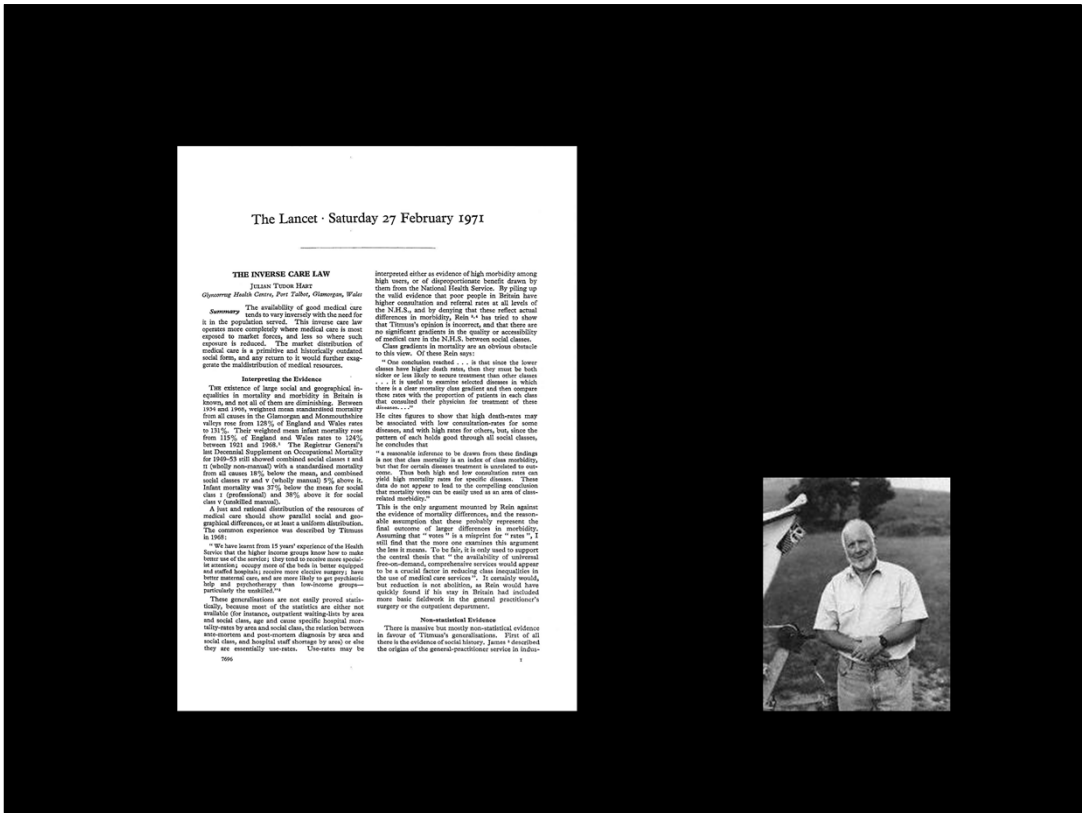

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THE INVERSE CARE LAW

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Summary The availability of good medical care tends to vary inversely with the need for it in the population served. This inverse care law operates more completely where medical care is most exposed to market forces, and less so where such exposure is reduced. The market distribution of medical care is a primitive and historically outdated social form, and any recurn to it would further exaggerate the maldistribution of medical resources.

Interpreting the Evidence

THE existence of large social and geographical inequalities in mortality and morbidity in Britain is known, and not all of them are diminishing. Between 1924 and 1963, weighted mens standardised mortality from all causes in the Glamorgan and Monmouthshire valleys rose from 128% of England and Wales rates to 131%. Their weighted mean infant mortality rose from 115% of England and Wales rates to 124% between 1921 and 1968.[1] The Registrar General's last Decennial Supplement on Occupational Mortality for 1949–53 still showed combined social classes I and II (wholly non-manual) with a standardised mortality from all causes 18% below the mean, and combined social classes IV and V (wholly manual) 5% above it. Infant mortality was 37% below the mean for social class I (professional) and 38% above it for social class V (unskilled manual).

A just and rational distribution of the resources of medical care should show parallel social and geographical differences, or at least a uniform distribution. The common experience was described by Titmuss in 1968:

> "We have learnt from 15 years' experience of the Health Service that the higher income groups know how to make better use of the service than the lower income groups (get more attention); occupy more of the beds in better equipped and staffed hospitals; receive more elective surgery; have better maternal care, and are more likely to get psychiatric help and psychotherapy than low-income groups—particularly the unskilled."[2]

These generalisations are not easily proved statistically, because most of the statistics are either not available (for instance, outpatient waiting-lists by area and social class, age and cause specific hospital mortality-rates by area and social class, the relation between ante-mortem and post-mortem diagnosis by area and social class, and hospital staff shortage by area) or else they are essentially use-rates. Use-rates may be interpreted either as evidence of high morbidity among high users, or of disproportionate benefit drawn by them from the National Health Service. By piling up the valid evidence that poor people in Britain have higher consultation and referral rates at all levels of the N.H.S., and by denying that these reflect actual differences in morbidity, Rein [3,4] has tried to show that Titmuss's opinion is incorrect, and that there are no significant gradients in the quality or accessibility of medical care in the N.H.S. between social classes.

Class gradients in mortality are an obvious obstacle to this view. Of these Rein says:

> "One conclusion reached . . . is that since the lower classes have higher death rates, then they must be both sicker or less likely to secure treatment than other classes . . . It is useful to examine selected diseases in which there is a clear mortality class gradient and then compare these rates with the proportion of patients in each class that consulted their physician for treatment of these diseases . . ."

He cites figures to show that high death-rates may be associated with low consultation-rates for some diseases, and with high rates for others, but, since the pattern of each holds good through all social classes, he concludes that

> "a reasonable inference to be drawn from these findings is not that class mortality is an index of class morbidity, but that for certain diseases treatment is unrelated to outcome. Thus both high and low consultation rates can yield high mortality rates for specific diseases. These data do not appear to lend to the compelling conclusion that mortality rates can be easily used as an area of class-related morbidity."

This is the only argument mounted by Rein against the evidence of mortality differences, and the reasonable assumption that these probably represent the final outcome of larger differences in morbidity. Assuming that " rates " is a misprint for " rates ", I still find that the more one examines this argument the less it means. To be fair, it is only used to support the central thesis that " the availability of universal free-on-demand, comprehensive services would appear to be a crucial factor in reducing class inequalities in the use of medical care services ". It certainly would, but reduction is not abolition, as Rein would have quickly found if his stay in Britain had included more basic fieldwork in the general practitioner's surgery or the outpatient department.

Non-statistical Evidence

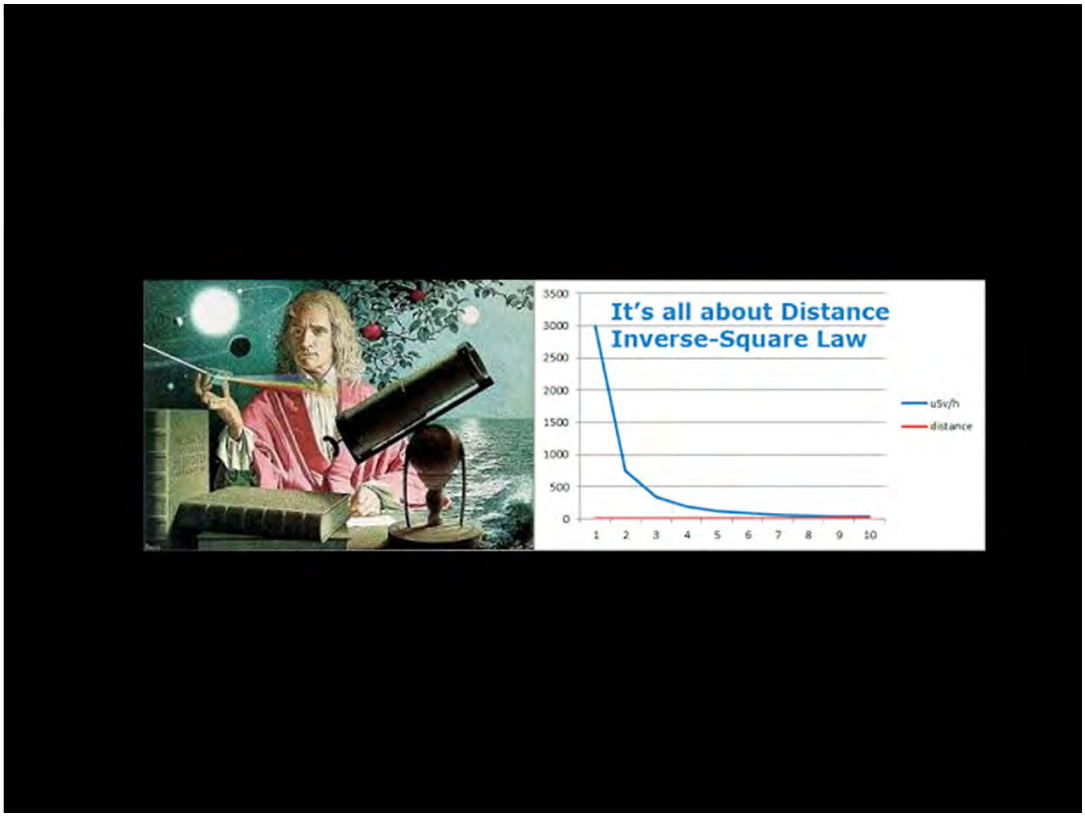
There is massive but mostly non-statistical evidence in favour of Titmuss's generalisations. First of all there is the evidence of social history. James [5] described the origin of the general-practitioner service in indus-

SLIDE 1

It is nearly 50 years since Julian Tudor Hart first described the Inverse Care Law, observing that the availability of good medical care tends to vary inversely with the need for it in the population served

SLIDE 2

People think that because the NHS deals with emergencies in an equitable way, it does so for everything, but that's not the case with access to specialists, nor is it the case in ordinary general practice.



SLIDE 3

The original paper was more of a polemic than a scientific paper. Its main target was private medicine, then as now, ready to seep poison into the system. It also highlighted the maldistribution of doctors and resources, relative to need, and the difficulty of practising the best medicine in such circumstances.

The phrase "inverse care law" was an adaptation of Isaac Newton's Inverse Square Law. In physics, an *inverse-square law* is any physical *law* stating that a specified physical quantity or intensity, such as gravity, is *inversely* proportional to the *square* of the distance from the source of that physical quantity. But the Inverse Care Law is not a law of nature, it's a man-made policy that restricts care in relation to need, in direct contradiction to what our NHS is supposed to stand for.

The paper has now been cited over 2500 times, according to Google Scholar, or nearly 1000 times according to the Web of Science, which is more than Tudor Hart's 25 next most cited papers put together. But although the paper has become famous, the problem it described remains. The monstrous longevity of the Inverse Care Law

SLIDE 4

Willie Fulton died nearly 20 years ago, aged 81, after a professional lifetime as a GP in Glasgow, starting practice in 1945. He lived in Jordanhill and practised in Scotstoun. For 32 years he was secretary of the Glasgow LMC, but he was also active in the College and the GMC. Perhaps his biggest impact he had in Glasgow was the incorporation of large numbers of general practices in health centres.

Some people here will remember him, always smart in a suit, his hair plastered down. For some reason, I have a memory of him wearing a leather helmet, the type that fighter pilots used to wear, holding a stopwatch, in all weathers, as a list A registered timekeeper at meetings of the Scottish Sporting Car Club.

Willie Fulton was a general practitioner through and through. We know that from his writing, with at least 4 pieces accessible via the web – including a 6 page BMJ report of a study tour of health care in the US, and a report in the Journal of the RCGP of his contribution to a conference on the art and science of medicine. Both have timeless elements and are worth reading

At a conference in Swansea in 1973, he spoke and wrote about psychotropic drugs, emphasising the need to make positive diagnoses, not just identifying mental health problems when physical causes have been excluded. He argued that GPs must learn to recognise fear as easily as fever, anger as well as angina and envy as they would eczema. While recognising the advantages of health centres, in terms of access to shared facilities, he was in no doubt about the need to preserve, within that context, the dedicated family practitioner role. He had no time for “nine to fivers”.

Slide 4 (i)

At the Swansea conference, he met Julian Tudor Hart. I worked with Julian in the 1980s and something I remember very clearly is the fond way he talked about Willie Fulton. Recently, he told me how they met.

The Swansea conference was chaired by a leading psychiatrist of the time, a great believer in psycho-active medication, in pre-frontal leucotomy, and non-believer in psychoanalysis or anything resembling what we now call cognitive therapy.

After lunch, the great man announced that as the meeting was running over time, and he still had some important further words to say, he had decided that the paper from Dr Willie Fulton would not be presented. All hell broke loose from everyone at the conference, not just from GPs but all the other eminent and interested parties. To which the great man replied, " Dr Fulton, you may not realise it but the people who came to this conference came here expecting to hear me. They did not come to hear you". At this point, he was drowned out by the thunderous chorus of dissent from virtually everyone attending. Willie Fulton proceeded to present his paper and you can read what he said in the Journal account.

After which, Willie and Julian became friends, unlikely friends in view of their political views. Julian had stood for parliament as a communist. There was never any prospect of Willie Fulton doing that. Julian, in his 90th year, wrote recently, "I met Willie several times after that, at other conferences, as friends and, for the most part, as allies. He was one of the reasons I came to believe that despite the general political illiteracy of practising doctors, they would have increasing potential as a progressive force in society, as history squeezed out corner shop practice and replaced it with evidence-based teamwork. I think he would have come over to our

side, had he lived another 50 years or so”.

Slide 4 (ii)

In his retirement, Willie Fulton did locums and in 1991 he wrote in the College Journal, “Being by nature a “slow” doctor myself, my work as a locum in various Glasgow practices over the last few years has been enlightening”.

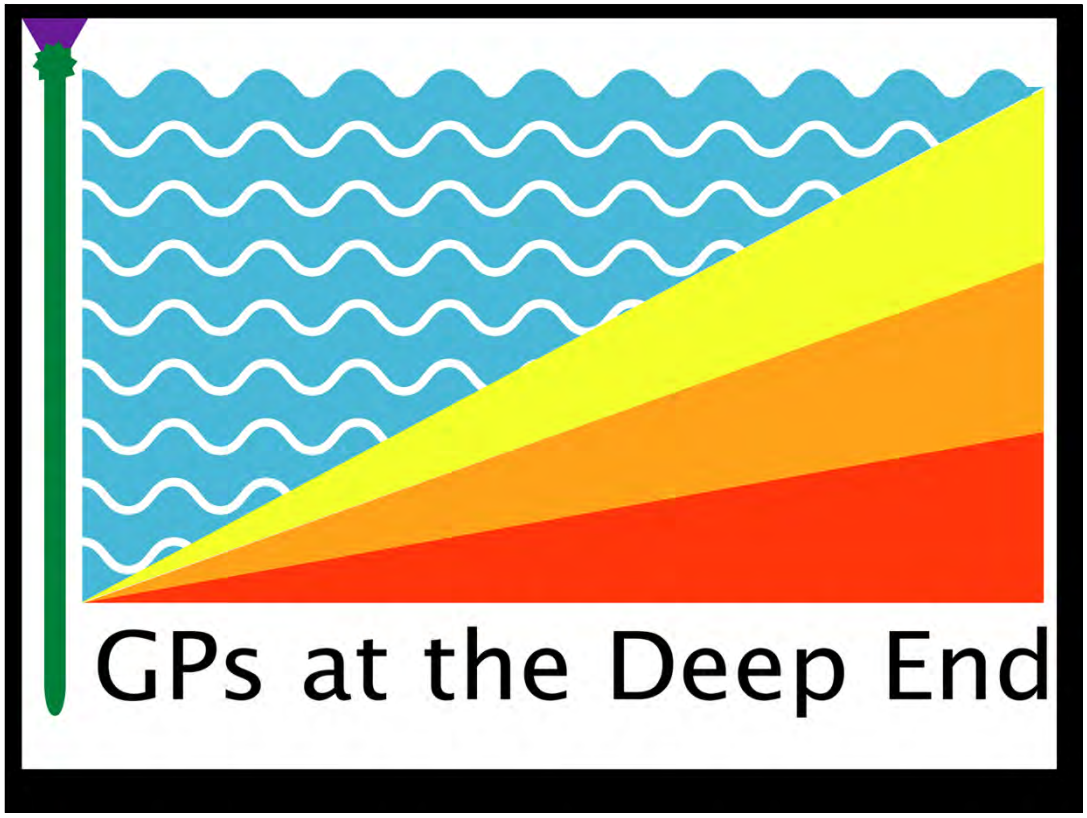
It was on one of these locums, that I had a personal consultation with Willie Fulton, who was standing in for my own GP at Woodside Health Centre. Perhaps I am the only Fulton lecturer to have had a consultation with Willie Fulton. It lasted at least 30 minutes, was full of chat, kept other patients waiting, and while I don’t recall the details, I’m sure I felt better for it.

Willie Fulton, wrote of his locum experience, “In some quality practices the consultations were at 10 minute intervals; others had 5 minute appointments and many extra appointments. In the former I saw 12 patients in two hours and then had time to attend to all the paper work; in the latter, mainly in the peripheral housing schemes, I saw 35 to 40 patients in three hours. I am in no doubt about the quality of care, or lack of it, in these situations.

He went on, “My observations (only impressions and not properly researched) confirm Julian Tudor Hart’s inverse care law. It is the patients in these areas of high deprivation with the greatest demand on services and the shortest consultation times who would benefit most from longer consultation times, where their doctors could try help solve their problems and offer advice to improve their physical, psychological and social health.

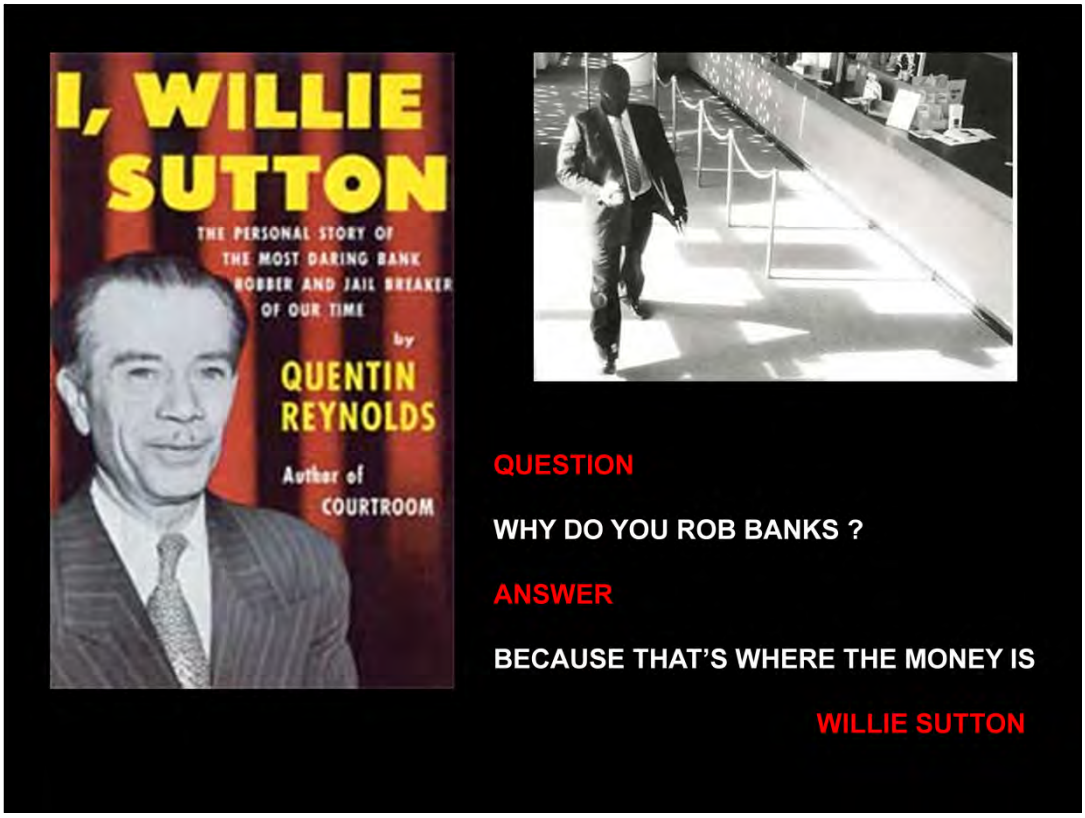
Slide 4 (iii)

The motivation of the doctors in these areas is high and they have been justly called medical missionaries. What has the new contract to offer them? What is the RCGP's role in supporting them? At the very least we must try to keep up their morale and avoid "peripheralizing" them, like the parts of our cities in which they work".



