Correspondence

Socioeconomic deprivation and proximity to general practices in England

Sirs,

In their recent paper, Jean Adams and Martin White\(^1\) make the observation that electoral wards in north-east England with low aggregate measures of education, employment or income generally have shorter straight-line distances to a general practice. They conclude that ‘more deprived areas tend to be better served by health services in terms of geographical proximity to general practices’ (p. 81). However, consideration of alternative measures of the availability of primary care does not support the view that deprived areas are better served by primary-care services.

First, Adams and White’s analysis lacks a population denominator. This may be significant, since it is well documented that deprived areas in England generally have fewer general practitioners (GPs) per 10 000 population.\(^2\) It has been suggested that this relative lack of access to primary care may contribute to worse health outcomes in deprived populations.\(^3\) The availability of primary-care professionals per 10 000 population was identified as a headline indicator on inequalities in health by the Department of Health.\(^4\) Secondly, the ‘general practice’ is not a fixed entity. There is a negative association between the Townsend deprivation score of an area and the partnership size (the number of GPs per general practice).\(^5\) Deprived areas generally have practices with few partners and a high proportion of single-handed practices, especially in London. For a given number of general practitioners per head of population, more deprived areas can be expected to have relatively more general practices but with less well developed facilities.

Tudor Hart’s ‘inverse care law’ referred specifically to inequalities in the availability of services.\(^6\) Current indicators show that socioeconomic inequalities in the availability of primary-care services still exist.\(^2\) In a small, densely populated country such as England, questions of geographical proximity to services are most relevant in more sparsely populated rural areas.\(^7\) A measure of geographical proximity may not provide the most relevant way of capturing the problems either of physical accessibility or availability of services in socioeconomically deprived environments, and may not offer the best single measure with which to judge questions of access to health care.

References


Yours faithfully,

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doi:10.1093/pubmed/fdi046
Advance Access Publication 13 July 2005

Concerning: ‘Mobile phones and driving’

Sirs,

It is heartening that Johal *et al.* observed a reduction in mobile phone use whilst driving, in the 10 weeks following the introduction of legislation.\(^1\) However, more significant is the long-term effects of the legislation, as there is evidence that it may not persist over time.\(^2\)

A study in New York State found that, although mobile phone use whilst driving fell following legislation, within a year usage had risen back close to pre-law levels.\(^2\) There is anecdotal evidence to suggest that this is also happening in the UK.\(^3\)

To explain and tackle this apparent short-term effect it is useful to distinguish between the introduction of the legislation itself (with the accompanying enforcement and penalty) and the publicity/education surrounding that legislation.

The observed short-term decreases in mobile phone usage whilst driving may be due to the legislation itself, and the consequent fear of being caught and penalised. However, the