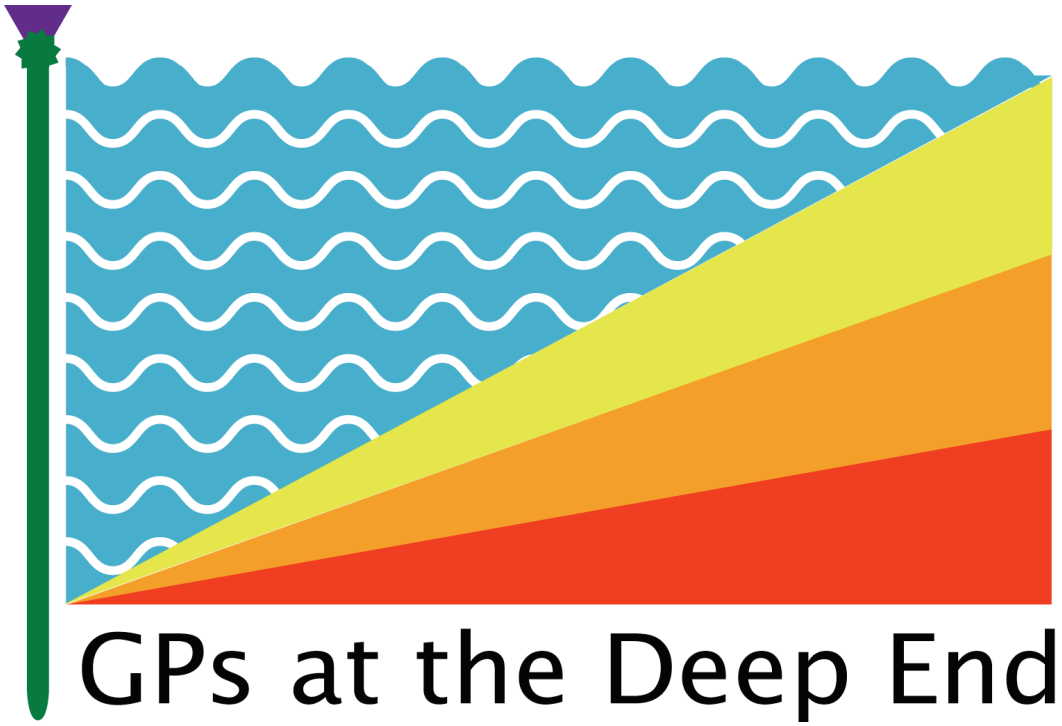
CREATING A FAIRER SCOTLAND

Response from



General Practitioners at the Deep End (www.gla.ac.uk/deepend) , serving the 100 most deprived communities in Scotland, which comprise 8% of the Scottish population, welcome the Scottish Government's commitment to reducing inequality and its initiative in seeking suggestions for creating a fairer Scotland.

The Government's explanatory leaflet includes examples of social and gender differences in wealth, employment, income, educational achievement, emotional difficulties in pre-school children, life expectancy, crime and social connections. ***There is no reference to NHS Scotland*** or social variations in access to needs-based health care. GPs at the Deep End suggest that this should be a core element of the Government's plan to create a fairer Scotland.

The first step is to acknowledge that there is a problem within the NHS. If unfairness is not recognised, it cannot be addressed. Successive Scottish Governments have been reluctant to engage with this issue. ***Their inaction continues to cost lives***.

The NHS is often said to be seen at its best in dealing with emergencies, where patients receive whatever care they require, with no financial checks or other tests of eligibility. ***Emergency care is only one aspect of health care***, however, and comes into play when problems occur unexpectedly, or when non-emergency care has fallen short.

Modern health care is delivered via a combination of community and specialist services, with an expectation that more care will be delivered in the community by primary health care teams. Such care can reduce and delay the need for emergency care.

The sterling record of the NHS in providing access to emergency care is not matched by its record in providing access to non-emergency care. The net effect is ***earlier, more chaotic use of unscheduled care services***, such as out of hours, accident and emergency and hospital admissions.

General practitioners at the Deep End are in daily contact with large numbers of patients in Scotland's poorest communities and have ***huge cumulative experience and knowledge*** of the problems experienced in such communities and the difficulties experienced by patients in accessing the best care.

We highlight two issues which the NHS must address if Government is to achieve its 2020 vision for improving the health of the Scottish population:-

1. ***The flat distribution of general practice resources throughout Scotland***
2. ***The dominance of demand over need***

Context

Although the principal social determinants of health operate outside health care, ***health care mitigates the effects of poor health*** by reducing the severity and delaying the progression of conditions. Whether such care reduces or increases heath inequalities depends on the extent to which it is delivered ***in proportion to need across the socio-economic spectrum.*** (1)

Most people need high quality care towards the end of their life, but in deprived areas ***where lives are shorter and harder***, the NHS, and especially primary care, has an important but under-resourced role in improving health, increasing longevity and narrowing health inequalities. (2)

Men and women in the most deprived fifth of the Scottish population die 10.4 and 6.9 years earlier, respectively, than men and women in the least deprived fifth (See ISD data in table overleaf). The differences in health life expectancy (the estimate of how many years people are expected to live in a 'healthy state') are even more stark. HLE in men and women in the most deprived fifth of the population ends 20.8 and 20.4 years earlier than in the least deprived fifth. When HLE ends, ***men and women in the most deprived fifth of the Scottish population spend twice as long in poor health*** before they die than men and women in the least deprived fifth of the population (23.0 v 12.6 years in men; 25.7 v 12.1 years in women).