SLIDE 5

I could not have a better introduction. But I disagree with “medical missionaries”. In my experience, GPs in deprived areas are ordinary men and women, doing their best, not missionaries. In 2009, when we had the first national Deep End conference, for GPs working in the 100 most deprived practices in Scotland, they had never been convened or consulted by anyone. Now they have identity, profile, voice, coherence, impact and increasingly, shared activity. I’m going to talk next about General Practitioners at the Deep End.



SLIDE 6

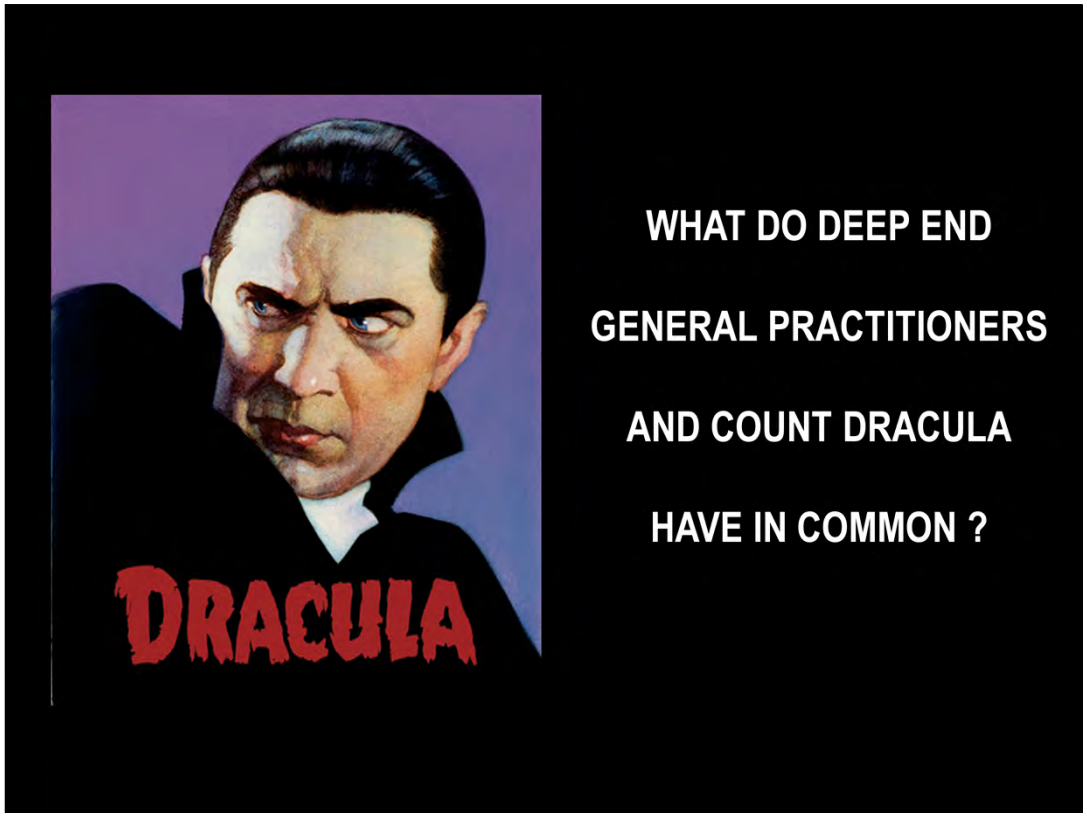
When asked why he robbed banks, Willie Sutton replied, "Because that's where the money is". Why the Deep End? Because that's where the deprivation is.

SLIDE 7

Not pocket deprivation, the small numbers of deprived patients to be found in most practices, or hidden in rural communities, but the blanket deprivation that dominates everything a practice does.

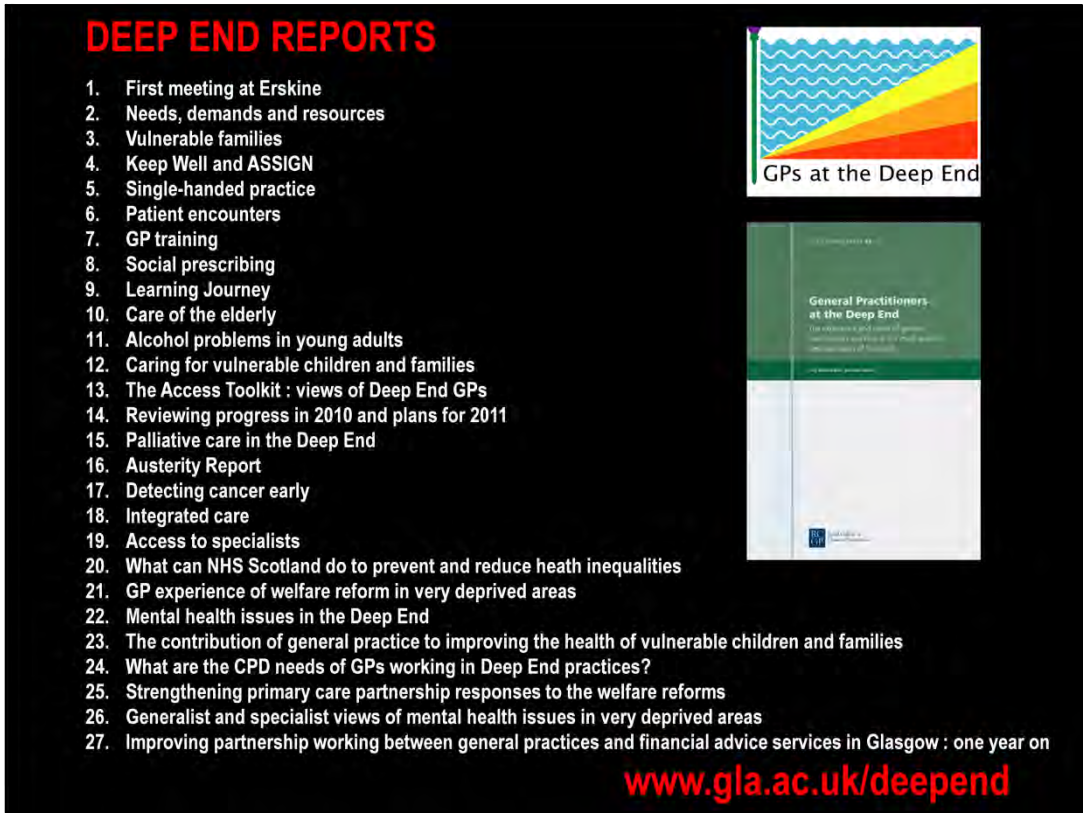
SLIDE 8

The beating heart of the Deep End Project, has been the steering group, an informal group of 10 to 16 GP colleagues, meeting every six weeks or so, in their own evening time. We don't usually have food and wine, but after 50 meetings, it seemed reasonable to celebrate. If it hadn't been for the steering group, the Deep End Project would have been just another short term initiative, trying to change general practice from the outside.



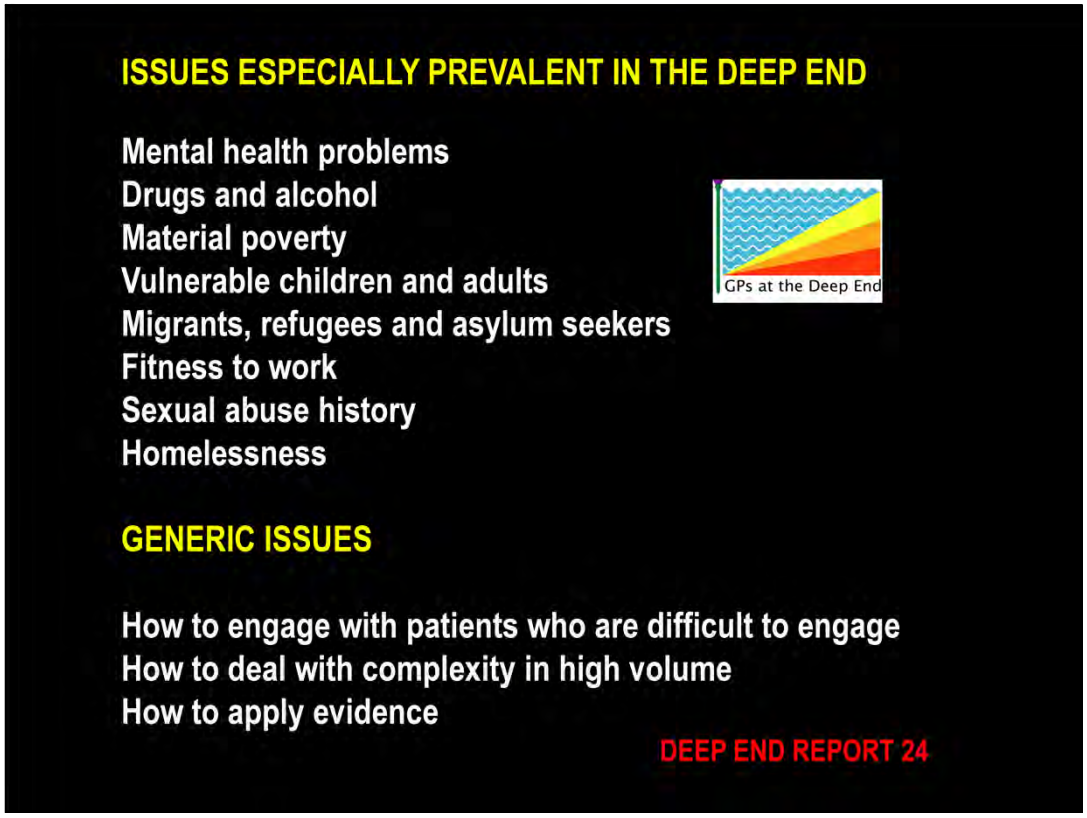
SLIDE 9

What do Deep End practitioners and Count Dracula have in common? They only come out at night, being occupied during the day. At the beginning we needed a locum budget that got colleagues out of practice, so we could capture their views and experience.



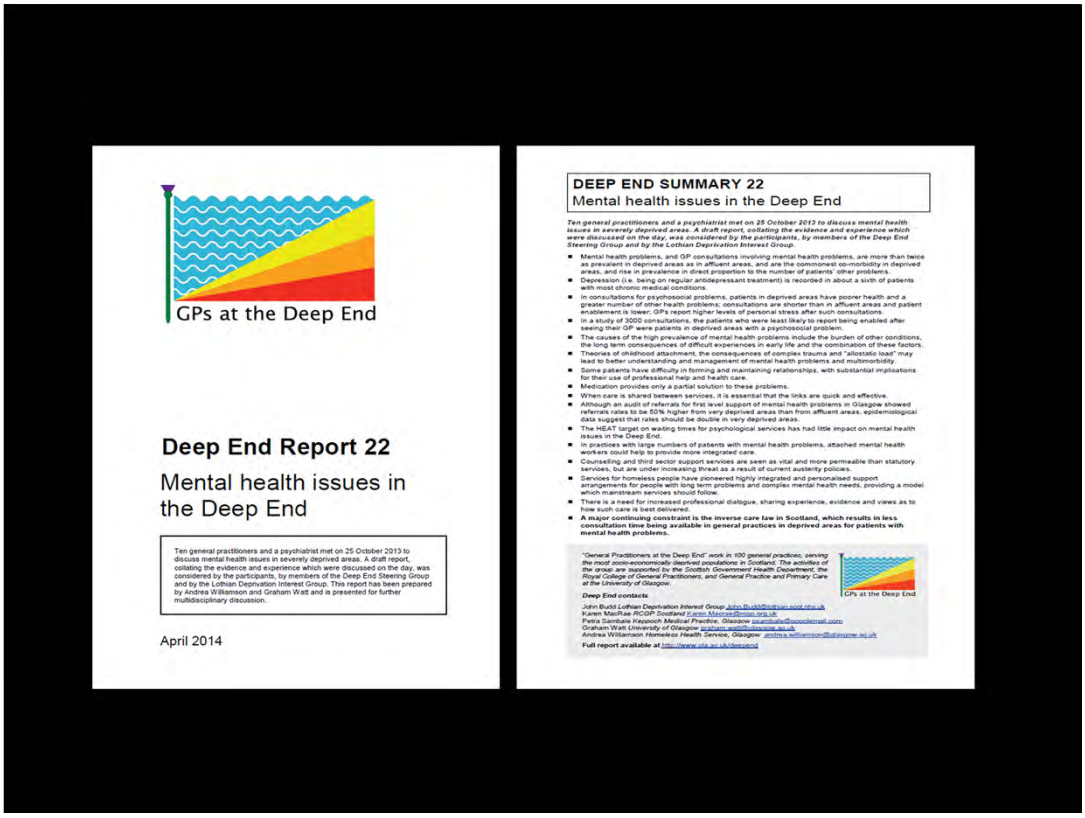
SLIDE 10

Which led to nearly 30 reports, all in short and long forms, available on our website, capturing GPs' experience and views on a range of topics, in language that is jargon-free and easily understood.



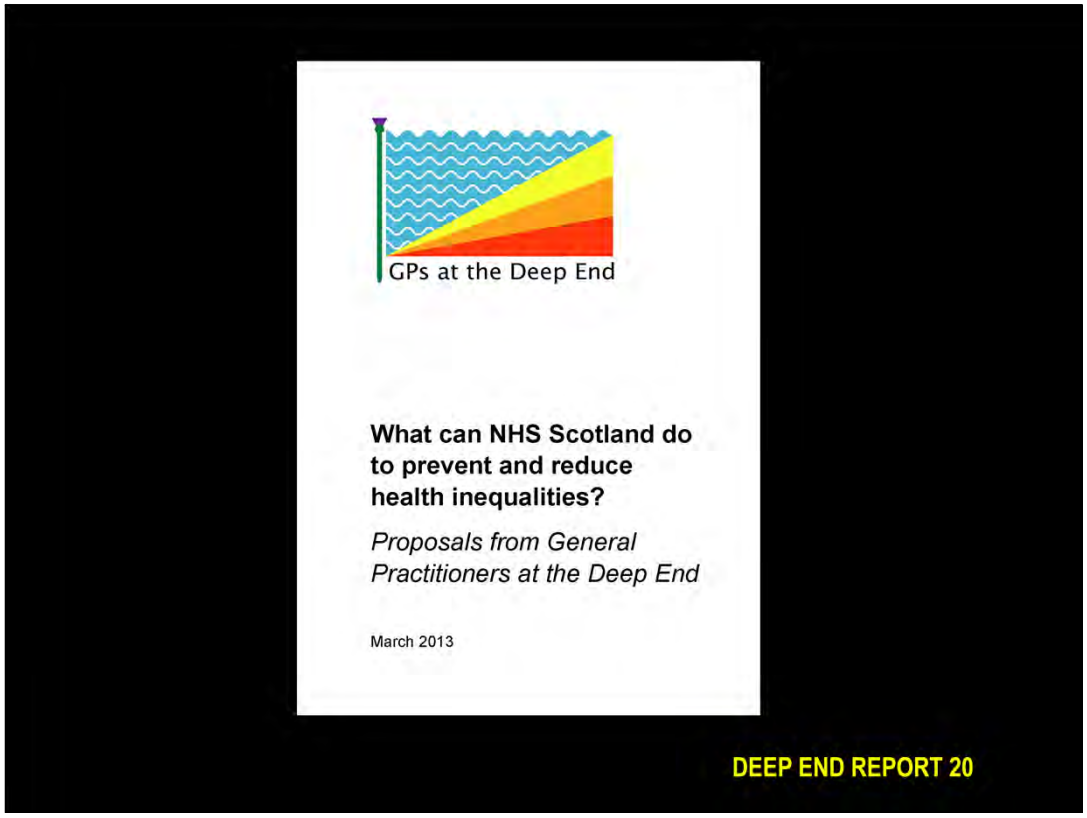
SLIDE 11

For example, this report on CPD needs identified the usual list of topics that occur most often in Deep End practice, but also generic issues, such as how to engage with patients who are difficult to engage, how to deal with complexity in high volume and how to apply evidence when so little of it is based on the types of patients you see in practice.



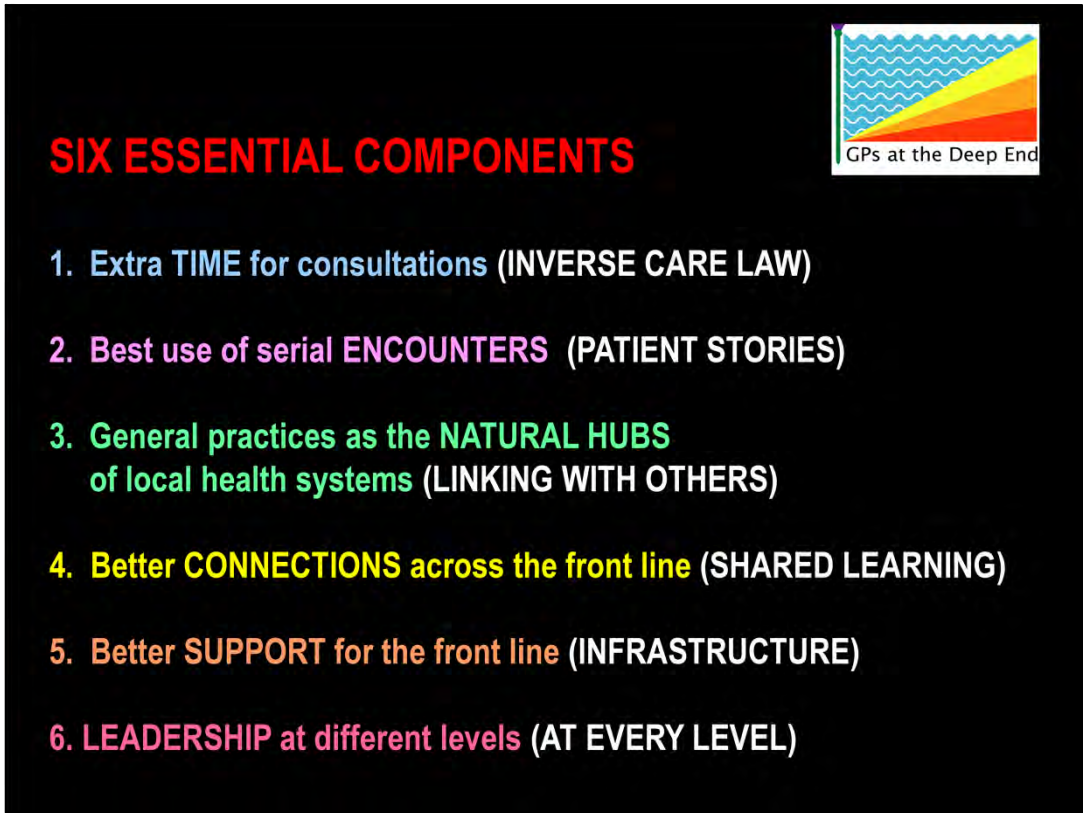
SLIDE 12

This report on mental health issues complimented local mental health services but pointed out that they leave a lot for general practice to do, with patients who don't meet referral criteria, are not good at accessing services or who are not made better by the protocols on offer.



