



University
of Glasgow | Institute of Health
& Wellbeing

Research into primary care and health inequalities

Stewart Mercer

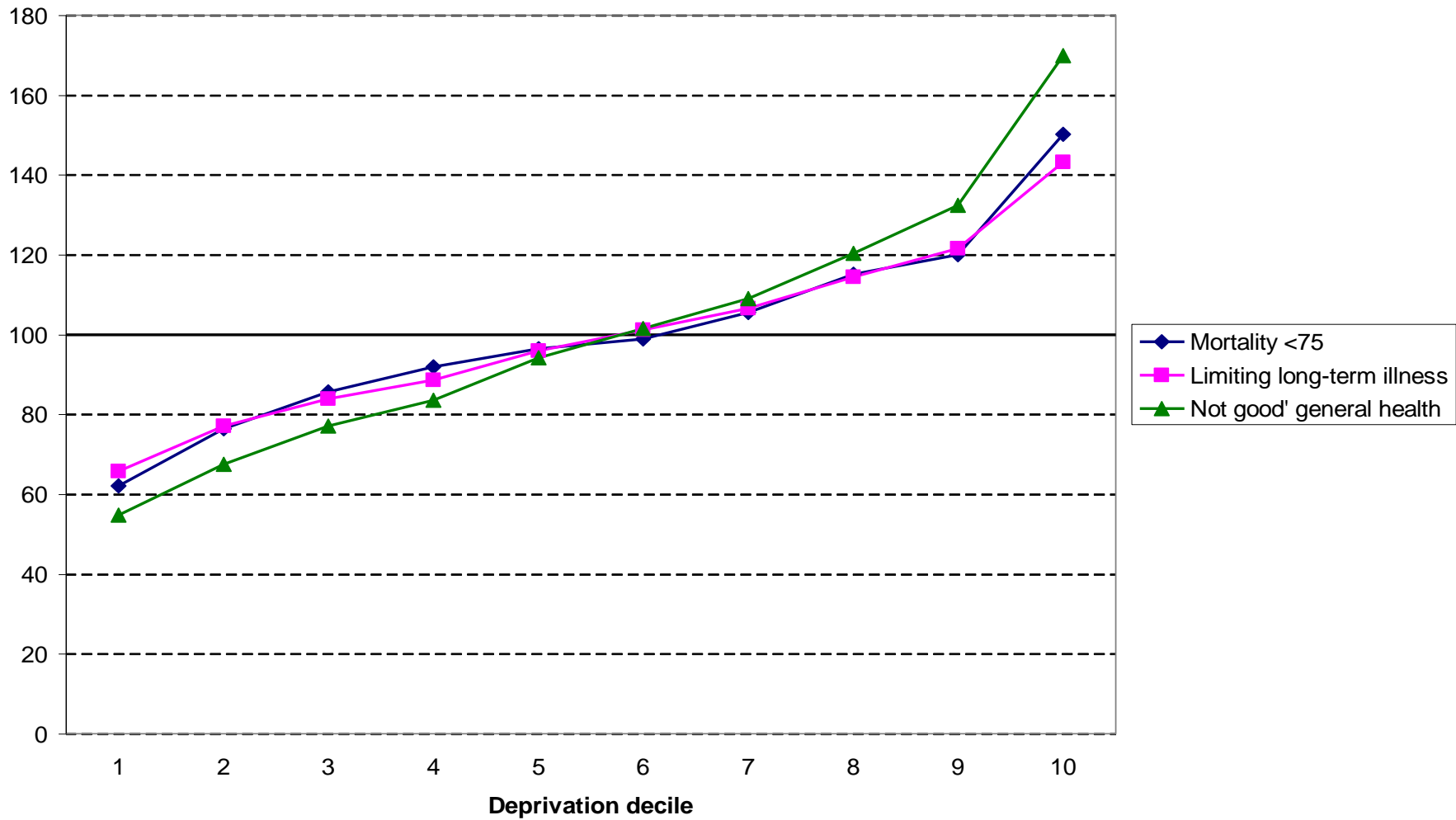
Professor of Primary Care Research

Director of the Scottish School of
primary care



