PrimaryCare 2001;1:657–662

L'exclusion sociale existe-t-elle en Suisse et les médecins généralistes y sont-ils confrontés?

«Je le déclare sans hésiter, je suis du parti des exclus et des proscrits». Victor Hugo

Willy Buss

A propos d'un groupe de travail de l'UEMO

A l'initiative de l'Association des médecins généralistes d'Amsterdam, a eu lieu dans cette ville, en novembre 1997, une Conférence Européenne d'experts concernant les problèmes rencontrés par les médecins travaillant dans des centres urbains défavorisés ou autres zones d'exclusion sociale.

Les documents publiés après cette conférence (UEMO 98/049 et UEMO 98/050) ont représentés la base théorique pour un nouveau groupe de travail de l'UEMO dont le but était d'étudier les problèmes rencontrés par les médecins généralistes travaillant dans de telles zones et les obstacles à la délivrance de soins de santé primaire.

Le groupe de travail s'est réuni pour la première fois à Utrecht (NL) en 1998, dirigé d'abord par Paul Rasch, de la LHV (Association des généralistes hollandais) puis par le soussigné, avec des délégués venant aussi d'Irlande, de Belgique et de Suisse (et ultérieurement d'Espagne, du Portugal et du Royaume Uni).

En 1999, un questionnaire à l'intention de toutes les délégations de l'UEMO a été élaboré, envoyé puis analysé. Les réponses ont fourni les éléments d'une déclaration politique de l'UEMO, «UEMO Policy Statement on Urban deprived areas and social exclusion», laquelle a été adoptée à l'unanimité à Malte lors de l'assemblée du 16 juin 2001.

Il appartient aux délégations nationales et à la présidence de l'UEMO de transmettre le document aux ministères, Commissions ou Directions Générales concernés, de manière à apporter leur soutien aux collègues et patients touchés par ces situations difficiles.

En Suisse, il ne semble pas y avoir pour l'instant de régions entières ou quartiers correspondant aux critères anglais ou hollandais de «deprived areas» (cf. documents). Mais les généralistes de notre pays reçoivent quotidiennement des patients confrontés soit au chômage, à l'insécurité de l'emploi, au mobbing, à l'invalidité, ou souffrant de toxicomanies ou de comorbidités psychiatriques. A l'avenir, la médecine des migrants et des requérants d'asile pourrait prendre davantage d'importance, ce qui nécessite un travail d'équipe (cf. documents).

Une tâche essentielle de la SSMG est à cet égard la défense du maintien d'une «couverture médicale universelle (CMU)» pour laquelle, en l'an 2000, la Suisse a reçu, d'une fondation européenne, un prix d'excellence (en même temps que la Hollande pour son réseau de médecine de premier recours).

Willy Buss
Président du groupe de travail UEMO
«Urban deprived areas»

Aus einer Arbeitsgruppe der UEMO

Einleitung

Angeregt durch die «Association des médecins généralistes d'Amsterdam» hat in dieser Stadt im November 1997 eine Europäische Expertenkonferenz über die Probleme der Ärzte, die in benachteiligten Stadtteilen oder anderen Zonen sozialer Ausgrenzung, stattgefunden.

Die nach dieser Tagung publizierten Dokumente (UEMO 98/049 und UEMO 98/050) haben die theoretischen Grundlagen für eine neue Arbeitsgruppe der UEMO geliefert, deren Ziel es ist, die Probleme der Allgemeinmediziner, die in solchen Gebieten arbeiten, und die Schwierigkeiten in der primären Gesundheitsversorgung zu analysieren.

Die Arbeitsgruppe hat sich zum erstenmal

Dr Willy Buss
1a, ch. de la Jonchère
CH-2052 Fontainemelon
e-mail: wbuss@hin.ch

1998 in Utrecht (NL) getroffen, geleitet von Paul Rasch von der LHV («Association des généralistes hollandais»), später von dem Unterzeichnenden, mit Delegierten auch aus Irland, Belgien und der Schweiz (in der Folge auch aus Spanien, Portugal und England).