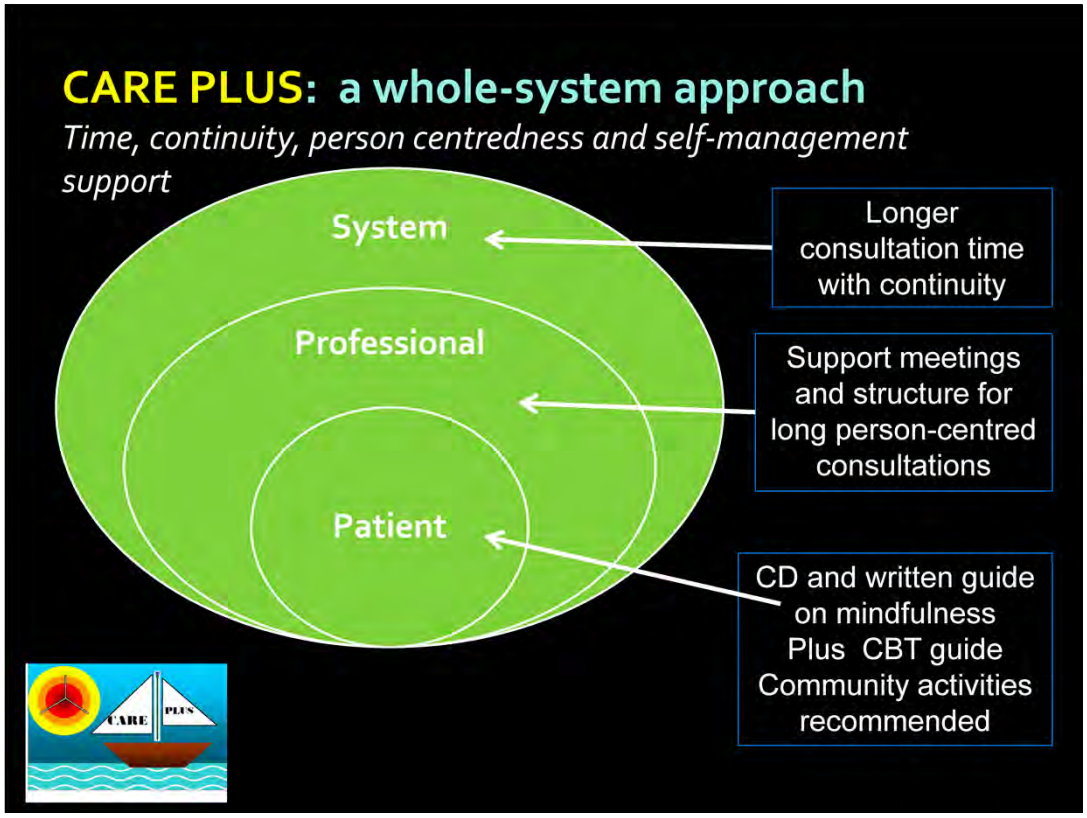
SLIDE 13

The Deep End Manifesto was published in 2013, in Report No 20.



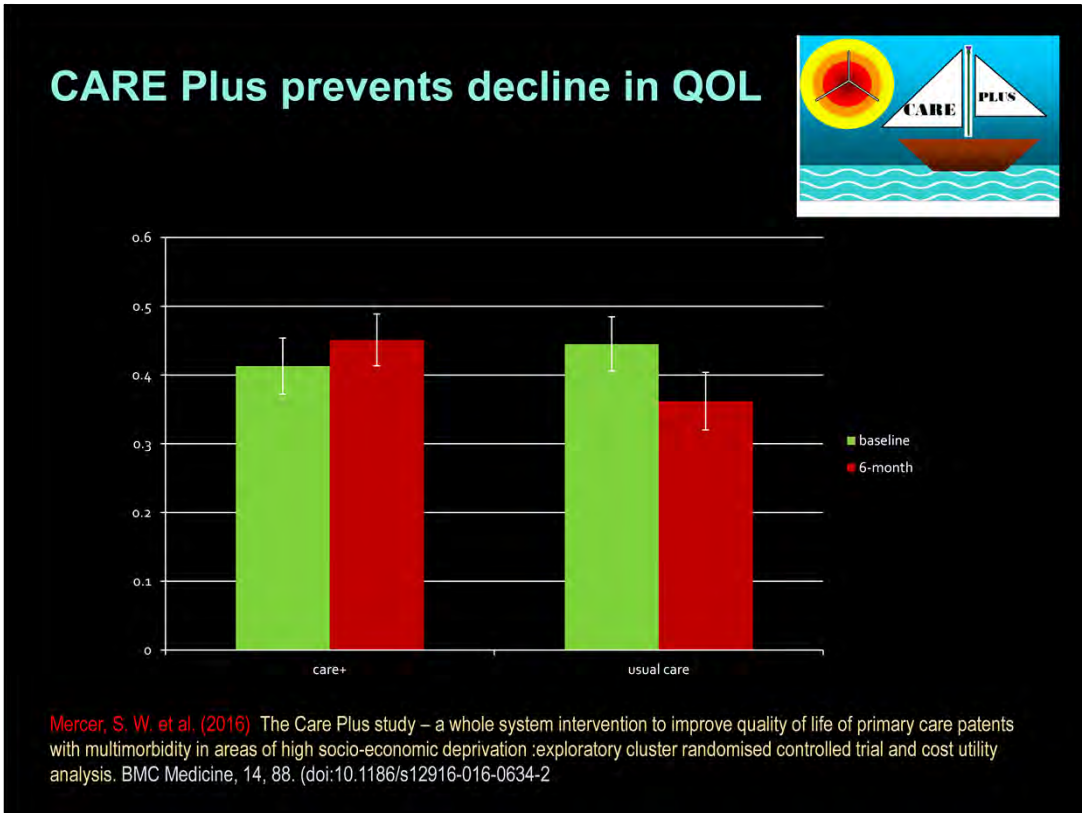
SLIDE 14

It argued for: extra time, to address the inverse care law; better use of serial encounters, to build patient narratives; general practice as the natural hub of local health systems; better connections across the front line, for shared learning; better support from central organisations; and stronger leadership at every level, sharing power, resource and responsibility. I'm going to describe four projects, giving expression to these aims.



SLIDE 15

The recently published CARE Plus Study, led by Stewart Mercer and Bridie Fitzpatrick, involved 152 patients in 8 Deep End Practices in a RCT of extra consultation time for complex patients, plus support for practitioners and patients. About an hour extra per patient per year, spent mostly on a long initial consultation.



SLIDE 16

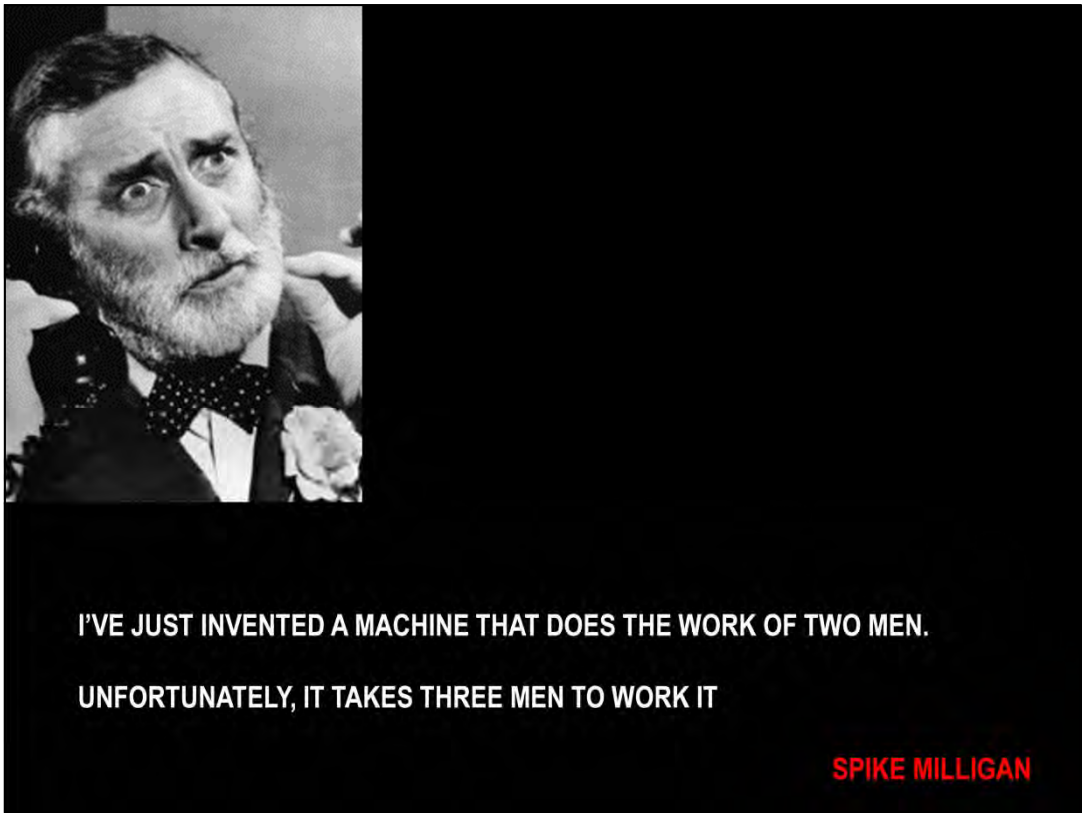
After 6 and 12 months, Quality of Life was higher in the intervention group, on the left, not so much because it improved in this group, but because it got worse in those not getting the intervention, on the right. The intervention slowed decline. That's a crucial observation.

SLIDE 17

And it was cost-effective, coming well below the NICE threshold. If this were a drug or technology, it would be funded, and sail into policy and practice.

SLIDE 18

The Link Worker Programme has embedded a full-time community links practitioner in 7 Deep End practices. They do several things: connecting with community resources, helping patients who need help to access community resources, one to one serial encounters. But when link workers also help patients floundering between dysfunctional and fragmented health care arrangements, a bigger issue is being addressed.

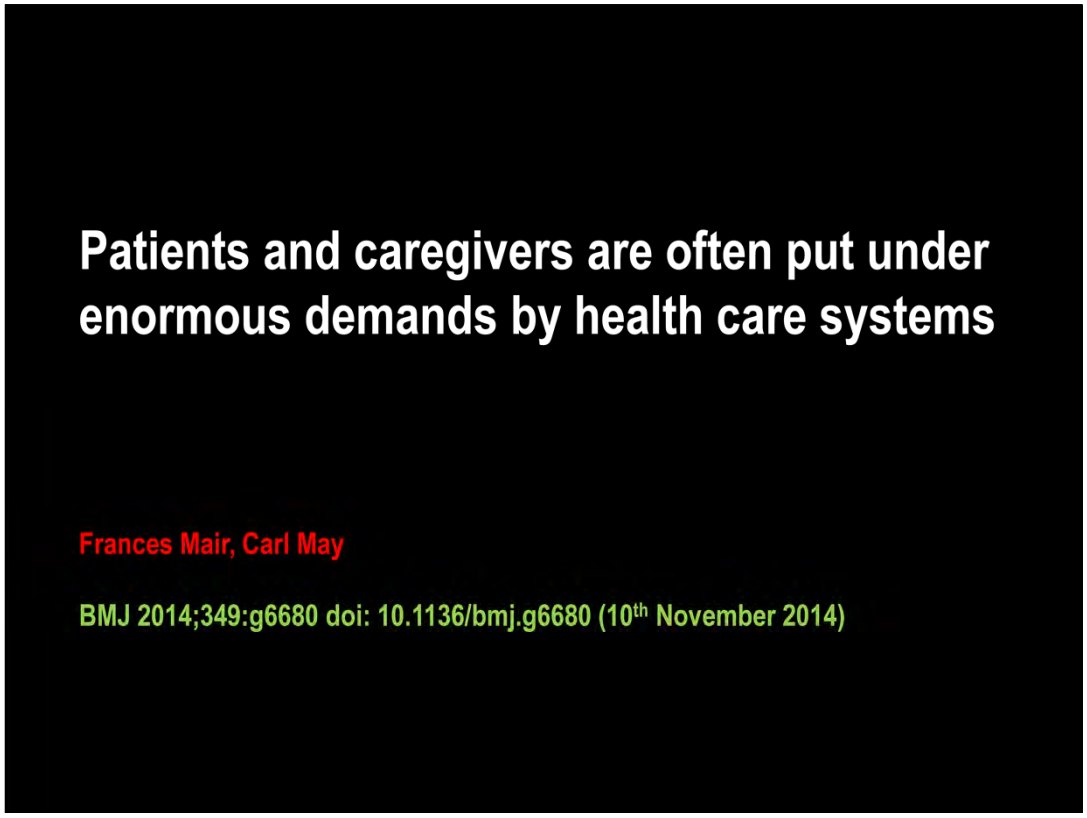


SLIDE 19

Spike Milligan described a machine that did the work of two men, but took three men to work it. Modern health care in a nutshell.

SLIDE 20

There are too many hubs, or centres doing a particular thing, with referral criteria, waiting lists to control demand, evidence-based protocols to deliver, and discharge back to practice when they're done. All that may be done well, but as I repeat, specialist services often leave a lot for general practice to do, with patients who don't fit the criteria, are not good at accessing unfamiliar services or who are not made better by treatment.

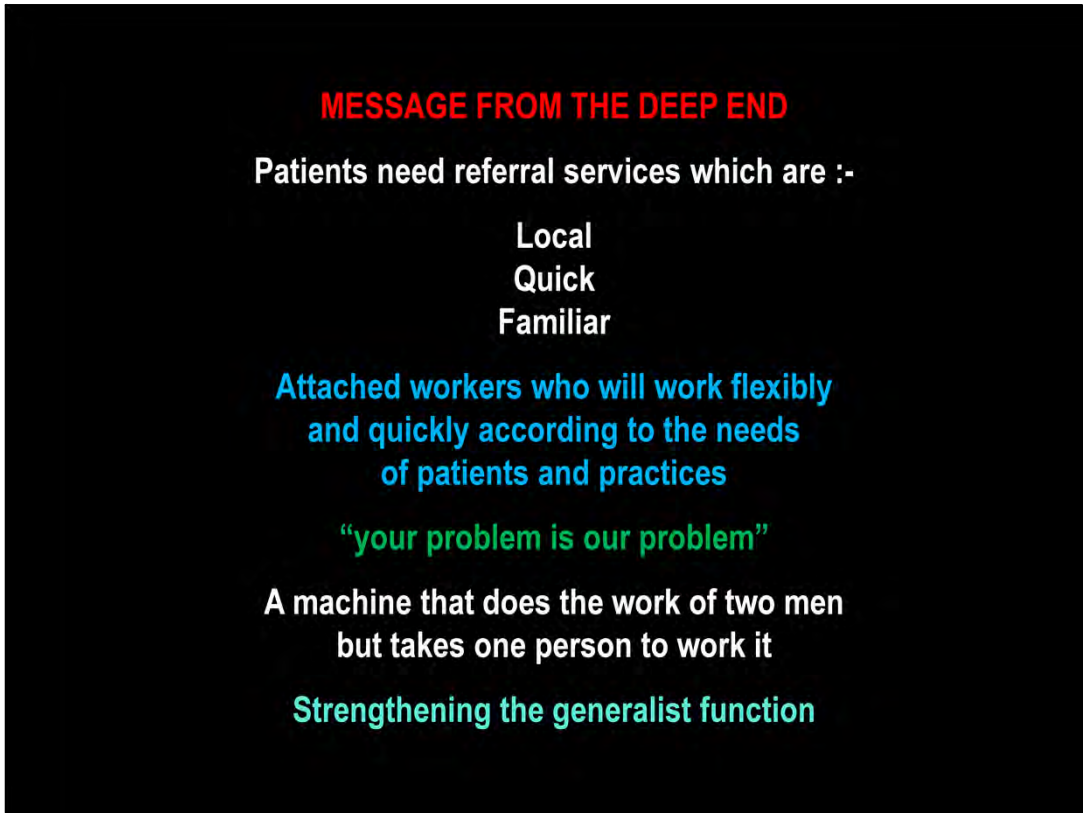


SLIDE 21

When patients with multiple problems have to attend multiple clinics, life is made more difficult by what's been called the "treatment burden". What's convenient for professionals and services is often burdensome for patients. The irony is that while everyone is practising "patient-centred medicine", somehow the patient isn't at the centre.

SLIDE 22

For some patients, healthcare is like a pinball machine



SLIDE 23

Link workers often help patients engage with the services they need. In doing so, they support rather than challenge dysfunctional, fragmented arrangements.

In the Deep End, patients need referral services that are quick, local, and familiar; preferably via attached workers who can work flexibly according to the needs of patients and practices, not external criteria. Accepting that “Your problem is our problem”.