LIFE EXPECTANCY AND HEALTHY LIFE EXPECTANCY IN SCOTLAND 2011-12

		Life Expectancy (years)	Healthy Life Expectancy (years)	Years spent in poor health
Least deprived quintile				
	Men	81.7	69.1	12.6
	Women	84.0	71.9	12.1
Most deprived quintile				
	Men	71.3	48.3	23.0
	Women	77.2	51.5	25.7

Source of Data – Scottish Public Health Observatory, 2015

1. The flat distribution of general practice resources throughout Scotland

Although the prevalence of health problems increases 2-3 fold across the social spectrum***, the number of general practitioners and levels of general practice funding are broadly flat*** across the same range (3). In 2012, the average spend per patient per annum in general practice (meeting expenditure on staff, premises and running costs, but not prescribing) was £118 in the most deprived fifth, compared with the Scottish average of £123, and £127 per patient per annum in the least deprived (most affluent) fifth (4).

This distribution of funding provides no basis for addressing the increased levels of health needs in deprived areas. Research shows that as a result consultations in general practices in deprived areas are characterised by ***greater multimorbidity*** (health and social problems) at younger ages***, less time, lower expectations, less patient enablement*** (especially for mental health problems, which are the commonest co-morbidity in deprived areas) and ***greater practitioner stress*** (5).

While the majority of Scottish general practices have some patients who live in areas of deprivation (so called "pocket deprivation"), the issues described above most affect general practices with large numbers of such patients ("***blanket deprivation***"). In Deep End practices, 44-89% of patients live in Scotland's 15% most deprived data zones.

With no additional funding, general practitioners in deprived areas can only increase their consultation rates, by working longer days and/or having shorter consultation times. The situation is exhausting, unsustainable, threatens recruitment and ***does not provide the conditions necessary to improve health and narrow health inequalities***.

All general practices "cope" at some level, but in deprived areas there is a substantial burden of ***unmet need which cannot be addressed***. By definition, unmet need goes unrecorded in routine data and is excluded from NHS resource distribution formulae.

Simple estimates of the need for health care, based on use of services, not only ignore unmet need but also ***fail to distinguish between need and demand***. Measuring how busy the NHS is provides little information on whether it is equitable in addressing patients' needs.

The Inverse Care Law states that ***the availability of good medical care tends to vary inversely with the need for it in the population served*** (6). It is not a law of nature, however, but a longstanding man-made policy which restricts access to care based on need.

In current circumstances, the Inverse Care Law is compounded by ***factors which are putting all general practices under pressure***, such as shortened hospital stays, the under-resourced transfer of clinical and paper work from secondary care and problems in GP recruitment and retention.

It is also compounded, however, by ***factors particular to very deprived areas***, such as the higher prevalence of mental health problems, addictive behaviours (alcohol, cigarettes, drugs misuse), vulnerable families, the associated clinical and social complications and the volume of work generated by welfare benefit reform, including paper work to support appeals and the additional clinical time needed to address the distress caused

Current funding formulae take no account of the ***additional time and support needed*** by patients la***cking knowledge, agency and confidence***, (especially patients with multiple problems) when accessing an increasingly fragmented and complicated service.

2. The dominance of demand over need

Although centralised services are provided with the intention of open access, uptake data show that less deprived (i.e. more affluent) groups are better able to achieve their needs and demands than patients in deprived areas. To paraphrase the inverse care law "The use, rather than the availability, of specialised medical care tends to vary inversely with the need for it in the population served" (6).

Multimorbidity occurs 10-15 years earlier in deprived areas (7), where the commonest co-morbidity is a mental health problem (in contrast to multimorbidity in elderly patients where the commonest co-morbidity is high blood pressure).

Increasingly it is recognised that multimorbidity involves substantial "work" for patients in coping with different conditions, treatments and services (8). ***The "treatment burden" increases when the delivery of care is fragmented between different services*** and patients lack the means or agency required to access such services.

The trend towards specialist services (which focus on a limited list of conditions, with referral criteria, waiting lists, evidence-based protocols etc, and including centralised services in primary care) ***discriminates against patients in deprived areas*** for whom patient-centred care needs to be timely, local and familiar. ***The requirement for patients to deploy "self-help" and "self management"*** also discriminates against patients who lack the resources, agency or mental health to cope with multiple conditions and complicated services.

The Link Worker programme, funded by the Scottish Government in 7 of the 100 Deep End practices, is not only improving the links between general practices and community resources for health "(***social prescribing***"), but is also highlighting ***the important role of helping patients access fragmented, dysfunctional services.*** Deep End practices need reliable, sustained support for both these functions.

Conclusion

The NHS is increasingly able to help patients live longer and better lives, partly as a result of ***evidence-based medicine*** but also via the delivery of ***unconditional, personalised continuity of care***, for whatever combination of problems a patient may have. The corollary is that inequitable delivery has become an important new social determinant of health and a new explanation of ***the failure to reduce health inequalities***.

Equitable access to emergency care has been a shining example of the NHS commitment to comprehensive health care, based on need and free at the point of use. A similar commitment is needed to reduce inequitable access to non-emergency care, especially general practice, and to reduce social variations in access to specialised and centralised services.

General Practitioners at the Deep End *work in 100 general practices, serving the most socio-economically deprived populations in Scotland. The activities of the group are supported by the Scottish Government Health Department, the Royal College of General Practitioners, and General Practice and Primary Care at the University of Glasgow.*

GPs at the Deep End

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