The Scottish School of Primary Care

Health inequalities in Scotland





The Scottish School of Primary Care

Multimorbidity in Scotland

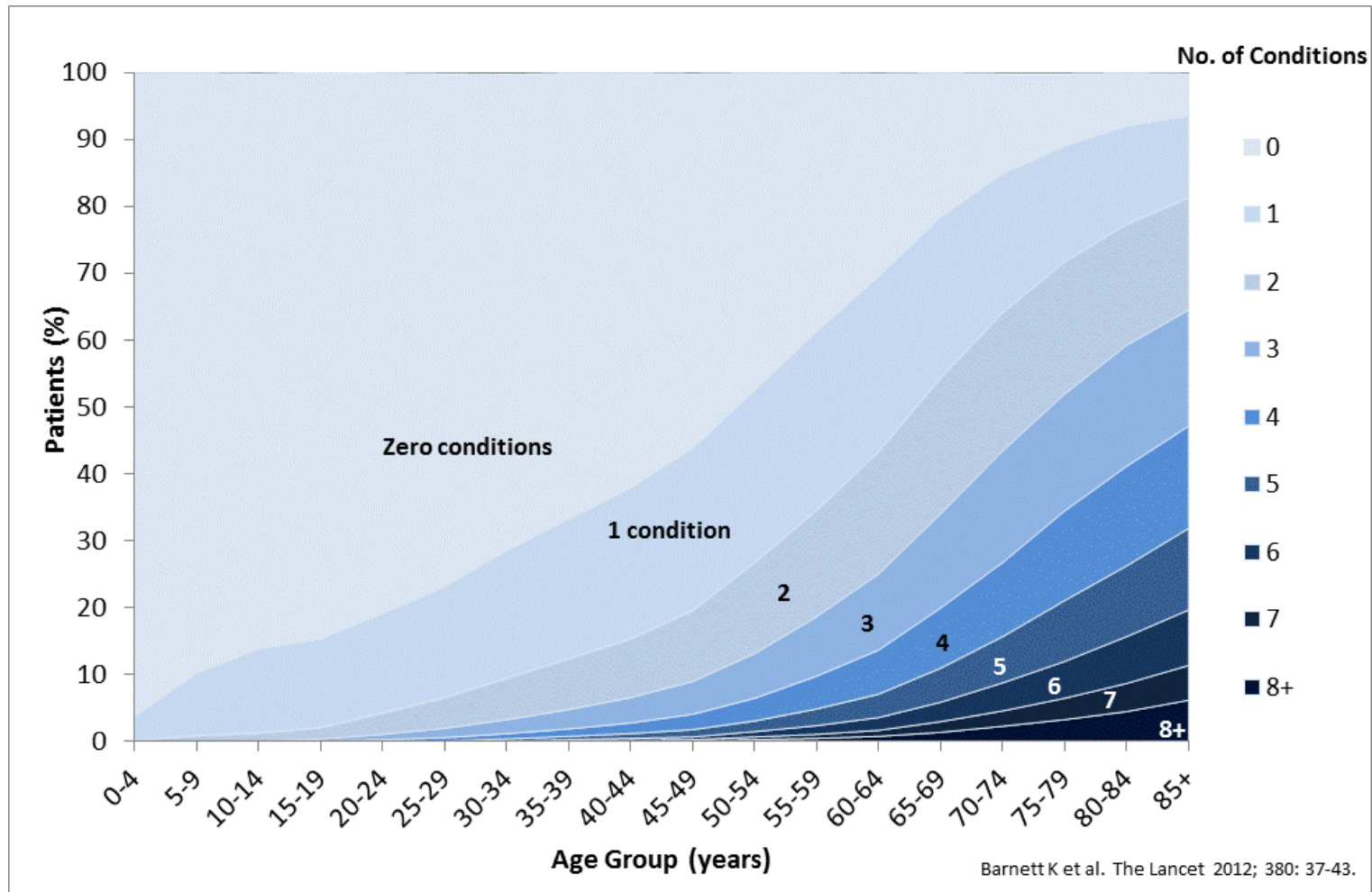
The Scottish School of Primary Care's Multimorbidity
Research Programme



