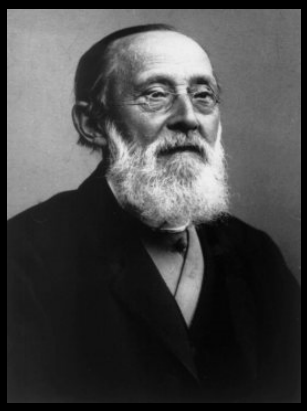
http://www.bbc.co.uk/news/uk-scotland-34957653



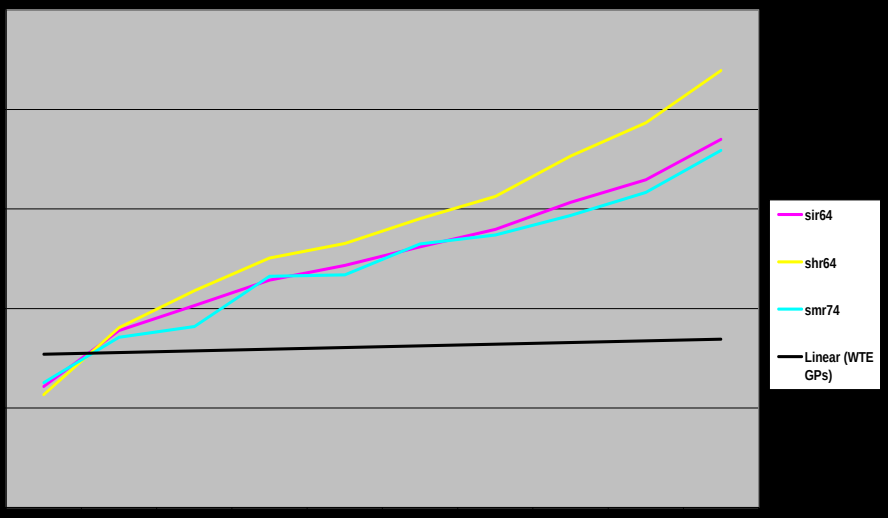
RUDOLF VIRCHOW

Medicine is a social science,
and politics nothing else but medicine on a large scale

SOCIAL MEDICINE

Diagnosing and treating the ills of sick societies

THE INVERSE CARE LAW IN SCOTLAND



Watt G The inverse care law today Lancet 2002;360:252-254

FEATURES OF GP CONSULTATIONS IN VERY DEPRIVED AREAS

Multiple morbidity and social complexity
Shortage of time
Reduced expectations
Lower enablement
Health literacy
Practitioner stress

Mercer SW Watt GCM
The Inverse Care Law : clinical primary care encounters in deprived and affluent areas of Scotland
Annals of Family Medicine 2007;5:503-510

The Herald
FOUNDED ON MONDAY JANUARY 27, 1783

Give care services more resources

GPs at the Deep End

Our health service should be at its best where it is needed most

SCOTLAND has an admirable record of providing comprehensive health care which is free at the point of use, and has been steadfast in protecting its NHS from the ravages of market competition, which continue to threaten the NHS in England.

However, as the continuing statistics on health inequality show, NHS Scotland has still to address the inverse care law, whereby the availability of good medical care tends to vary inversely with the need for it in the population served.

While NHS resource distribution formulae and general practitioner contracts have recognised for a long time the increased health problems, multiple morbidity and needs for care of elderly populations, they have been much less effective in providing resources to meet the increased health problems, multiple morbidity and social complexity of younger patients living in very deprived areas.

As general practitioners working in the 100 most deprived general practices in Scotland, we are the front line of the NHS in Scotland as it battles with health inequality. We are in daily contact with large numbers of patients, with unrivalled levels of continuity and coverage, and have substantial experience and knowledge of the health problems of people living in Scotland's poorest communities, including vulnerable children, and those struggling with mental health and addiction problems, in addition to physical ailments.

The inverse care law in Scotland is not a matter of good medical care in affluent areas and bad medical care in deprived areas. It is the difference between what general practice and primary care can currently achieve, in meeting the needs of patients in very deprived areas, and what could be achieved if the service were better resourced to address levels of need.

The major issue which must be addressed, and whose solution requires political action, is the shortage of time within consultations to address a patient's needs in very deprived areas. Although other measures are needed, without this essential building block, the NHS will continue to fail in its attempts to narrow health inequalities.

Longer consultations are needed to work with patients on their problems, to take a preventive approach and to instigate links to other services.

The NHS has many challenges to face, but should be at its best where it is needed most. We call on political parties contesting the forthcoming election to commit themselves to eliminating the inverse care law in Scotland. Their first step should be to provide general practices in the front line with additional time for patient consultations.