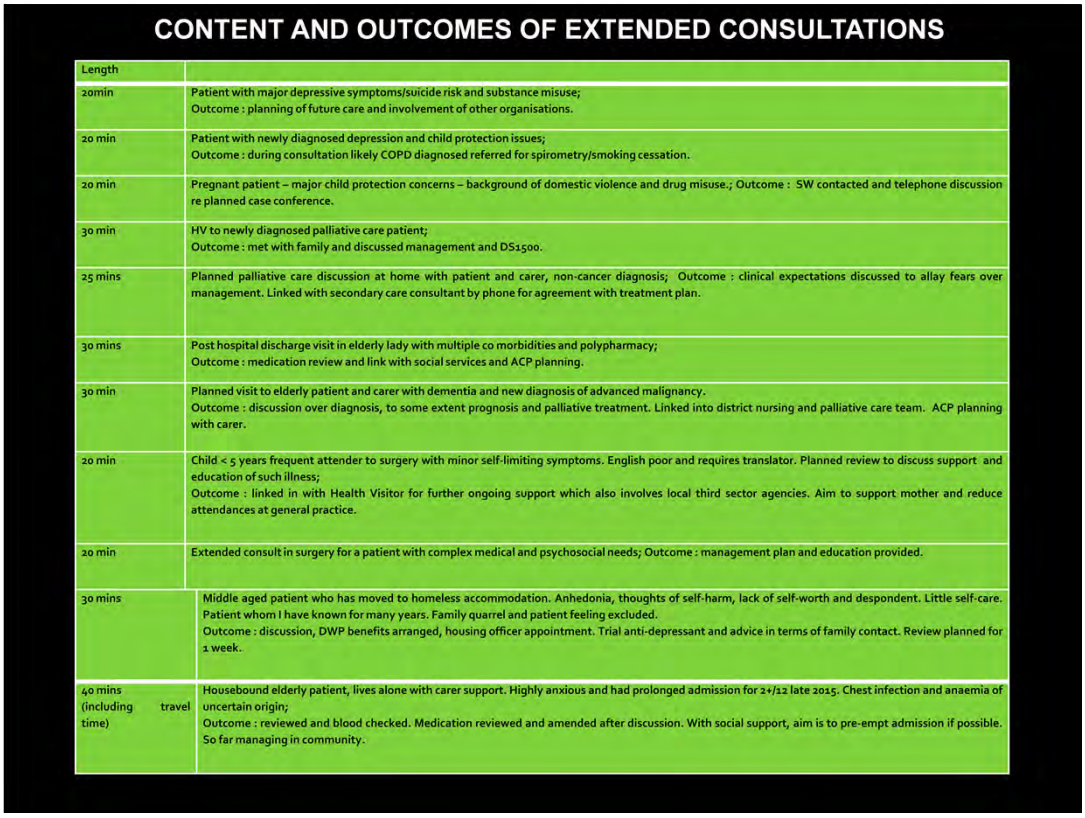
The health care equivalent of machines that do the work of two men, but need only one person to work them, are small local teams of doctors, nurses, link workers and others, working as generalists, unconditionally, knowing their patients well.

SLIDE 24

The Govan SHIP Project (standing for Social and Health Integration Partnership, but based near shipyards that built the Queen Mary) adds clinical capacity (about 10%) to 4 Deep End practices via permanent locums, releasing a protected session per week for all 15 GPs. There are two attached social workers, 2 attached link workers and support for monthly multidisciplinary team meetings in each practice.

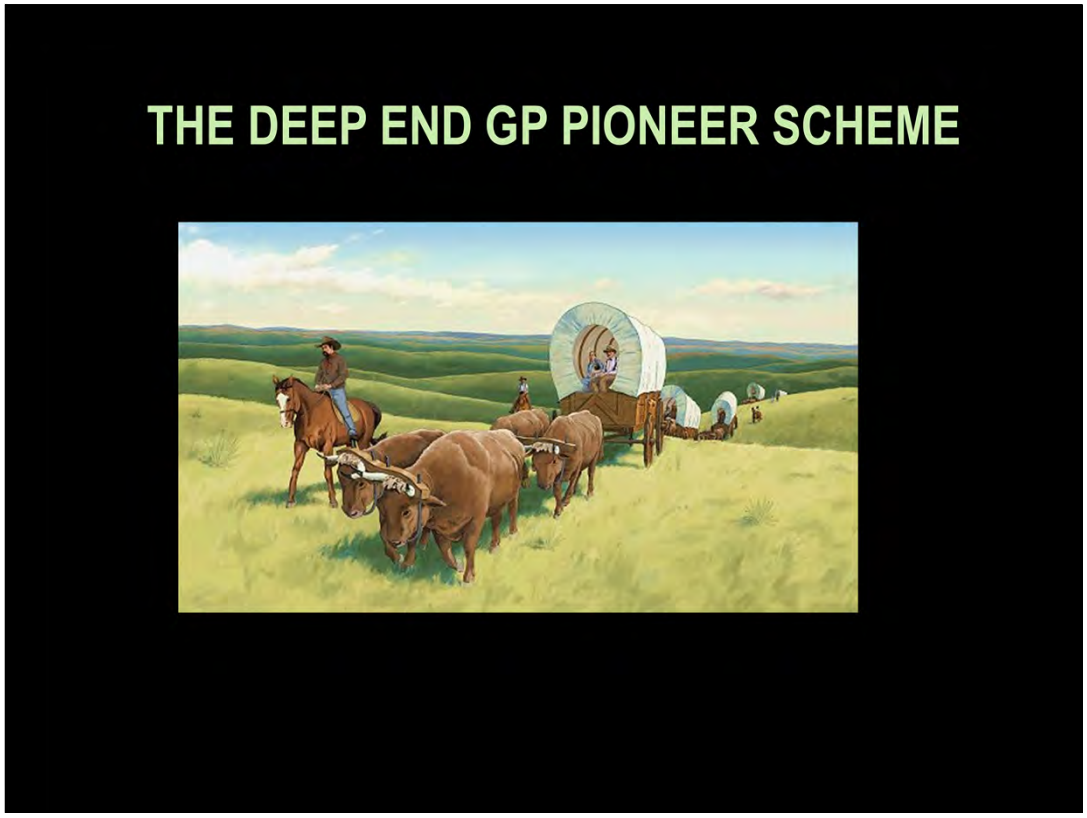
SLIDE 25

This audit described what the 15 GPs did with their protected sessions during two weeks in February. 136 documented activities, of which 76 were extended consultations, in the surgery or at home, and 14 were case note reviews without the patient being present.



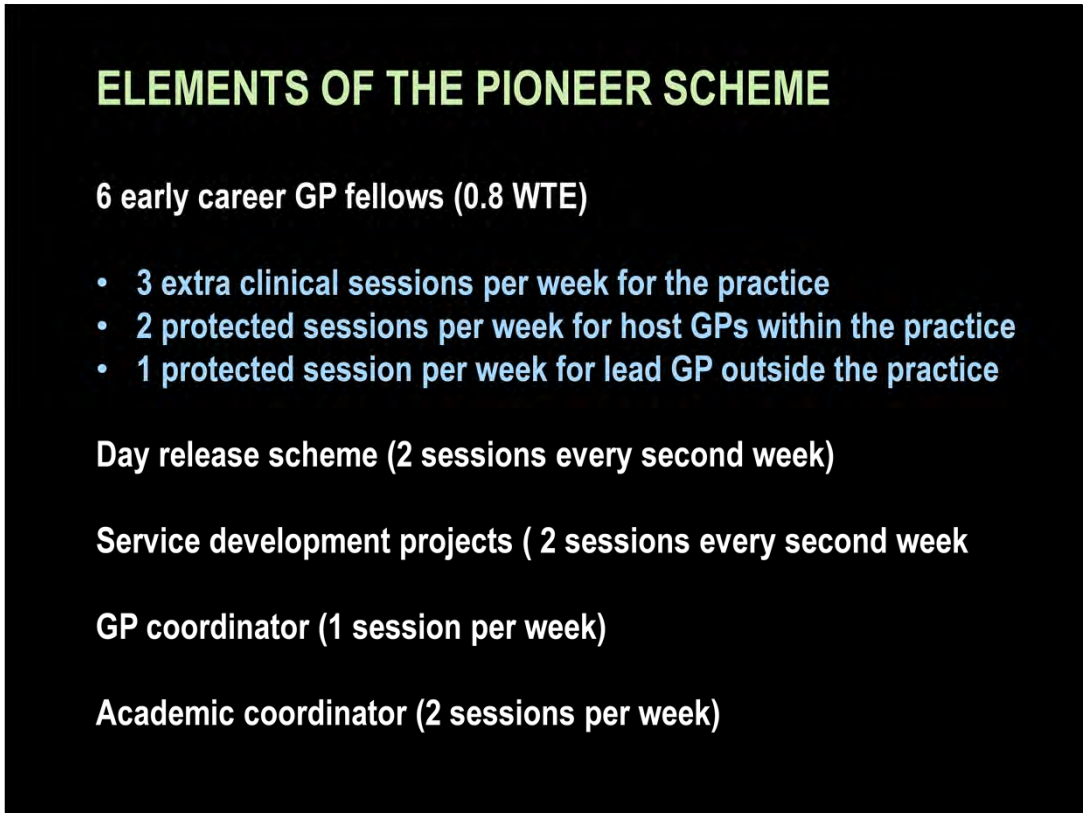
SLIDE 26

Here is a sample of the extended consultations, all for complicated combinations of medical, psychological and social problems. In one sense they are all different; in another, they are all the same, requiring unconditional, personalised, coordinated, continuity of care. This work, driving integrated care from a re-assessment of patients' problems needs clinical generalists, not nurses or pharmacists working in circumscribed areas. Every case demonstrates unmet need, or more precisely, uncoordinated care, the consequences of the inverse care law, that added clinical capacity can address. Deep End report 29 is on the web and I commend it to you.



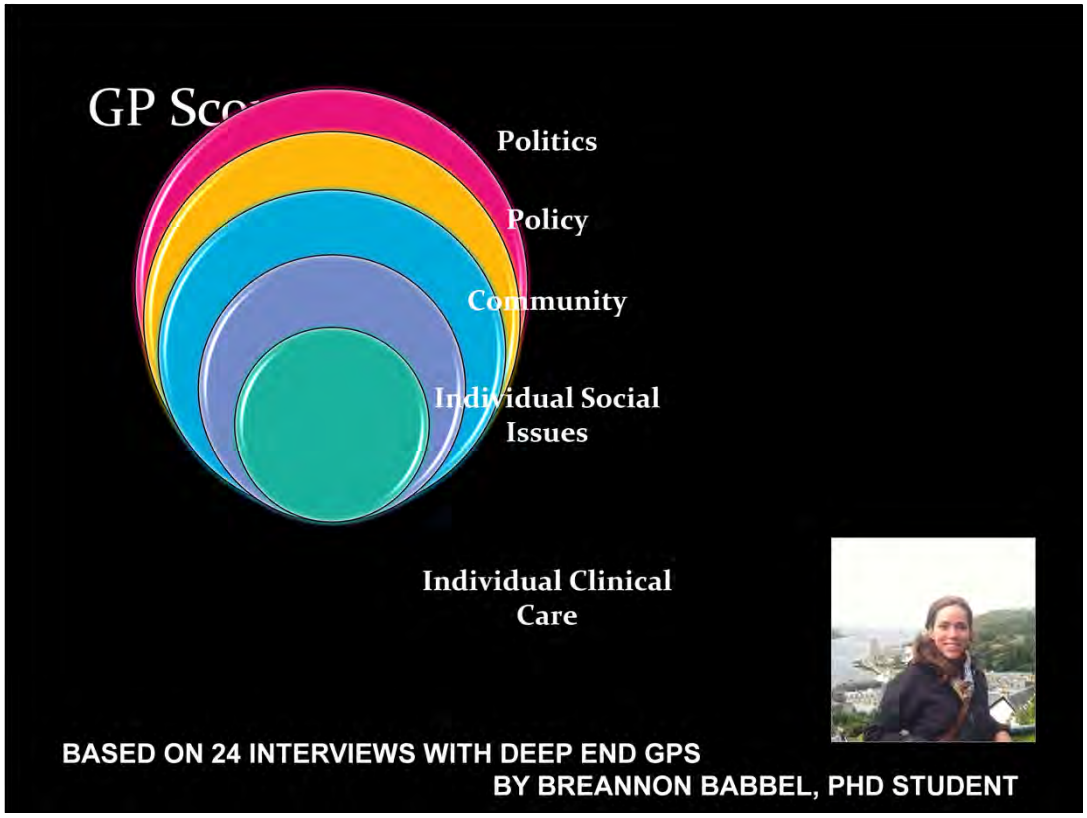
SLIDE 27

We are excited by the new Deep End GP Pioneer Scheme.



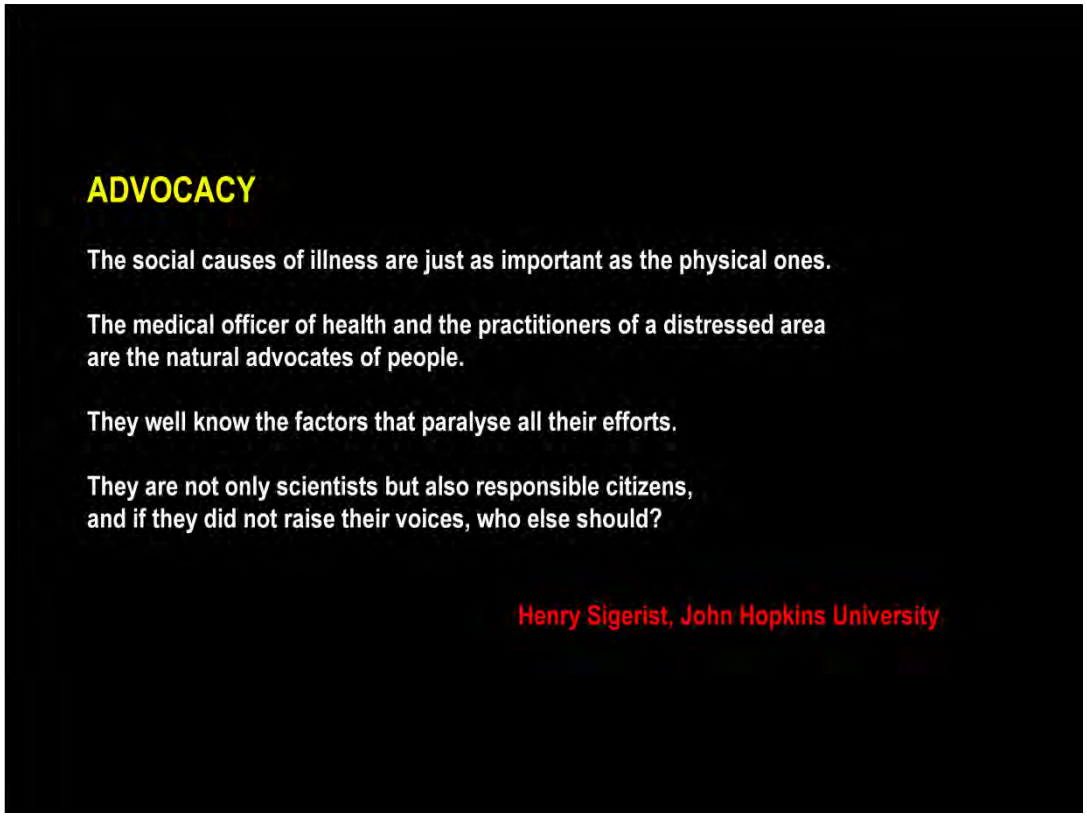
SLIDE 28

6 early Career Fellows have been appointed, and attached to 6 host practices. Their 8 sessions per week comprise three extra clinical sessions for the practice (about 10% extra), 2 protected sessions per week for host GPs to use as they wish; 1 protected session per week for a lead GP to help run the Scheme; and 2 protected sessions per week for the Fellows to attend a day release programme, addressing their own learning needs as Deep End GPs and, in doing so, producing learning materials and activities for others to use. Fellows and lead GPs will work together a programme of service developments. There are extra sessions for GP and academic coordinators. It is a huge opportunity for GP-led, primary care transformation, addressing GP recruitment, retention and new ways of working.



SLIDE 29

My PhD student, Breannon Babbel from Oregon, interviewed 24 GPs working in very deprived areas to ask them what they thought their role could be. Some saw no further than the conventional medical model; others broadened the consultation to include social issues; others looked outside their practice to the local community; while others took advocacy positions, trying to influence local and national policies, engaging with managers and politicians



SLIDE 30

Take advocacy. As Sigerist put it, “The practitioners of a distressed are the natural advocates of people. They well know the factors that paralyse all their efforts. They are not only scientists but also responsible citizens, and if they did not raise their voices, who else should?”

SLIDE 31

…… a role exemplified by several Deep End Reports on the havoc being wrought on patients by changes to the welfare benefit system. Based on the recent experience of practitioners and patients, these reports had huge authority, and travelled fast.

SLIDE 32

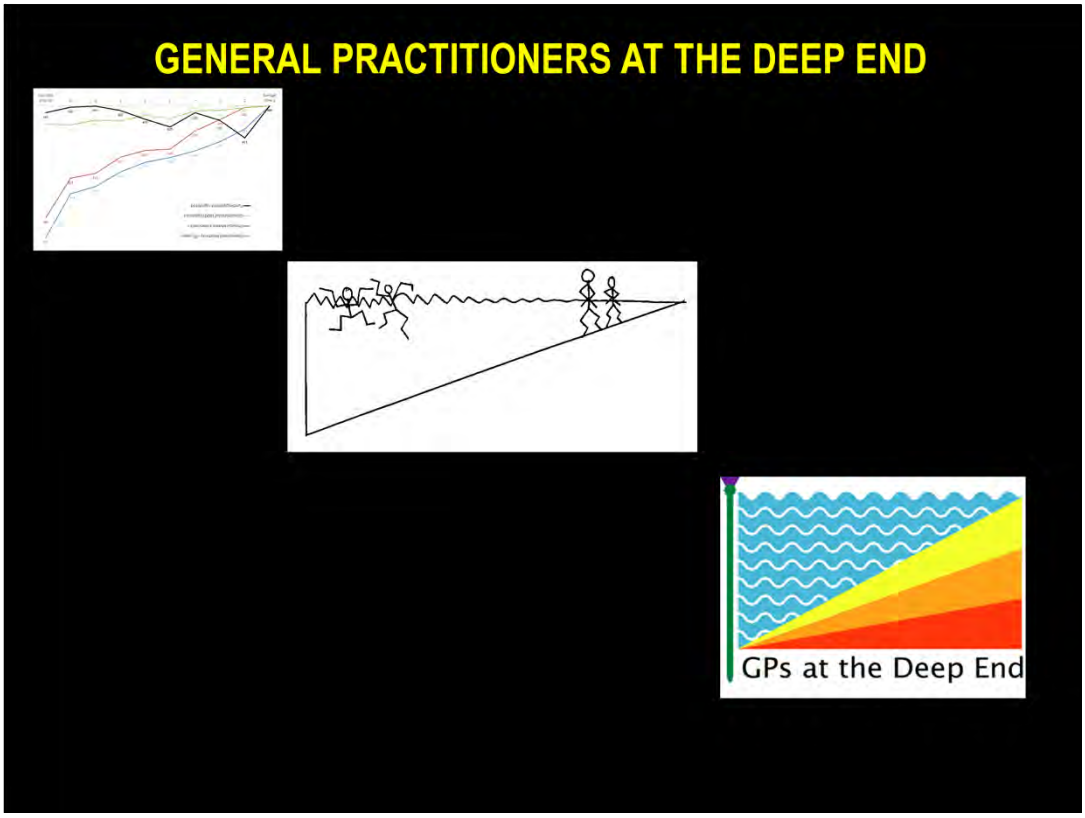
But our main advocacy activity, that I'm going to describe next, has concerned the inverse care law.

In 2002, I had an essay published in the Lancet, entitled, "The Inverse Law Today", now cited over 200 times (which is pretty good – it's a great leveller to see how rarely much of one's written output is cited).

I argued that Julian's original paper was no longer sufficient, that as health care was increasingly able to improve health and prolong lives, the inverse care law was now an important determinant of public health, and widening health inequality. This paper also introduced the metaphor of the swimming pool, family doctors in deprived areas treading water in the deep end, receiving deprivation payments for their trouble.