1999 wurde ein Fragebogen zuhanden aller Delegationen der UEMO ausgearbeitet, anschliessend verschickt und ausgewertet. Die Antworten lieferten die Elemente für die politische Deklaration der UEMO «UEMO Policy Statement on Urban deprived areas and socal exclusion», die anlässlich der Versammlung vom 16. Juni in Malta einstimmig genehmigt wurde.

Es ist die Aufgabe der nationalen Delegationen und der Präsidentschaft der UEMO, die Dokumente an die Ministerien und Kommissionen weiterzuleiten, um deren Unterstützung für die Kollegen und Patienten in schwierigen Situationen zu erhalten.

In der Schweiz scheint es momentan keine Regionen oder Stadtquartiere zu geben, welche die englischen oder holländischen Kriterien der «deprived areas» (siehe unten) erfüllen. Aber die Allgemeinärzte in unserem Land empfangen regelmässig Patienten mit Problemen wie Arbeitslosigkeit, unsicherer Arbeitstelle, Mobbing, Invalidität, Toxikomanie oder psychiatrischer Komorbidität. In Zukunft wird die medizinische Betreuung von Migranten und Asylbewerbern zunehmend an Bedeutung gewinnen, was Teamarbeit notwendig macht (siehe unten).

Eine zentrale Aufgabe der SGAM ist hier die Aufrechterhaltung einer «couverture médicale universelle» (CMU), für die die Schweiz im Jahre 2000 eine Auszeichnung von einer europäischen Stiftung bekommen hat (gleichzeitig mit Holland, das für sein Grundversorger-Netz ausgezeichnet wurde).

Willy Buss
Präsident der Arbeitsgruppe UEMO «Urban deprived areas»
(Übersetzung: Romaine Viollier)

UEMO Policy statement on Urban deprived areas and social exclusion[1]

European Union of General Practitioners – UEMO
Europäische Vereinigung der Allgemeinärzte – UEMO
Union Européenne des Médecins Omnipraticiens – UEMO

UEMO – Presidency
Via il Prato 66
I-50123 Firenze
E-Mail: uemo@dada.it

Background

Europe is a region of great contrasts, where rich countries lie side by side with much poorer nations and the latter struggle with the consequences of social, economic and cultural changes that have occurred in a very short span of time.

For political and economic reasons, the EU countries have had to face in the last decade an important immigration flow, especially from Eastern Europe countries, former Yugoslavia and from Asian and African countries.

The health of the population is influenced by several factors that act upon the population simultaneously. These factors can be of general nature such as the demographic factors of age and gender. Other factors are environmental, economic (the general level of prosperity), social (family and social relations, life style) and cultural (level of education) and even the type of political system that exists in a country affects the health of the population.

Good and equal health is not only essential for a sustainable social development and economic growth but is also a fundamental human right for all people and a basis for democracy in a country.

Problems of health care in the European inner cities

About 15 years ago, British and Dutch colleagues began studies and researches in order to cope with the growing difficulties in delivering primary health care to inhabitants of certain of their inner cities.

Criteria for defining deprived areas were found and diverse researches have proven that the health situations in these areas are worse than in other areas, due to the accumulation of problems:

The effects of unemployment, bad housing (or even homelessness), poor sanitation,

[1] This article will appear in the UEMO Reference book 2001 version 2.

lack of adequate schools, cultural diversity, one-parent families, social isolation, etc.

The life expectancy of these populations is shorter, the prevalence of chronic illness is much higher than in other regions and more people suffer from alcohol, tobacco or drug addiction.

For these populations access to preventive measures, to GP registration and to medical and surgical treatments is very often delayed.

Deprived people are mostly concentrated in certain areas of inner cities but can also be dispersed everywhere, even in rural areas. Most European GPs don't work in deprived areas but even they face daily the problems of unemployment, job insecurity, harrassment, migration, asylum seekers, etc. but in smaller degree. The impression that social insecurity unfavourably influences the health of the patients is confirmed by diverse medical literature. There exists a correlation between unemployment, morbidity and mortality, and this correlation also applies to people who fear the loss of their jobs. Unemployment is increasing the probability of a man dying in the next ten years by a third.