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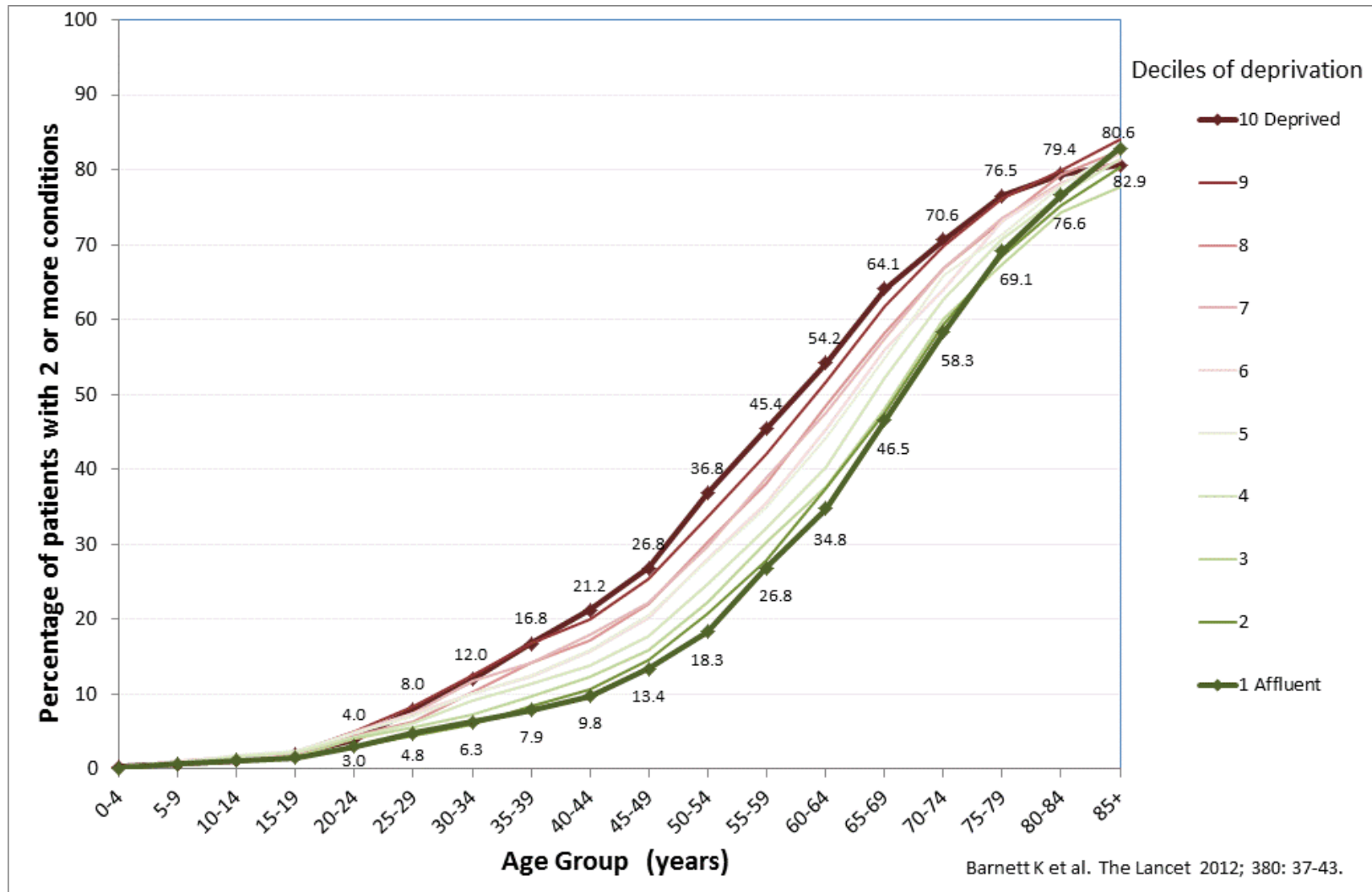