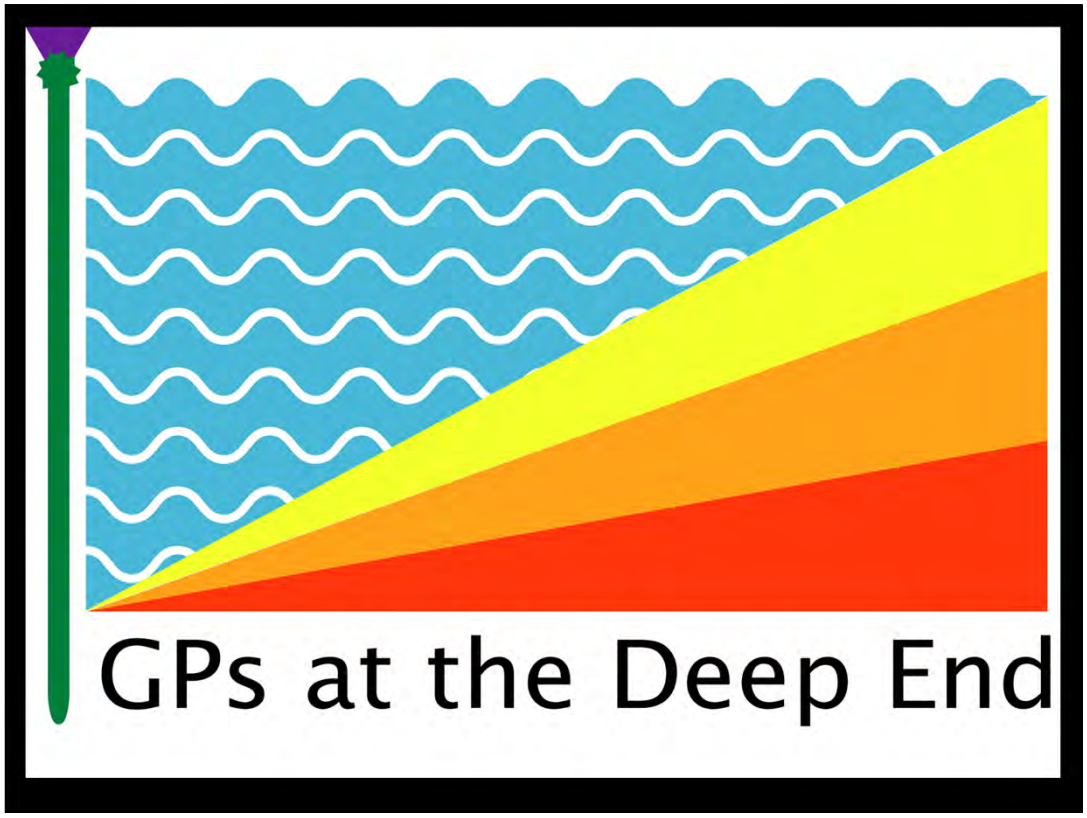
SLIDE 33

In 2005, Danny Mackay, Matt Sutton and I published a short paper in the BMJ showing the generally flat distribution of GPs in whole time equivalents, across tenths of the distribution of deprivation in the general population. The data were used subsequently to produce this figure, which appeared in 2008 in a report of the Glasgow Centre Population Health, the only report in the entire history of that Centre which has ever mentioned or commented on general practice numbers being a public health issue in Glasgow. Greater Glasgow and Clyde Health Board, the University of Glasgow and the Royal College of Physicians and Surgeons have been similarly silent.



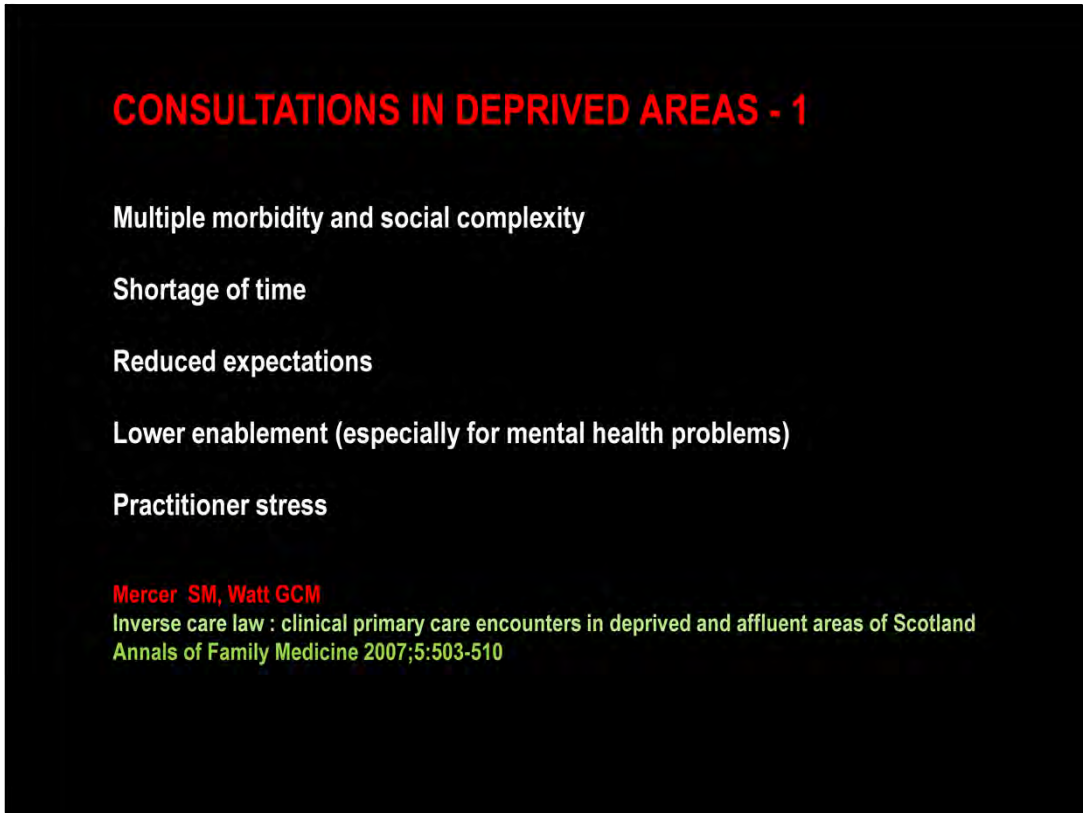
SLIDE 34

Turn the slide upside down, and the swimming pool takes shape, with a deep and shallow end



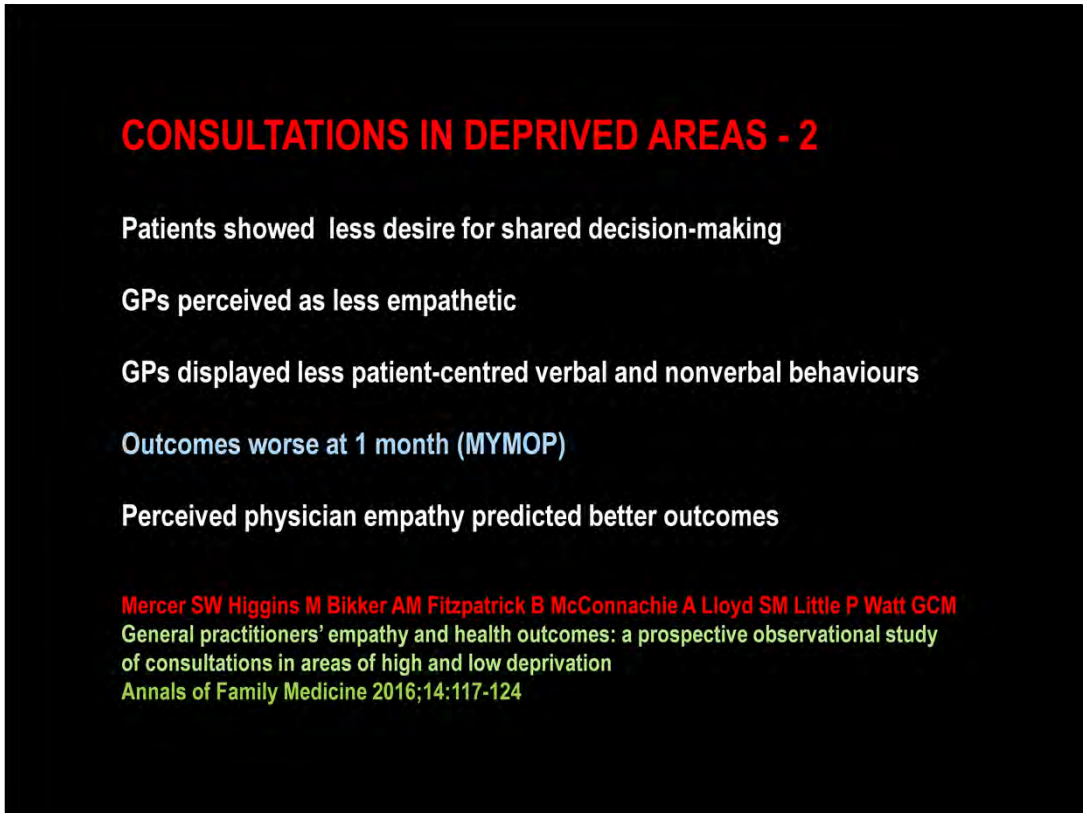
SLIDE 35

The Deep End logo shows the swimming pool, the steep gradient of need, the flat slope of resource, a sunrise or a sunset, a thistle and a spurtle, that's a traditional kitchen stirring implement. The whole thing is a flag, for rallying under. There are similar logos, with different colour schemes, for Deep End Projects in Yorkshire and Humber, and in Ireland.



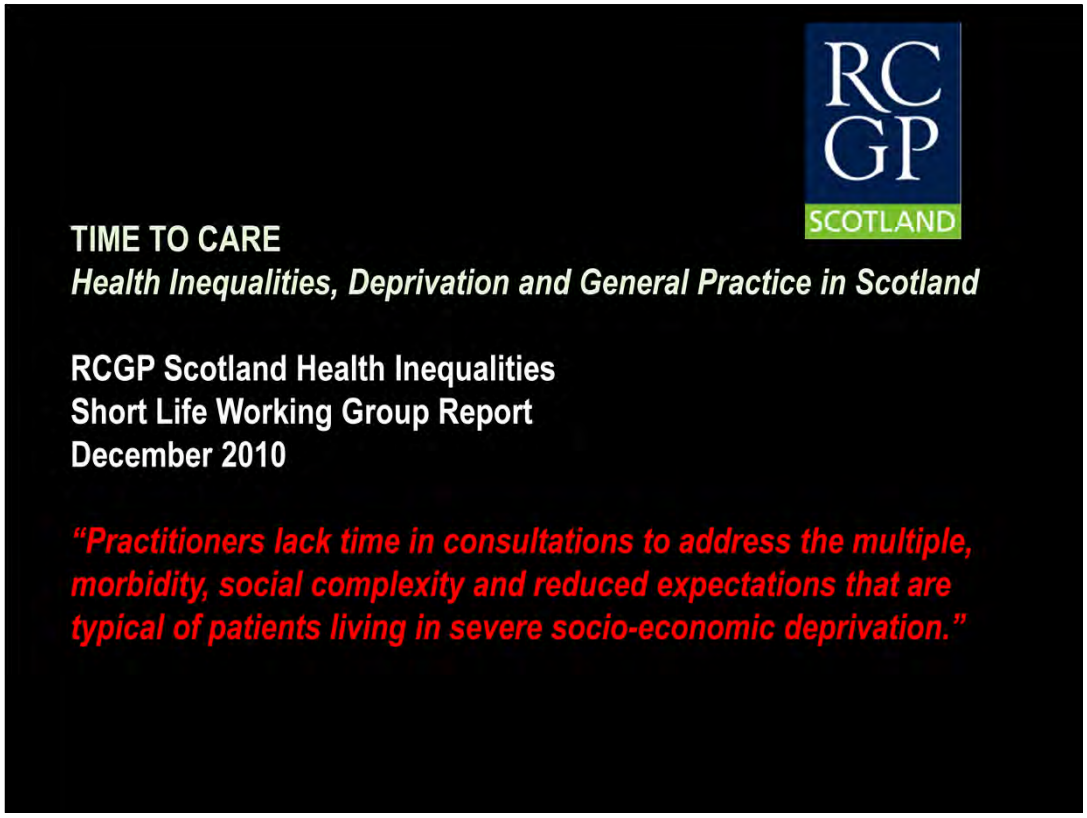
SLIDE 36

In 2007, Stewart Mercer and I published this paper in Annals of Family Medicine, describing the consequences for patients and practitioners of being in the Deep End – more problems to deal with, less time to deal with them, lower enablement, especially for patients with mental health problems, the commonest co-morbidity in deprived areas, and greater GP stress.



SLIDE 37

A similar paper, published earlier this year showed that outcomes were also poorer after one month in deprived areas.

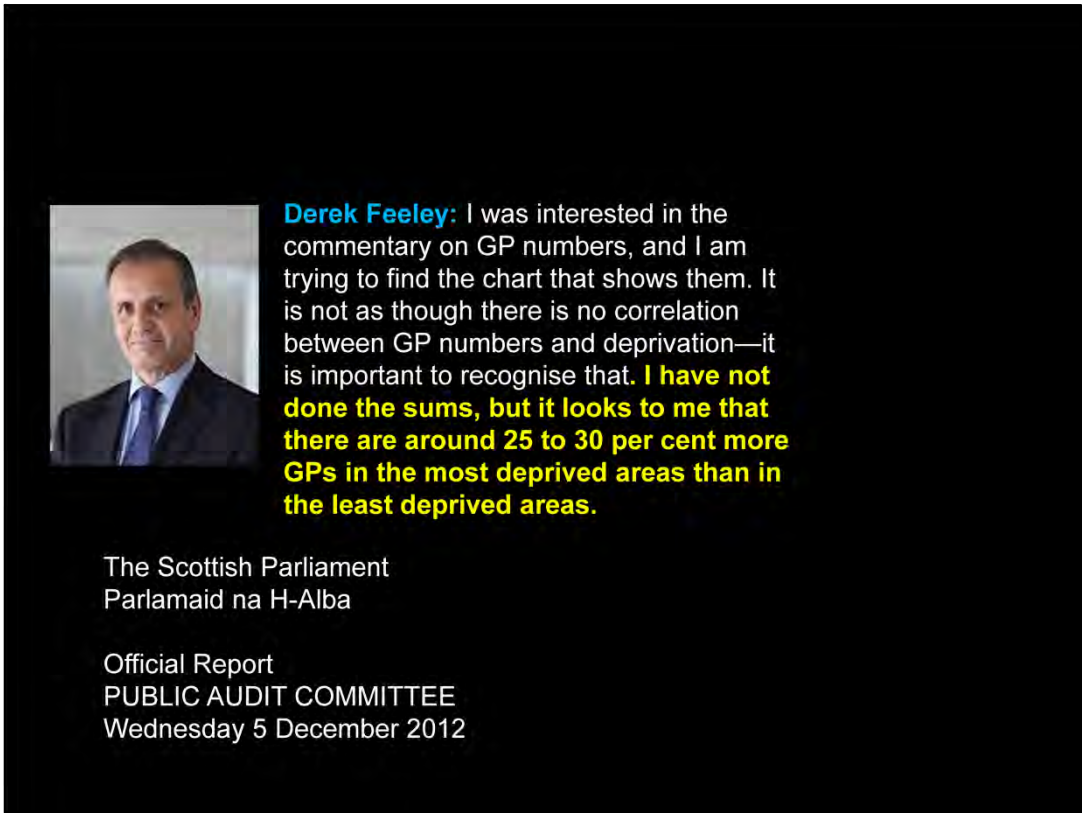


SLIDE 38

In 2010, the RCGP Scotland report on health inequalities, informed by these studies and by the first Deep End conference, was entitled Time to Care, and was the first report on health inequalities in Scotland to mention the inverse care law as it affects general practice

SLIDE 39

In 2012, the message was picked up by Audit Scotland, the Scottish Government watchdog, which independently scrutinises Government activities, in a report on health inequalities which specifically mentioned the shortage of GPs in deprived areas.



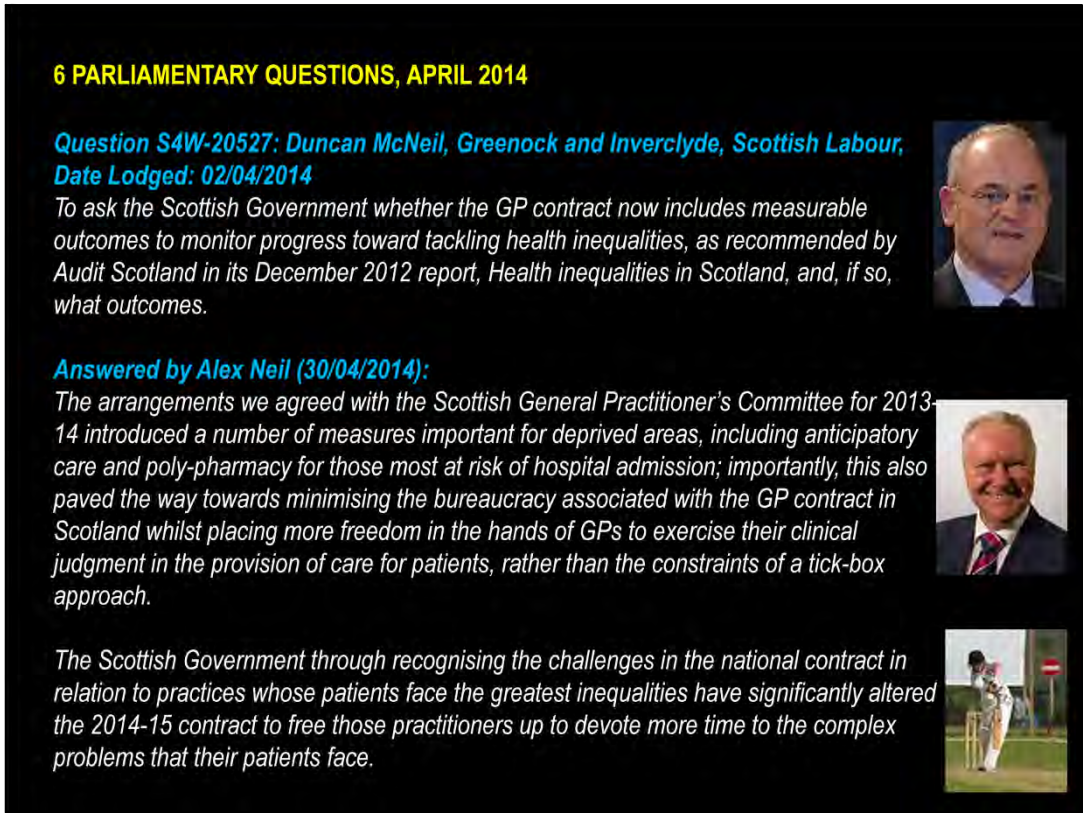
SLIDE 40

This report was then considered by the Public Audit Committee of the Scottish Parliament, which took evidence from experts, including the Chief Executive of NHS Scotland, who is quoted on the parliamentary record as saying, “it looks to me that there are around 25 to 30% more GPs in the most deprived areas than in the least deprived areas. Sitting next to him, as he told this whopper, was the Chief Medical Officer, Sir Harry Burns, who said nothing to correct him.

