physical problems is seen as deprivation increases, which means increased clinical complexity and the need for holistic person centred care.<sup>2,5</sup>

What then are the implications of high burdens of multimorbidity for health and healthcare in deprived areas? The inverse care law, which observes that: the availability of good medical care tends to vary inversely with the need for it in the population served, and which “operates most completely where medical care is most exposed to market forces and less so where such exposure is reduced,”<sup>6</sup> remains the key factor. Inequities in the distribution of general practitioners are especially prominent in market based healthcare systems,<sup>7</sup> but even in the UK, with its tradition of universal coverage through the NHS, the distribution of general practitioners is based on local population size rather than on need.<sup>8,9</sup>

More multimorbidity in deprived areas means that patients die younger, are sicker for longer before they die, and that they (and their families) present more complex problems to general practitioners and primary care teams. Primary care in these areas is in turn relatively understaffed, under-resourced, and less able to deal with patients’ needs than in more affluent areas. Secondary care manages emergencies, but emergency services

are a poor and inefficient substitute for the personalised integrated primary care that patients with multimorbidity need.

The inverse care law directly affects the clinical encounter and the doctor-patient relationship. Compared with their counterparts in more affluent areas, patients in deprived areas with complex problems feel less enabled and their doctors feel more stressed after consultations.<sup>5</sup> The key deficit is time.<sup>9,10</sup> Too little consultation time is the mechanism that—within the complex context that shapes encounters between patients and doctors living and working in deprived areas—reduces patients’ expectations and what doctors can deliver.<sup>11</sup> Perversely, neither the inverse care law, nor its principal mechanism, shortage of time, are mentioned in most high level reports on health inequalities.

Healthcare itself becomes a social determinant of health when it falls short of meeting the needs of the sickest patients. Current and planned changes in primary care in the NHS in England herald a worsening of the manifestations of the inverse care law by distributing resources solely on the basis of age. Such a change effectively takes money away from practices in deprived areas, where fewer people survive into old age but younger patients have a higher burden of disease.<sup>12</sup>

The inverse care law is not a natural law but the result of policies that restrict access to effective needs based care. It mainly affects patients of low socioeconomic status with multimorbidity, who have a mix of physical, psychological, and social problems, and consequently need time, empathy, and a holistic patient centred approach to care. The law therefore results in healthcare underachieving in poor areas. For healthcare services to narrow rather than widen inequalities in health, they need to be at their best when meeting the challenge of caring for patients with multimorbidity in deprived areas. For this to occur, the allocation of resources will need to match the greater needs of deprived populations at younger ages, rather than resources being distributed on the basis of age.

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