Members of the Deep End Steering Group: Georgina Brown, GP, Springburn Health Centre; John Budd, GP, Edinburgh Homeless Practice; Peter Cawston, GP, Drumchapel Health Centre; Margaret Craig, GP, Possil and Springburn; Susan Langridge, GP, Possilpark Health Centre; Stewart Mercer, Professor of Primary Care Research, University of Glasgow; Catriona Morton, GP, Craigmillar Health Centre; Anne Mullin, GP, Govan Health Centre; Jim O'Neill, GP, Lightburn Medical Centre; Euan Paterson, GP, Govan Health Centre; Petra Sembels, GP, Keppoch Medical Centre; Graham Watt, Professor of General Practice, University of Glasgow; Andrea Williamson, GP, Glasgow Homeless Health Services.

RC GP SCOTLAND

TIME TO CARE

Health Inequalities, Deprivation and General Practice in Scotland

RCGP Scotland Health Inequalities
Short Life Working Group Report
December 2010

"Practitioners lack time in consultations to address the multiple, morbidity, social complexity and reduced expectations that are typical of patients living in severe socio-economic deprivation."

AUDIT SCOTLAND December 2012

PUBLIC AUDIT COMMITTEE
REPORT ON HEALTH INEQUALITIES, APRIL 2013
http://www.scottish.parliament.uk/S4_PublicAuditCommittee/Reports/paur-13-01w.pdf

The report's main recommendations were that the Health and Sport Committee should address the following issues :-

*overcoming the practical barriers to collating **WTE headcount figures for GPs**, and providing this information broken down according to the level of deprivation*

*the increasing importance of **the primary care team** as a whole in tackling health inequalities in deprived areas*

increasing the proportion of GPs based in deprived areas

increasing the number of fellowships in deprived areas

*shifting towards treating patients based on **multimorbidity,** and how the effectiveness of any such shift will be measured*

*considering the potential merits of a cen**trally funded research function** to asses specific initiatives*

Derek Feeley: I was interested in the commentary on GP numbers, and I am trying to find the chart that shows them. It is not as though there is no correlation between GP numbers and deprivation—it is important to recognise that**. I have not done the sums, but it looks to me that there are around 25 to 30 per cent more GPs in the most deprived areas than in the least deprived areas.**

The Scottish Parliament
Parlamaid na H-Alba

Official Report
PUBLIC AUDIT COMMITTEE
Wednesday 5 December 2012

HOLYROOD COMMITTEES

Public Audit Committee

Health and Sport Committee

Welfare Reform Committee

Equal Opportunities Committee

CROSS PARTY GROUP ON HEALTH INEQUALITIES

6 PARLIAMENTARY QUESTIONS, APRIL 2014

Question S4W-20527: Duncan McNeil, Greenock and Inverclyde, Scottish Labour, Date Lodged: 02/04/2014

To ask the Scottish Government whether the GP contract now includes measurable outcomes to monitor progress toward tackling health inequalities, as recommended by Audit Scotland in its December 2012 report, Health inequalities in Scotland, and, if so, what outcomes.

Answered by Alex Neil (30/04/2014):

The arrangements we agreed with the Scottish General Practitioner's Committee for 2013-14 introduced a number of measures important for deprived areas, including anticipatory care and poly-pharmacy for those most at risk of hospital admission; importantly, this also paved the way towards minimising the bureaucracy associated with the GP contract in Scotland whilst placing more freedom in the hands of GPs to exercise their clinical judgment in the provision of care for patients, rather than the constraints of a tick-box approach.

The Scottish Government through recognising the challenges in the national contract in relation to practices whose patients face the greatest inequalities have significantly altered the 2014-15 contract to free those practitioners up to devote more time to the complex problems that their patients face.

99. This is not to suggest that we think that health services do not have an important role to play in reducing health inequalities. As we have indicated in the report, the least well-off and most vulnerable individuals and communities often have the poorest access to primary health services and this remains an issue that the NHS will need to make efforts to improve, by whatever means.

Scottish Parliament
Health and Sport Committee
Report on Health Inequalities
January 2015

Alex Neil MSP
Cabinet Secretary for Heath and Sport

Michael Matheson MSP
Minister for Public Health

Jamie Hepburn MSP
Minister for Public Health

CRISIS AT THE BALMORE PRACTICE


FAMILY DOCTORS APPEAL FOR HELP AS FUNDING AND RECRUITMENT CRISIS SABOTAGE CARE

EMERGENCY SURGERIES

SUNDAY MAIL
30th August 2015

MEMBER'S DEBATE
SCOTTISH PARLIAMENT
28th OCTOBER 2015

GENERAL PRACTICES AT THE DEEP END (HEALTHY LIFE EXPECTANCY)

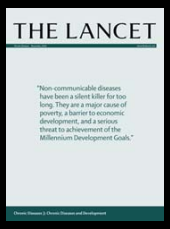
The Deputy Presiding Officer (John Scott): The final item of business is a members' business debate on motion S4M-14164, in the name of Patricia Ferguson, on general practitioner practices at the deep end, healthy life expectancy. The debate will be concluded without any question being put.