SLIDE 41

Jim O'Neil, Susan Langridge and I were also invited to give evidence to this committee, based on facts and experience, not ignorant and arrogant impressions. The Committee's final report on health inequalities, made several recommendations, all addressing aspects of the inverse care law, while ending its involvement and handing the issue over to the Health and Sport Committee.

So, Peter Cawston, Susan Langridge and I went to the Health and Sport Committee, saying our piece again, and getting our comments on to the parliamentary record.

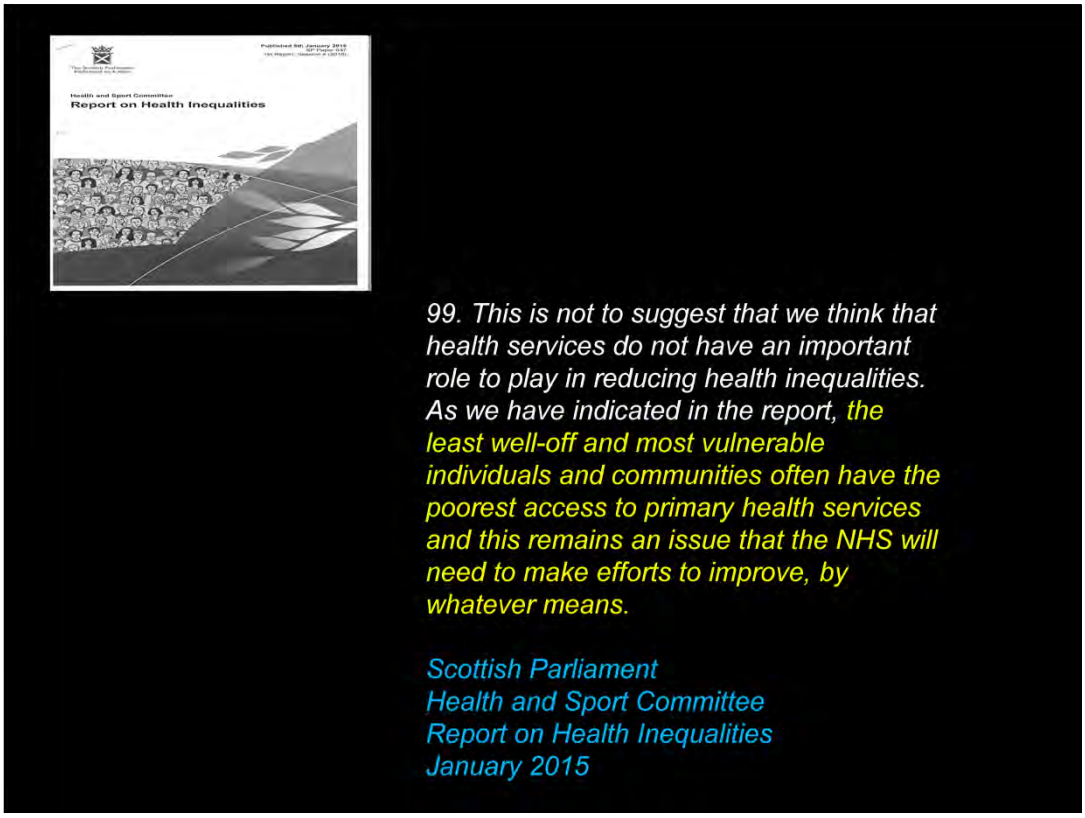


SLIDE 42

An outcome of that was that Duncan McNeil Labour MSP for Inverclyde and Chair of the Health and Sport Committee, submitted parliamentary questions on all of the issues raised by Audit Scotland and the Public Audit Committee. Now, PQs are taken seriously, consuming civil servant time to ensure that Ministers give authoritative replies, but in this case, all the Minister, Alex Neil, said in his replies, scripted by civil servants, was flannel.

SLIDE 43

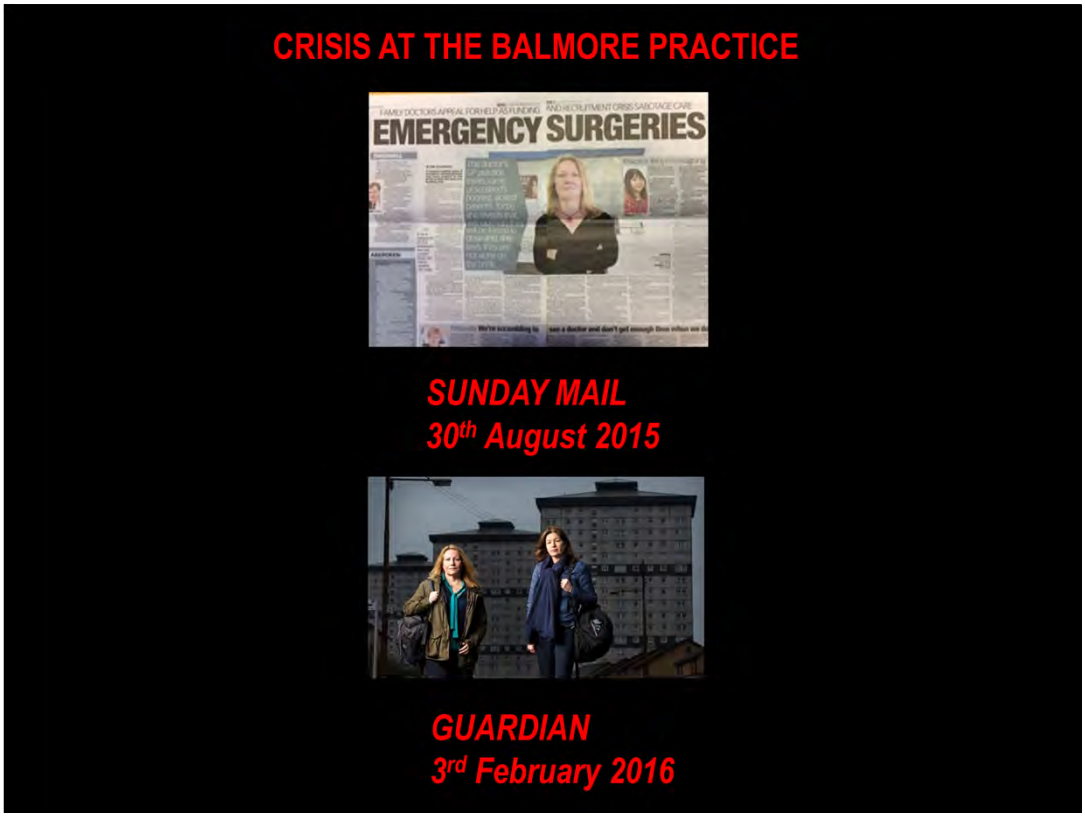
Confirming our experience, having met Alex Neil, and Michael Matheson and Jamie Hepburn, all health ministers, that if they don't want to see you, there is no point in going to see them. You will get a pleasant hearing, even a suggestion that something will be done, but then civil servants will rein the Minister in, explaining why nothing should or can be done.



SLIDE 44

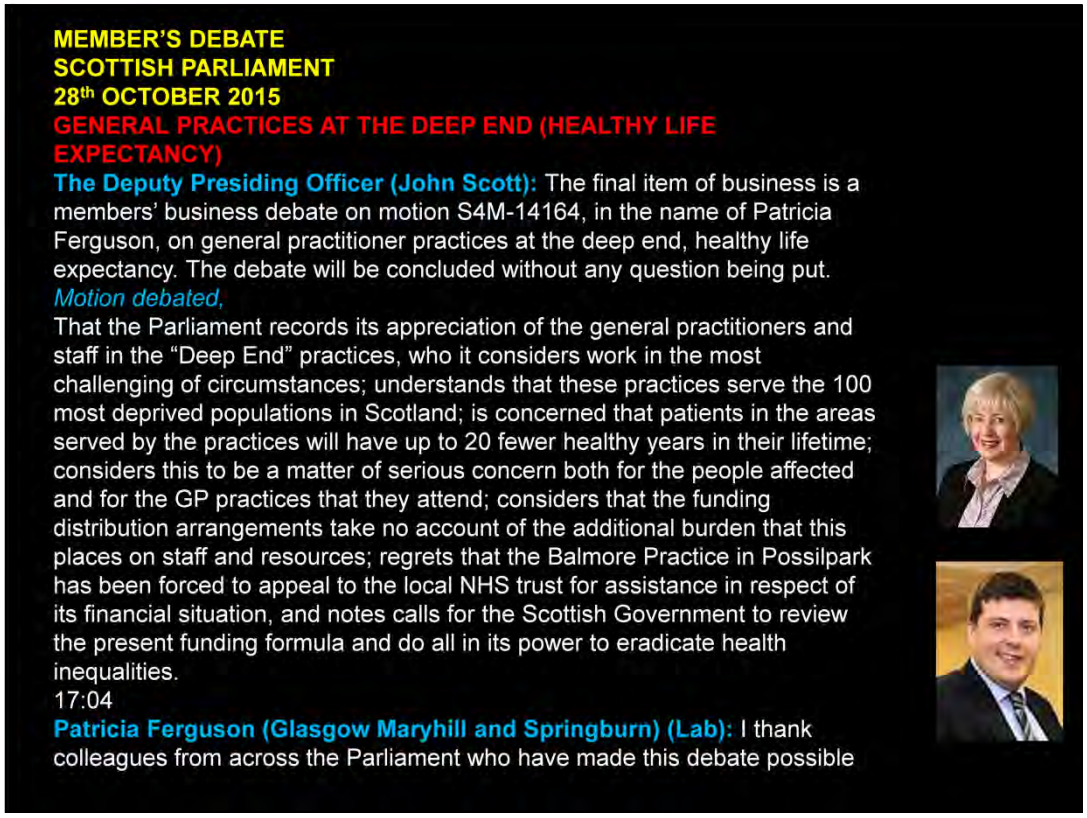
When the Health and Sport Committee produced its report on Health Inequalities, in January 2015, all it had to say about the inverse care law was “the least well-off and most vulnerable individuals and communities often have the poorest access to primary health services and this remains an issue that the NHS will need to make efforts to improve, by whatever means”

Then off they went to listen to their favourite radio programme, *“I’m sorry I haven’t a clue”*



SLIDE 45

In August last year, the Balmore practice in Possilpark hit the headlines – a recruitment crisis exacerbating the practice's problems, as the 3rd most deprived practice in Scotland.



SLIDE 46

The local MSP, Patricia Ferguson initiated a member's debate at the Scottish parliament.

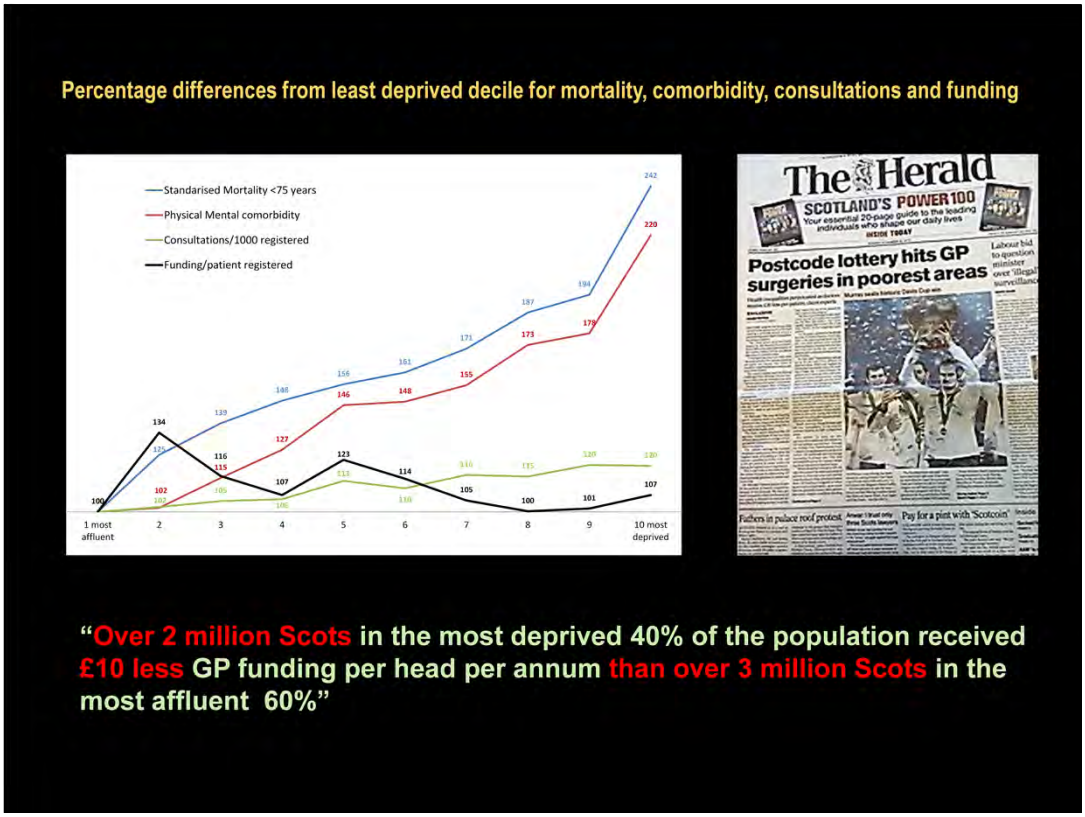
Meanwhile the Glasgow City Health and Social Care Partnership offered the practice temporary locum relief and sent in a team of investigators. The practice believe that the team was tasked to find inefficiencies in the practice, but found none.

The wider implications of the inverse care law were ignored. Nor indeed was their much sympathy for the practice from other practices. If they could cope, why couldn't Balmore?

SLIDE 47

In evidence to the Health and Sport Committee, David Williams, Chief Executive of the HSCP said his organisation had no control over GP funding. Any additional resource would have to come from the Centre.

At the same time, the position of the BMA, as stated by Alan McDevitt, was that additional resources for deprived areas should come from the new Integrated Joint Board budgets i.e. the HSCPs. Everyone is passing the buck.



SLIDE 48

We had one last piece of ammunition – this killer slide, published in the BJGP on 30th November last year. As the Government hadn't collected data on GP WTE for over a decade, we couldn't update the previous figure, but we could substitute the GP data with data on GP funding per patient per annum, from figures on the ISD website.

The figure divides the Scottish population into tenths, richest on the left, poorest on the right. Premature mortality in blue and complex multimorbidity in red more than double in prevalence across the spectrum, while general practice funding per patient, in black, is broadly flat. We have horizontal equity in terms of access, but not vertical equity in terms of needs-based care. Consultation rates do rise, by 20%, but can only do so by having shorter consultations, or working a longer day.The consequences in the bottom right hand side of the slide include: GP consultations that involve more problems, but are shorter and achieve less. Unmet need accrues. Inequalities in health widen.

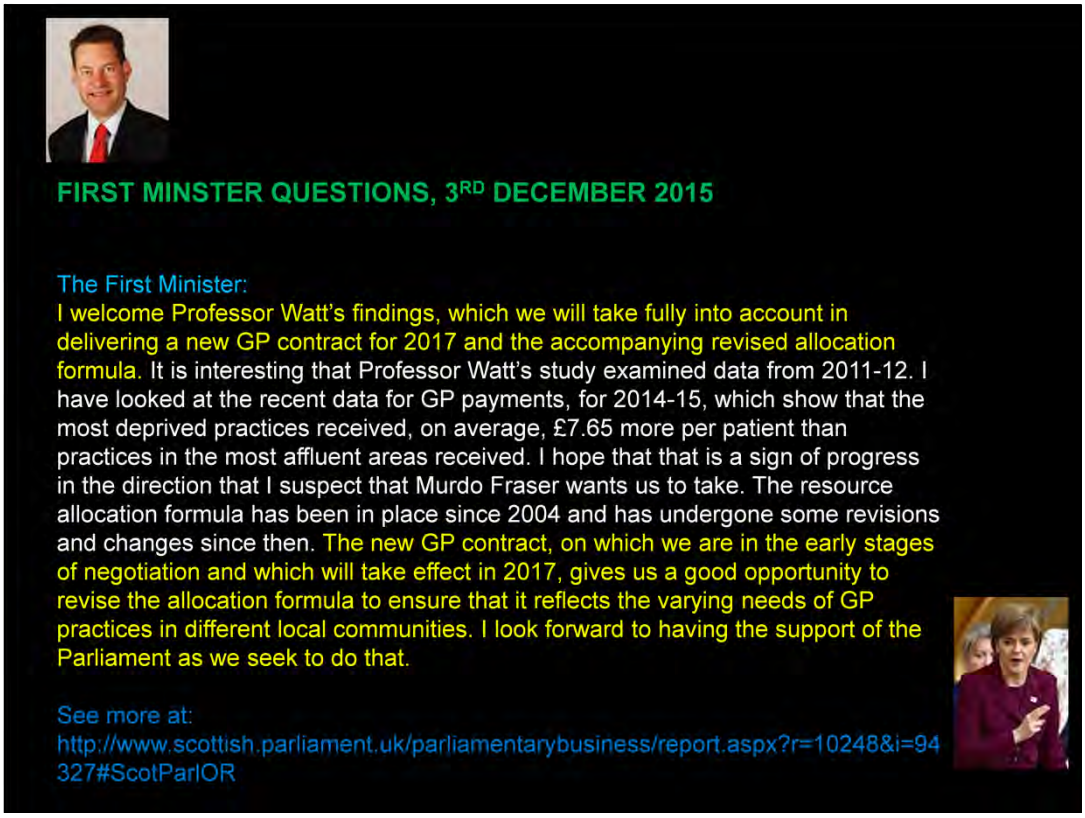
Note that the Inverse Care Law applies not just in the Deep End. In Scotland, over 2 million Scots, the most deprived 40%, get £10 less GP funding per head per annum than over 3 million Scots, the most affluent 60%. Note also that the most affluent tenth receives the least funding of all. The solution to this is not to target the Deep End; it is to provide resources pro rata across the board based on need.

SLIDE 49

On the Monday morning of publication it was front page news on the Herald and the leading item on Good Morning Scotland. It led again on Reporting Scotland on that evening's TV news. It also featured on STV news, their outside broadcast team, abandoning coverage of the Government's launch of Sir Lewis Ritchie's Out of Hours Report, to interview me in Glasgow and Alanna McRae in Greenock. We've been told that didn't endear us to the Minister.

SLIDE 50

Other media outlets were hot on the trail



SLIDE 51

Then, help from an unexpected source, Murdo Fraser, Conservative list MSP for Fife, submitted a question to the First Minister, Nicola Sturgeon, asking her "what

the Scottish Government is doing to reduce healthcare inequalities".

Three days later, on Thursday 3rd December, in the debating chamber, the First Minister replied, "One of the ways in which the Scottish Government is tackling health inequalities is by reforming the general practitioner contract, to reduce bureaucracy and give GPs more time to devote to the complex problems that patients can face, particularly in areas where patients face the greatest inequalities and health issues. Further changes will be made to the 2017 contract, which will include a review of the Scottish resource allocation formula, to ensure that GP surgeries in the areas of most need receive funding that is proportionate to the needs in their areas".