Identification of deprived areas

To distribute possible extra means, it is necessary to have a system to identify deprived areas.

In the Netherlands they are defined on the basis of 4 socio-economic and geographic criteria: average income, percentage of inactive people, percentage of the population from ethnic minority groups and the address density as measure for urbanisation.

In England, areas are identified on the basis of the Jarman index (include 8 factors: elderly living alone; under 5 s; unskilled; unemployed; single parents households; overcrowded households; persons who have moved house; residents in ethnic minority households).

In Ireland, a so-called Sahru Index is used and in UK a Townsend score. With the help of a questionnaire sent to all UEMO national delegation, the problem could be mapped out in 9 countries.

In UK, in 1998, the Acheson Report of the Independent Inquiry into Inequalities in Health summarises the effects of socio-economic inequalities on health and includes 529 references to other research on the issues.

Consequences for the patient

As already mentioned, lower social status not only means being poor, but enhances also poor health, a much lower life expectancy and more co-morbidity during life. The prevalence of chronic conditions is increased, leading to more passivity and more disability.

Frequently, language difficulties and low education lead to poor communication and constitute barriers to the access to primary health care.

The population's poor state of health results in a greater appeal to health care: a higher consultation rate, longer consultations and more complex requests for help.

Consequences for the GP's

Due to the poor health of the population, problems in communication and many social difficulties, consultations are much more time consuming and more frequent. GP's are confronted daily with a variety of problems that need solutions outside the health care system.

GPs in these areas experience a very heavy workload and feel isolated. In the worst cases, GPs will leave the area and it will be difficult to find a successor.

Special skills are often needed when GPs are confronted with immigrants and asylum seekers (tropical medicine, ethnological and anthropological knowledge, and the identification and management of post traumatic stress disorders).

In some areas, GPs are threatened and obliged to engage a bodyguard!

There is a growing shortage of human resources, of both doctors and nurses and of other health care professionals, in the deprived areas.

Needs for the patients

Urban deprivation – housing, environment, schools, safety in general has to be reduced with the cooperation of local authorities. Only then, the health authorities can work on equity of access to care.

Particular groups need special attention: ethnic minorities, refugees, asylum seekers, illegal immigrants, drug users and single elderly.

Curative care is fundamentally under-

mined if the foundations of a health service, such as sanitation, nutrition, hygiene, housing, immunization, maternal and child health, health education, etc are not provided.

Needs for the GP's

A clear distinction between Public Health and GP-tasks can help diminish the workload of the GP. As for preventive and educational measures effective cooperation between the two is necessary in all significant areas.

Extra funding is necessary to facilitate the working conditions of GP's working in deprived areas, for 4 reasons:

- It will allow extra support such as practice nurses, health instructors, migrant workers or translators, social workers or first-line psychologists. A multi-disciplinary team is required in these situations, including community leaders.
- GPs need to have fewer patients in these areas and to receive regular training on working methods and on special skills.
- To permit the provision of security measures when necessary, both for premises and for personnel, and to fund the necessary teaching on personal security
- To provide financial incentives and rewards to aid with recruitment to deprived areas and to encourage retention of GPs in those areas

Examples of structural measures are the merging of practices and the improvement of housing (more easily identifiable for patients, safer for the staff).

UEMO recommendations

The present extent of health inequality demands a combination of «upstream» and «downstream» solutions.

- Upstream, societal changes are required to prevent further damage.
- Downstream, the existing damage demands medical treatment for those already affected.
- EU and the governments should recognise the problems of health care by GP's in urban deprived areas. They should provide extra funding for adequate remuneration and logistical support.
- GP's in urban deprived areas have an important signalling function. They have a responsibility to make their understanding of the problems and solutions known to health and policy authorities.
- Solutions for the patients should include a clear link-up with education and employment.
- GP's should be integrated in a network with practice nurses, social services, voluntary organisations, schools, hospitals and other stakeholders.
- GP's need a special training including public health approaches and skills and ability to deal with aspects of a culturally pluralistic society.
- EU and the governments should guarantee the equity of access of each individual to the health care system (CMU: couverture médicale universelle).