Motion debated,

That the Parliament records its appreciation of the general practitioners and staff in the "Deep End" practices, who it considers work in the most challenging of circumstances; understands that these practices serve the 100 most deprived populations in Scotland; is concerned that patients in the areas served by the practices will have up to 20 fewer healthy years in their lifetime; considers this to be a matter of serious concern both for the people affected and for the GP practices that they attend; considers that the funding distribution arrangements take no account of the additional burden that this places on staff and resources; regrets that the Balmore Practice in Possilpark has been forced to appeal to the local NHS trust for assistance in respect of its financial situation, and notes calls for the Scottish Government to review the present funding formula and do all in its power to eradicate health inequalities.

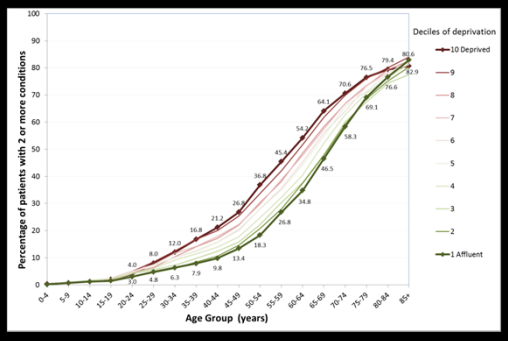
17:04

Patricia Ferguson (Glasgow Maryhill and Springburn) (Lab): I thank colleagues from across the Parliament who have made this debate possible ……..

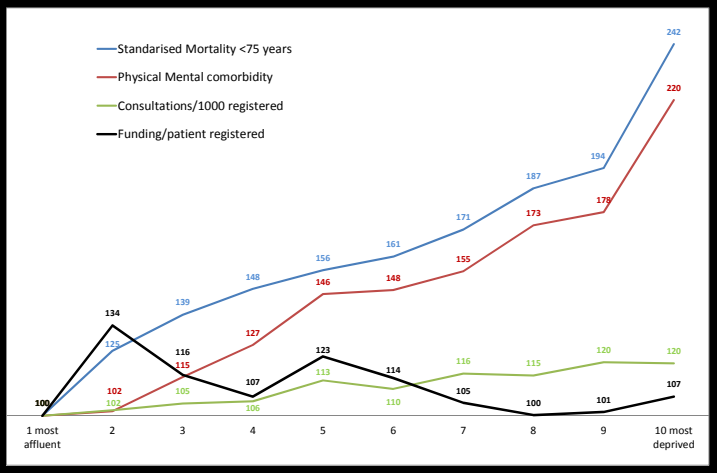


Karen Barnett, Stewart Mercer, Michael Norbury, Graham Watt
Sally Wyke, Bruce Guthrie

LANCET 12th May 2012



% DIFFERENCES FROM LEAST DEPRIVED DECILE FOR MORTALITY, COMORBIDITY, CONSULTATIONS AND FUNDING



British Journal of General Practice 2015; DOI:10.3399/bjgp15X687829

GENERAL PRACTICE FUNDING PER PATIENT

DECILE OF DEPRIVATION	TOTAL PRACTICE FUNDING PER PATIENT £	ESSENTIAL CONTRACT PAYMENTS £	QOF PAYMENTS £	ENHANCED CONTRACT PAYMENTS £
1 (most affluent)	111.5	84.8	22.3	4.3
2	142.6	114.9	23.5	4.2
3	126.6	98.3	24.0	4.3
4	120.4	91.2	25.0	4.2
5	133.7	104.4	25.0	4.2
6	126.9	97.5	25.3	4.1
7	117.4	89.0	24.4	4.0
8	114.6	85.3	25.3	4.0
9	116.2	86.7	25.7	3.9
10 (most deprived)	120.4	91.1	26.0	3.3
Total	123.3	94.6	24.7	4.0

SOUNDBITE

"Over 2 million Scots
in the most
deprived 40% of the population
received £8 less GP funding
per head per annum
than over 3 million Scots
in the most affluent 60%"