Murdo Fraser: The First Minister mentioned GP funding. She will be aware that earlier this week a report from the University of Glasgow, highlighted that GPs in the most deprived areas of the country receive £10 less per patient than GPs in wealthier areas receive. The report said that "We have got health inequalities which are the worst of any country in Western Europe", and went on to say that GP funding is one of the reasons behind that. In my region, every GP practice in Kirkcaldy is operating with a full list and cannot take on any new patients. What more can the Scottish Government do to combat inequalities?

The First Minister, "I welcome these findings, which we will take fully into account in delivering a new GP contract for 2017 and the accompanying revised allocation formula. 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."

SCOTTISH GOVERNMENT DEBATE ON REDESIGNING PRIMARY CARE
15TH DECEMBER 2015

Shona Robison

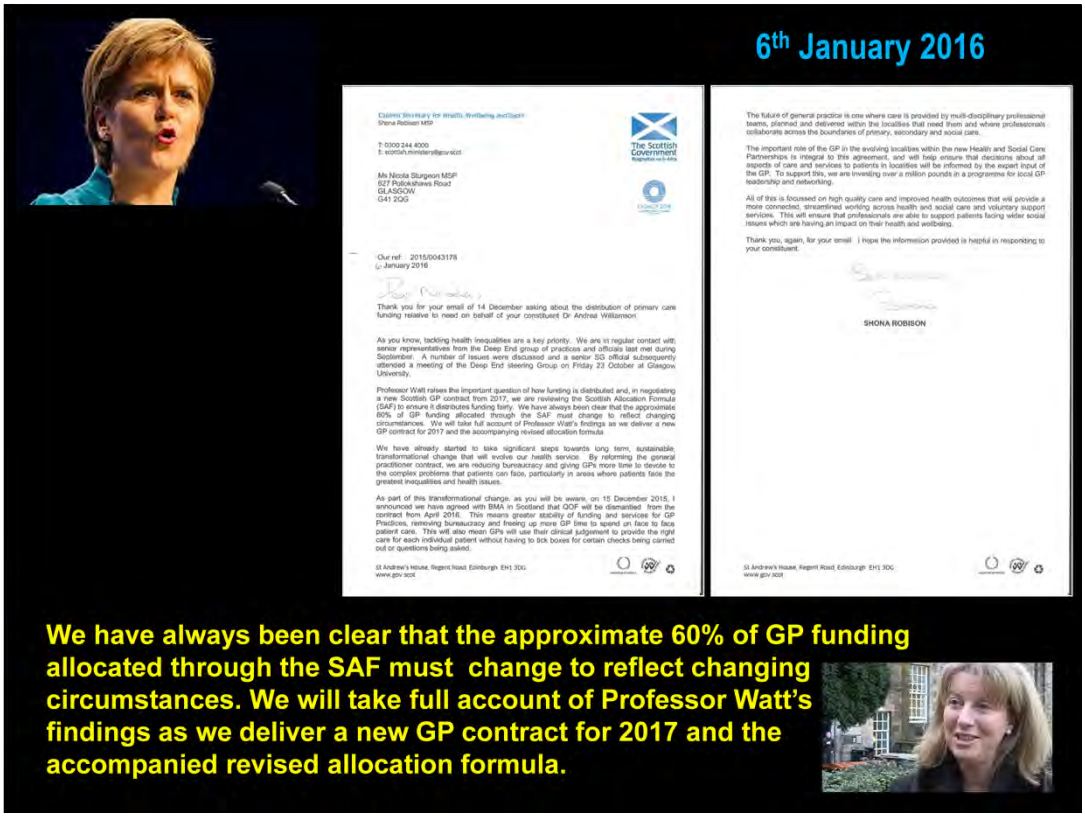
Drew Smith talked about Professor Watt's report, deep-end practices, the Scottish allocation formula and the need for us to ensure that there is more reflection of the needs of deprived communities in the resources that go to them through the formula. All those things are subject to negotiation in relation 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.

SLIDE 52

On 15th December, a Government debate on Primary Care Transformation, including contributions from ten MSPs concerned about the inverse care law, drew similar statements from the Cabinet Secretary for Health, Shona Robison.



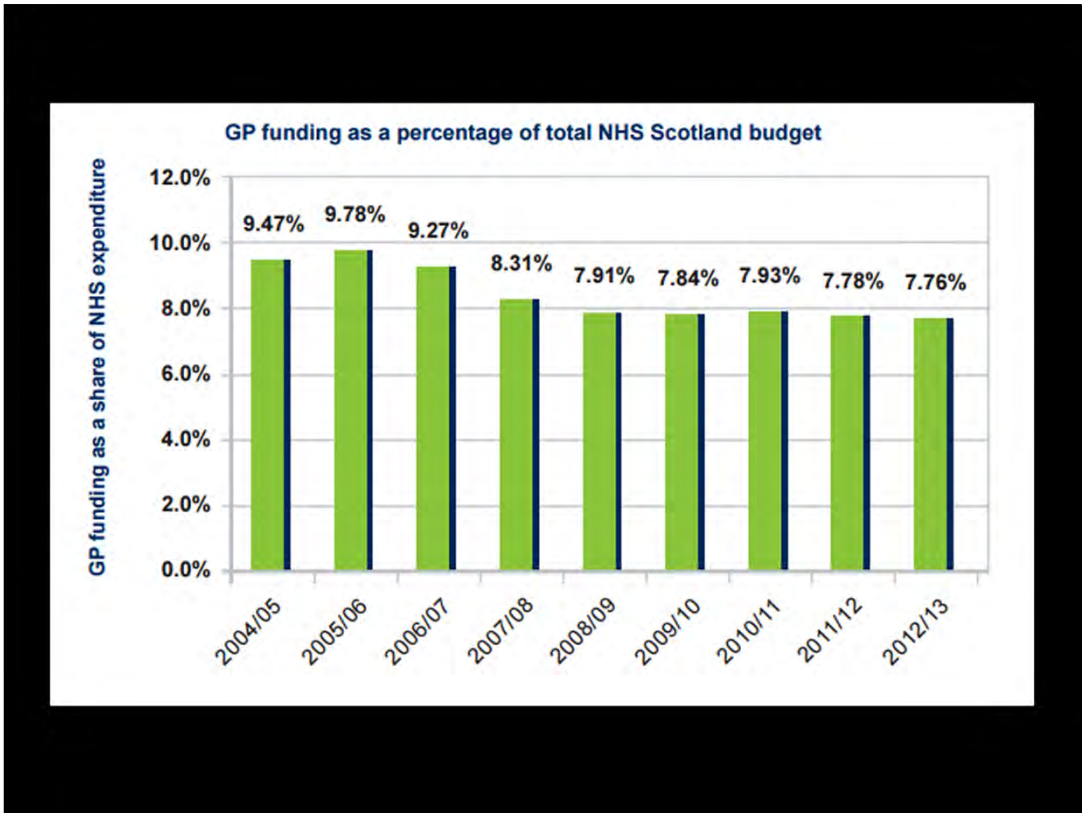
SLIDE 53

She said much the same thing on 6th January in a letter to Nicola Sturgeon, advising the First Minister on how to respond to a letter from a constituent, one Dr Andrea Williamson.

SLIDE 54

So we have statements on the parliamentary record, by both the First Minister and Cabinet Secretary, saying they expect the Scottish Allocation Formula component of the 2017 new GP contract to address this issue. Whether data exist to produce a suitable formula is not clear. Consultation data from PTI, used as a proxy measure of need, convey nothing of the content, length, quality or consequences of consultations. They only measure what was done, not what couldn't be done because of lack of time.

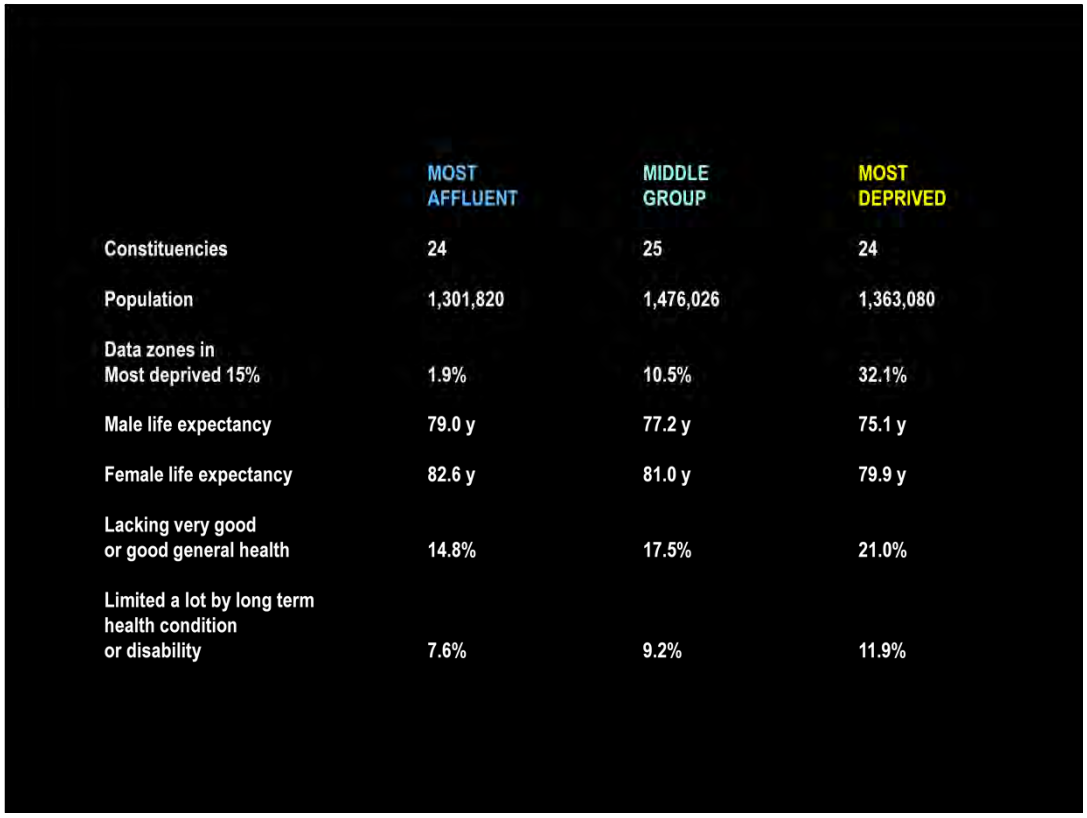
Will this happen? The BMA isn't keen, seeing the issue as divisive within Scottish general practice. RCGP Scotland said nothing about the inverse care law in its 2016 Scottish General Election manifesto. At the first health debate of the new parliament back in June, none of the three main parties said anything about the inverse care law. Last week, in its 50 point action plan to build a fairer Scotland, the only nod to the NHS was the plan to create 250 new Link Workers. That's welcome, but it's not addressing the Inverse Care Law.



SLIDE 55

As Helene Irvine has shown, the situation is made more difficult by the fact that general practice funding, as a proportion of NHS funding, has fallen across the board in the last ten years, by about a sixth, while almost every other part of the service has expanded.

It's inconceivable that the answer to the inverse care law could ever be redistribution of a reduced budget. Other GPs, politicians and the public wouldn't allow it. A better scenario is differential growth within an expanding budget. If the Scottish Government made the same commitment to rescue general practice that the English Government has made, that would be possible.



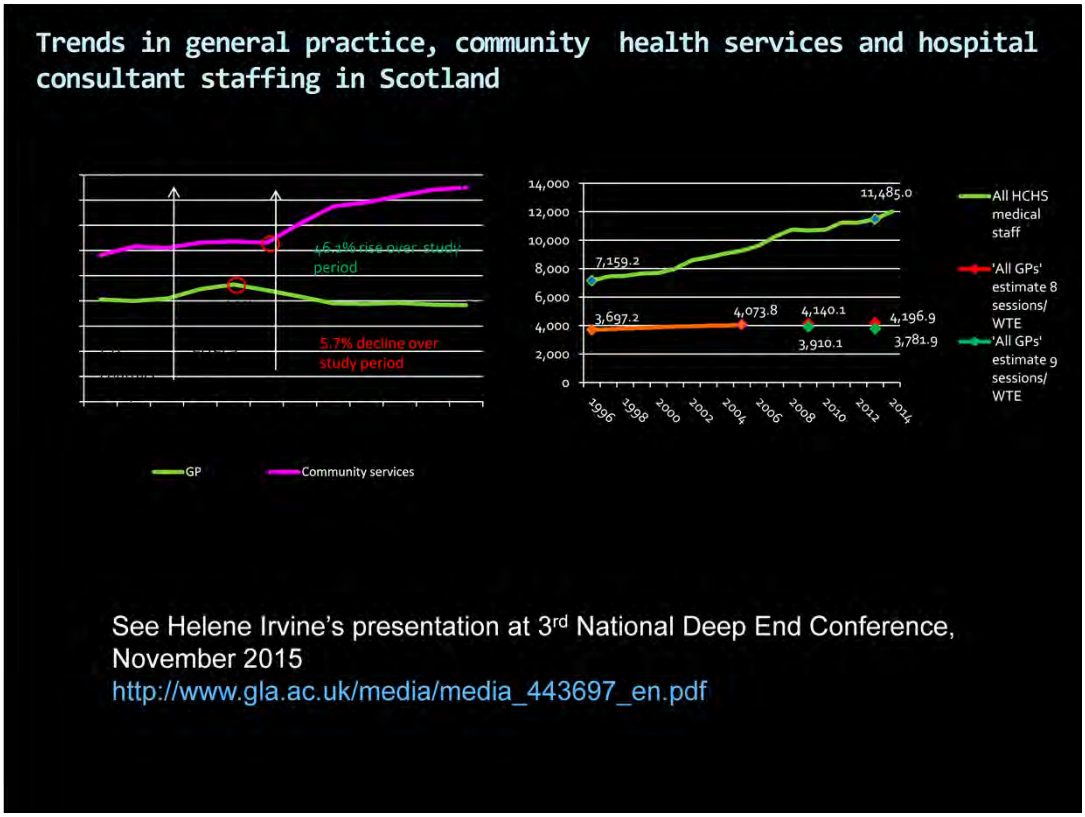
	MOST AFFLUENT	MIDDLE GROUP	MOST DEPRIVED
Constituencies	24	25	24
Population	1,301,820	1,476,026	1,363,080
Data zones in Most deprived 15%	1.9%	10.5%	32.1%
Male life expectancy	79.0 y	77.2 y	75.1 y
Female life expectancy	82.6 y	81.0 y	79.9 y
Lacking very good or good general health	14.8%	17.5%	21.0%
Limited a lot by long term health condition or disability	7.6%	9.2%	11.9%

SLIDE 56

This is an issue for politicians, not civil servants, NHS managers or professional bodies.This slide divides the 73 first past the post Scottish parliamentary constituencies into three groups, most, middle and least affluent. The prevalence of deprivation in the three groups rises from 2% to 10% to 32%, with associated differences in life expectancy and self-reported health. Larger health differences can be found between smaller groups. The important point is that these differences apply to huge numbers of people, with at least 1.3 million voters in each group

SLIDE 57

Here are the MSPs for the 73 constituencies, colour-coded yellow for SNP, blue for Conservative, red for Scottish labour and orange for Lib-Dems. All 23 MSPs representing the most deprived constituencies are SNP, including the First Minister and Cabinet Secretary for Health. These mice need to roar and we are doing what we can to encourage them



SLIDE 58

The explanation of the monstrous longevity of the inverse care law is that while everyone is against heath inequalities, none of the powerful interest groups within the NHS are prepared to give up what they have in order to address it. "Extra money" needs to be found from somewhere else. Given the large recent investment in specialist services, in secondary and primary care, increasing their share of the NHS budget by nearly 50%, it's not difficult to see where that "somewhere" might be. But these resources are defended by powerful interests. How can that change? Certainly, not by huffing and puffing, hoping the walls will fall down.

SLIDE 59

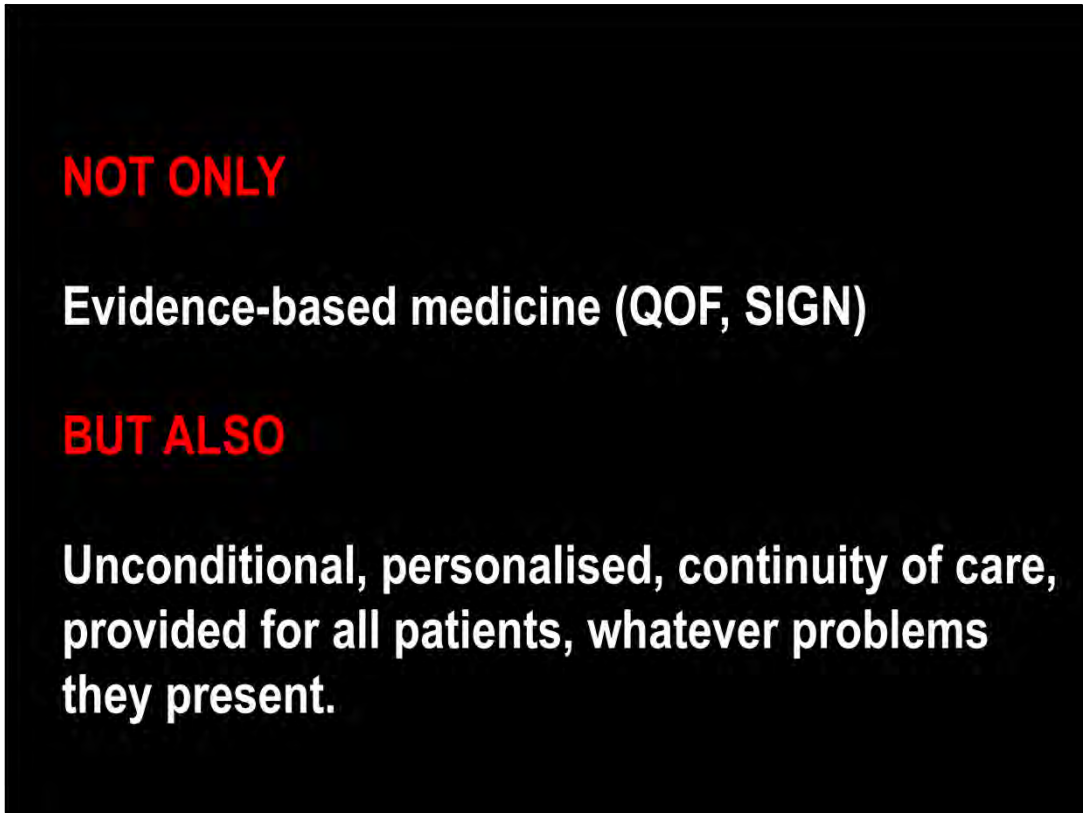
One of the most helpful bits of advice that I have come across, is that whenever power is involved, there has to be a competing narrative. Tudor Hart probably influenced UK general practice more by what he did than what he said. Our competing narrative is this.

SLIDE 60

General practice is important. The gatekeeping role keeps the NHS afloat, keeping most care in the community. There isn't an actual gate, only a gateway that patients can go through at any time, to Out of Hours, A&E or an acute hospital bed. The NHS under-resources general practice at its peril. What keeps patients in the community is satisfaction with the care they received, and the avoidance of complications.

SLIDE 61

As Barbara Starfield pointed out, the main contribution of health care is to reduce the severity of established conditions and delay their progression,thereby preventing, postponing or lessening complications.



SLIDE 62

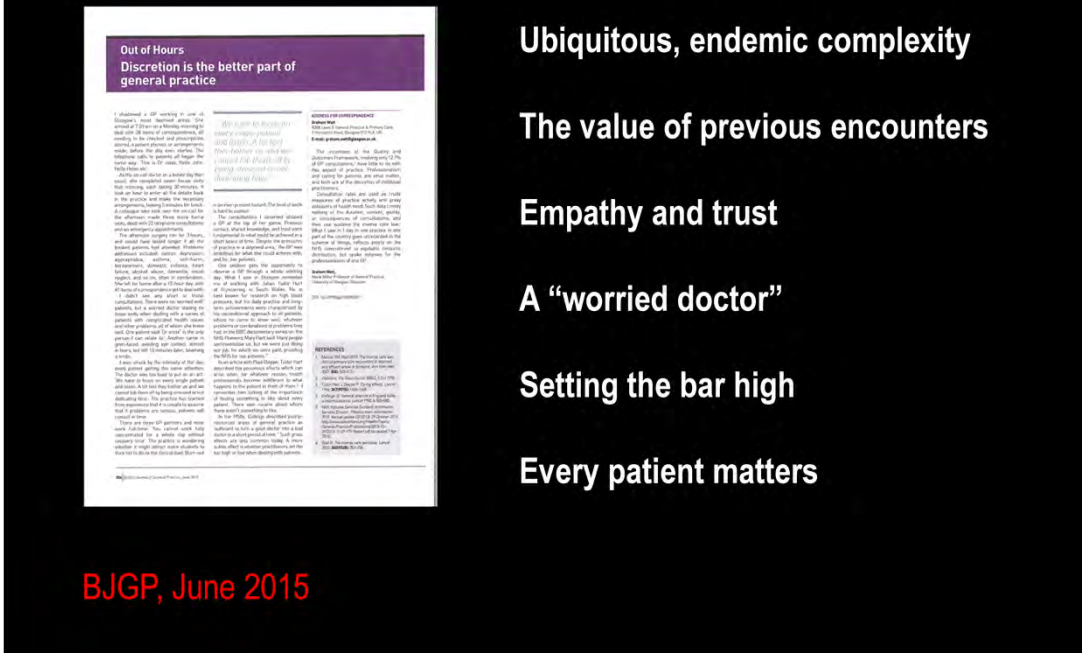
That's achieved partly via the delivery of evidence-based medicine, but also, and equally important, via unconditional, personalised continuity of care for all patients, whatever condition of combination of conditions they have.

The important word is "unconditional". General practice, within its working hours, is the only non-emergency service that doesn't systematically exclude.

SLIDE 63

The elephant in the room is that if general practice isn't delivered equitably, pro rata according to need, health inequalities will widen, something that has yet to be said in any UK report on health inequalities.

Of course, the main causes of poor health operate outside the health service, beginning in early life. Addressing the inverse care law won't change that, but it will stop existing differences getting worse – an important, neglected social determinant of population health.



SLIDE 64

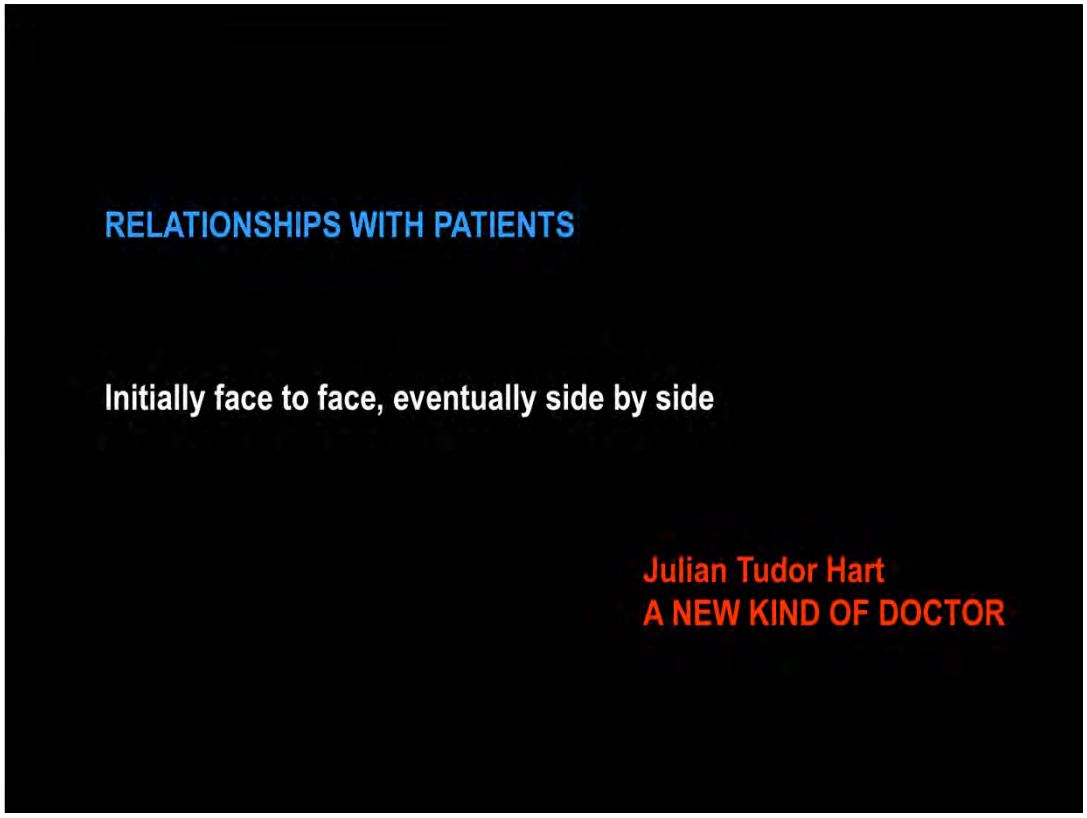
I spent a day shadowing a GP in Scotland’s most deprived general practice. I saw endemic multimorbidity and social complexity; the importance of previous encounters and shared knowledge, for anything much to be achieved in a short consultation; the value of empathy and trust; I didn’t see any worried well patients, but I did see a worried doctor, taking it upon herself to anticipate problems and take avoiding action; she set the bar high; every patient mattered.

SLIDE 65

That was just one day in the life of a GP. At Govan Health Centre in Glasgow, these three GPs have over 60 year's experience of one community between them. What might they have achieved in thousands of days, throughout their professional lifetimes?

SLIDE 66

In life, as in the film, nothing very much happens in brief encounters. It's the serial encounter that matters, all the contacts strung together, with starts, stops, re-starts, diversions, events, successes, failures, but underlying it all, consistent direction.

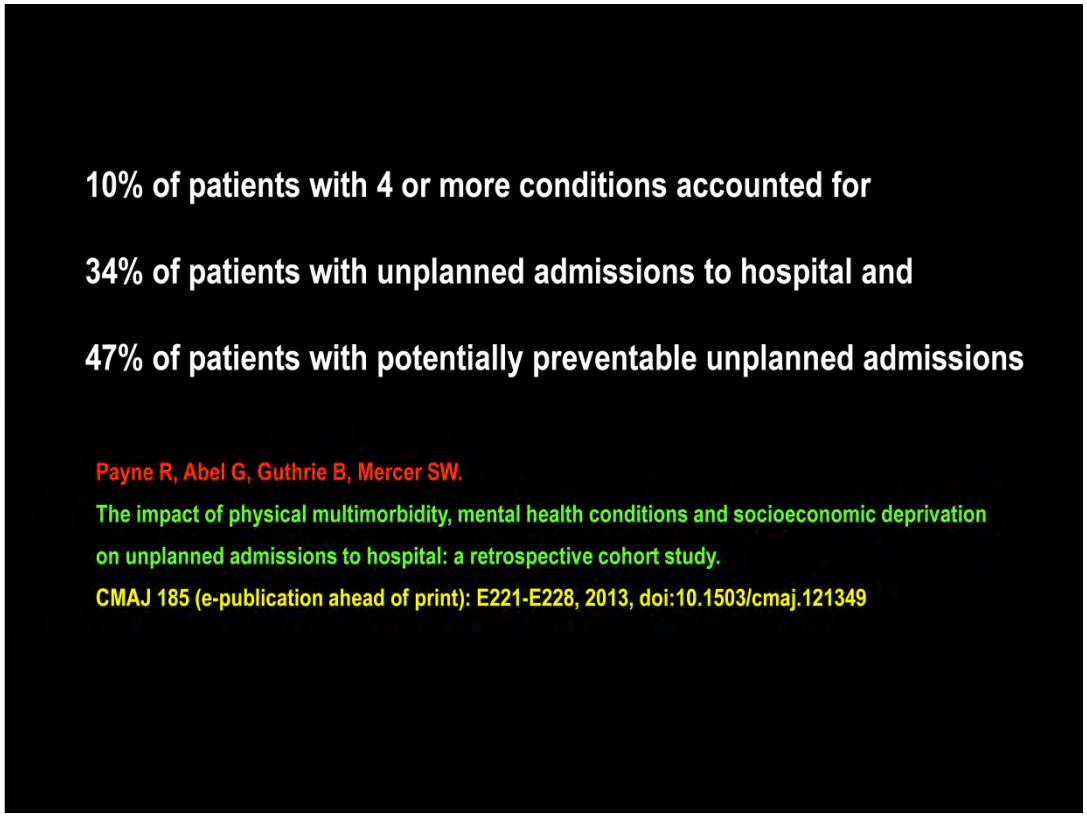


SLIDE 67

As Tudor Hart put it, initially face to face, eventually side by side. In deprived areas, self-help and self-management are destinations not starting points. Our CMO needs to be more realistic about that.

SLIDE 68

In Tales of the Arabian Nights, Scheherezade had to make up a new story every day. Her life depended on it. That's also the business of general practice, making up thousands of stories, building knowledge and confidence, helping patients live long and well, avoiding the complications of their conditions.



SLIDE 69

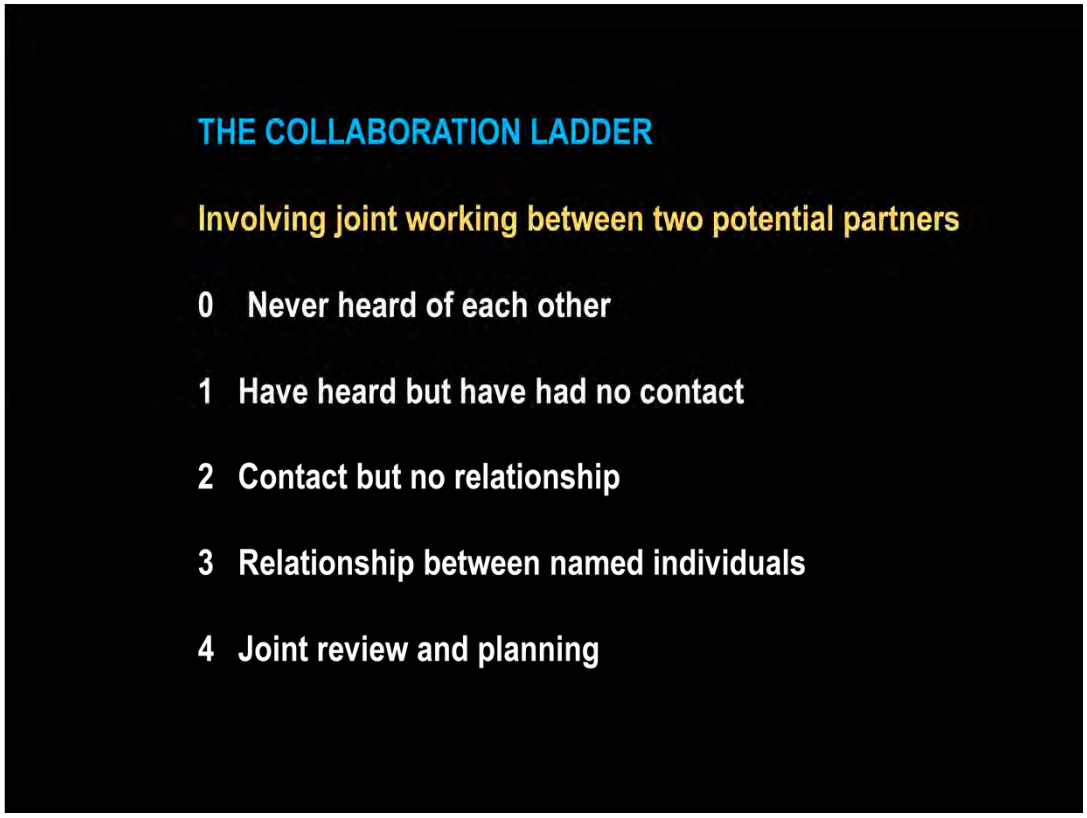
Not every patient needs this, but the 10% of patients in Scotland with 4 or more conditions, who account for a third of all unplanned admissions to hospital, and a half of all potentially preventable unplanned conditions, certainly do.

SLIDE 70

It used to be that a single-handed GP knew everything and did everything, like Dr Ciriani here at Kremmling, Colorado, in this famous Life magazine photo-essay, but no more

SLIDE 71

The intrinsic features of general practice – patient contact, population coverage, continuity, flexibility, long term relationships and trust – are essential, they make general practice the natural hub of local health systems, but they are not sufficient. Links are needed to a host of other resources and services.



SLIDE 72

Two professionals might work in the same community. On the Collaboration Ladder, zero means they have never heard of each other; 1 they have heard of each other but have never met; 2, they've met but that's it; 3, they work together haphazardly; 4, they sit round a table to review and plan joint work.

SLIDE 73

Local health systems can be resource poor but people rich – think of Cuba, or resource rich and people poor – think of the US. Who knows how our local health systems measure up on this scale?

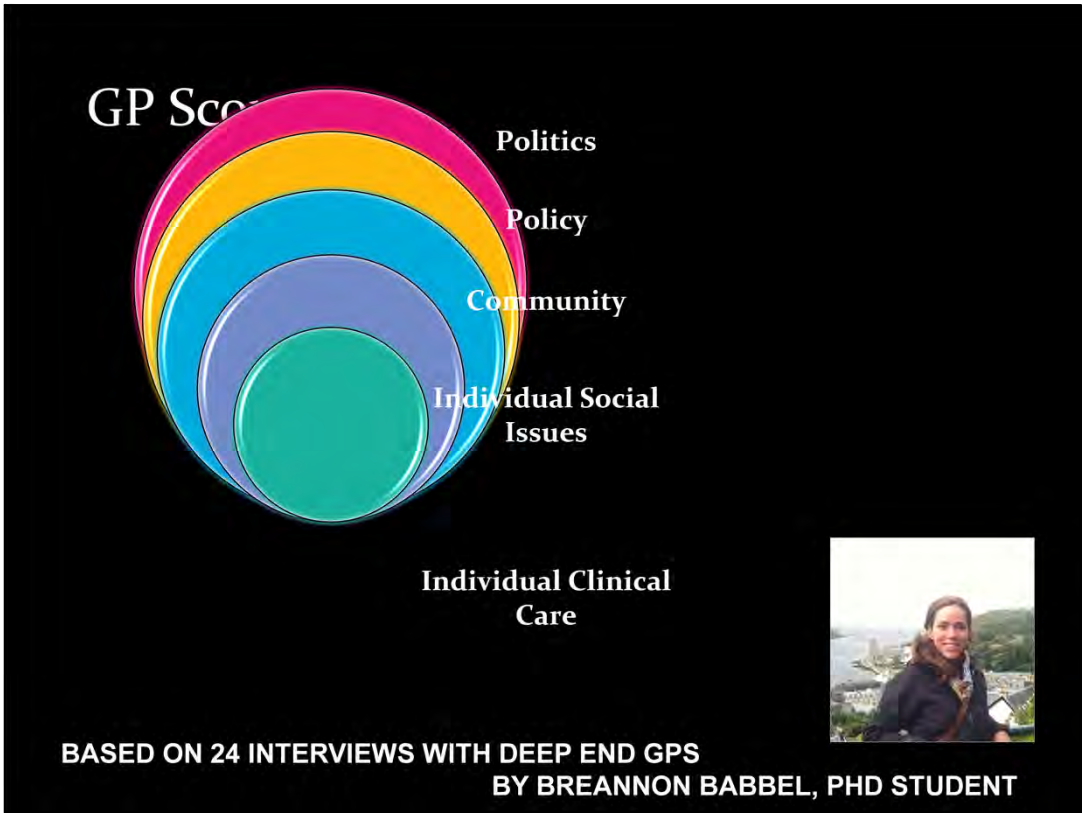
SLIDE 74

So we need a building programme, based not on bricks and mortar, but relationships, building patient stories on the one hand, better relationships with colleagues on the other.

But if general practice is a building site, who is the site manager? Not the Director of Primary Care, sitting far away in an office. Not the expert clinical generalist, cloistered in his or her consulting room (incidentally, the narrower the expert clinical generalist role is define, the surera prescription it will be for burnout).

SLIDE 75

For primary care transformation, (and primary care does need to be transformed – manpower issues will force it) we need help from powerful people (who control resources) and clever people (often not as clever as they think), but this work can only be done locally, by streetwise people, who have contact with real people. Only strong local teams can do this, machines that do the work of two for one. There is no other affordable, sustainable solution, but it needs to be shown.



SLIDE 76

My PhD student, Breannon Babbel has coined the term “street level professional” to capture the distinctive role and contribution that can be made by GPs. All of this is possible, but only if GPs have the interest, time and support, enabling them to do it.

SLIDE 77

There's an important role for academic support. Decisions in general practice are usually based on experience, sometimes informed by evidence, always underpinned by values. Academic support can draw on practitioner experience, produce the evidence, distil the values. A key aspect of the Deep End Project has been to write things down. That's not what Universities generally expect their academics to do, but we need to do it more, to be relevant.

SLIDE 78

When basic needs are met, the three essential ingredients of professional satisfaction are autonomy (the ability to make decisions, to fashion the future), mastery (that's the feeling of being valued for what you do and doing it well) and purpose (the sense of having a clear shared direction). In a small way, the Deep End Project is trying to achieve that. I say small because the Deep End Projects currently involve only 18 of the 100 practices. There is an onus on these practices to show what GP-led primary care transformation can deliver.

SLIDE 79

Our aspiration, especially via the Pioneer Scheme, is to be a learning organisation, sharing knowledge, information, evidence, experience and values, so that the "best anywhere" becomes the "standard everywhere".

There isn't a blue print, or logic plan, waiting to be rolled out, the boxes ticked – only a direction, a commitment to learn, by trial and error, and to share learning.

Many of you will be thinking, that competing narrative is not specific to the Deep End. It applies to the whole of general practice. Of course, that's correct, but here's the sting.

The Herald

FOUNDED ON MONDAY JANUARY 27, 1783

GPs at the Deep End

Give care services more resources

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 Sembala, GP, Keppoch Medical Centre; Graham Watt, Professor of General Practice, University of Glasgow; Andrea Williamson, GP, Glasgow Homeless Health Services.

SLIDE 80

If the NHS is not at its best where it is needed most, inequalities will widen. Is that a challenge we shall continue to kick into the future, or is it something to be addressed now?

Thank you for listening.

Professor Graham Watt

MD FRCGP FRSE FMedSci

Norie Miller Professor of General Practice

University of Glasgow