Monday 30th November 2015

FIRST MINSTER QUESTIONS, 3RD DECEMBER 2015

The First Minister:
I welcome Professor Watt's findings, which we will take fully into account in delivering a new GP contract for 2017 and the accompanying revised allocation formula. It is interesting that Professor Watt's study examined data from 2011-12. I have looked at the recent data for GP payments, for 2014-15, which show that the most deprived practices received, on average, £7.65 more per patient than practices in the most affluent areas received. I hope that that is a sign of progress in the direction that I suspect that Murdo Fraser wants us to take. The resource allocation formula has been in place since 2004 and has undergone some revisions and changes since then. The new GP contract, on which we are in the early stages of negotiation and which will take effect in 2017, gives us a good opportunity to revise the allocation formula to ensure that it reflects the varying needs of GP practices in different local communities. I look forward to having the support of the Parliament as we seek to do that.

See more at:
http://www.scottish.parliament.uk/parliamentarybusiness/report.aspx?r=10248&i=94327#ScotParlOR

SCOTTISH GOVERNMENT DEBATE ON REDESIGNING PRIMARY CARE 15TH DECEMBER 2015

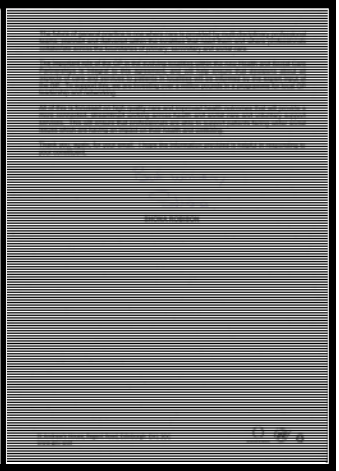
Shona Robison

Drew Smith talked about Professor Watt's report, deep-end practices, the Scottish allocation formula and the need for us to ensure that there is more reflection of the needs of deprived communities in the resources that go to them through the formula. All those things are subject to negotiation in relation to the GP contract. However, we need to ensure that all the challenges that are faced by those practices operating in more deprived communities are recognised in the resources that are provided to primary care. I correct Drew Smith's reading of the motion. The motion clearly says that the new contract provides

"the opportunity to go even further to tackle health inequalities in communities".

I deliberately put that in the motion in order to recognise that point.

6th January 2016



We have always been clear that the approximate 60% of GP funding allocated through the SAF must change to reflect changing circumstances. We will take full account of Professor Watt's findings as we deliver a new GP contract for 2017 and the accompanied revised allocation formula.

Dear Dr Williamson

Thank you for your email in relation to the parliament's recent debate on primary care.

The Scottish Conservatives are concerned by the mounting pressures being placed on General Practice and wider primary care services. We have met with the British Medical Association and the Royal College of General Practitioners to discuss these problems and possible solutions.

The Scottish Conservatives are committed to solving these problems. However, we cannot do so alone. Instead what is required is cross party collaboration, in which the Scottish Conservatives will play a vital role to deliver a better service, not just for patients, but for those who work in General Practice as well.

All parties need to work together to deliver multidisciplinary teams that include GPs, nurses, AHPs, community pharmacists, social care and other specialists all working together to secure the best out-of-hours care for patients in urgent-care resource hubs across Scotland. We also believe that GP-attached health visiting teams in a universal service across Scotland, with an additional concentration of that resource in areas of greater inequality could help solve many of the problems that General Practices face.

We also welcome the £1.3 billion in consequentials arising from the UK Government's increased health spending during this session. By the end of the next five years, we should see an additional £800 million annually for the health service in Scotland.

My colleagues, Jackson Carlaw MSP, Scottish Conservative Health Spokesman, and Dr Nanette Milne MSP, Scottish Conservative Public Health and a former GP, took part in Tuesday's debate on behalf of the Scottish Conservatives. A full transcript of the debate, including Jackson and Nannette's contributions, can be found here: http://www.scottish.parliament.uk/parliamentarybusiness/report.aspx?r=10277&i=94546

I thank you again for taking the time to contact me.

Yours sincerely,

Ruth Davidson MSP

TENTATIVE CONCLUSIONS

Newspaper coverage is easy, but not very effective and can be counter-productive

Holyrood committees and parliamentary questions are accessible, involve due process, but lack bite.

There is no point in seeing a Minister unless the Minister wants to see you

Events provide opportunities to engage with MSPs

The issue has to have wide application, possibly with cross party support

New research can make an impact, especially with a simple message, a killer slide and exclusive media coverage.

A constituency letter can have surprising results, especially when your MSP is the First Minister.

So far we have achieved statements of intent recorded in reports of the Scottish Parliament.

Continued political scrutiny and pressure will be needed to see it through