Multimorbidity is common in Scotland

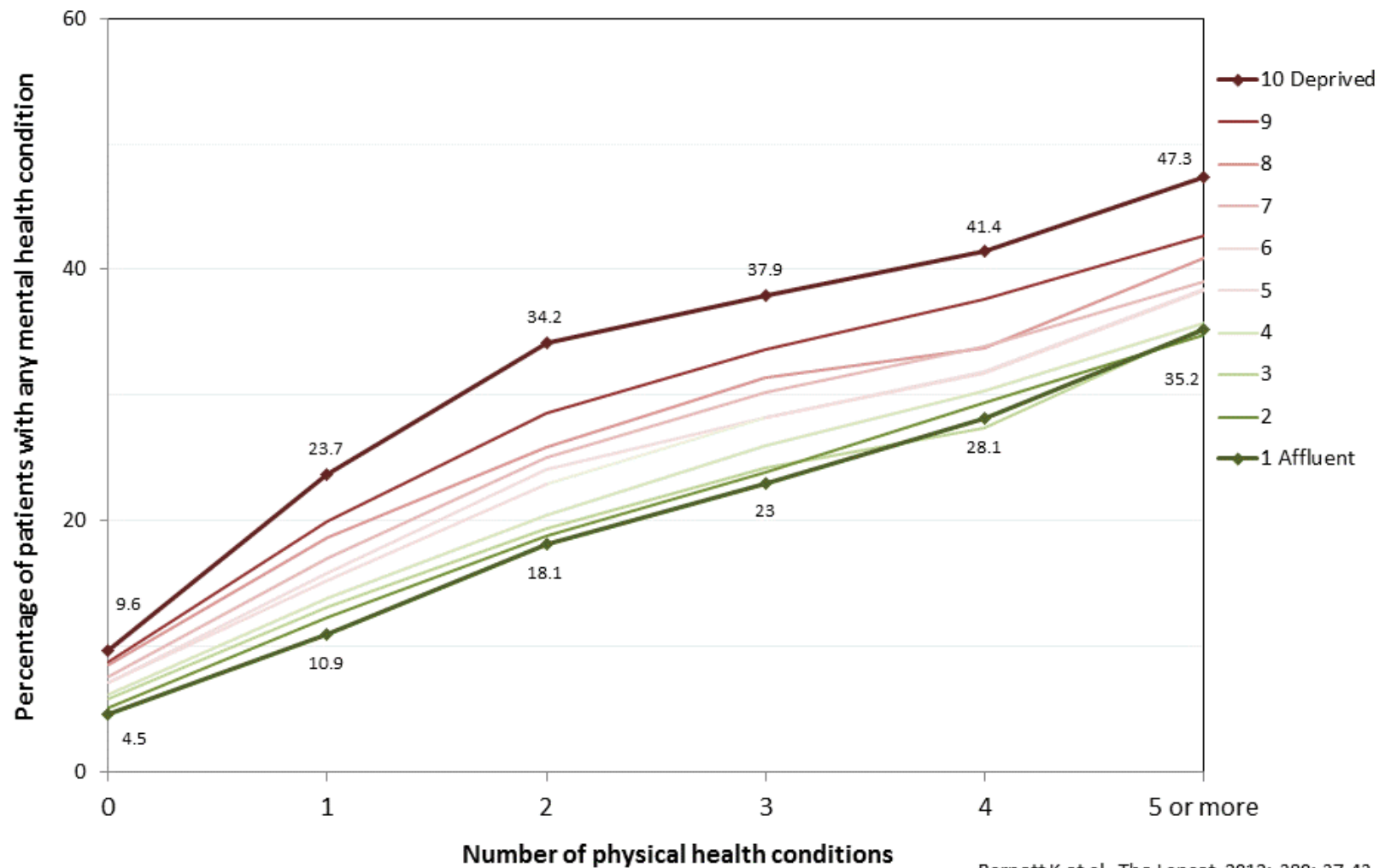


- The majority of over-65s have 2 or more conditions, and the majority of over-75s have 3 or more conditions
- More people have 2 or more conditions than only have 1

People living in more deprived areas in Scotland develop multimorbidity 10 years before those living in the most affluent areas

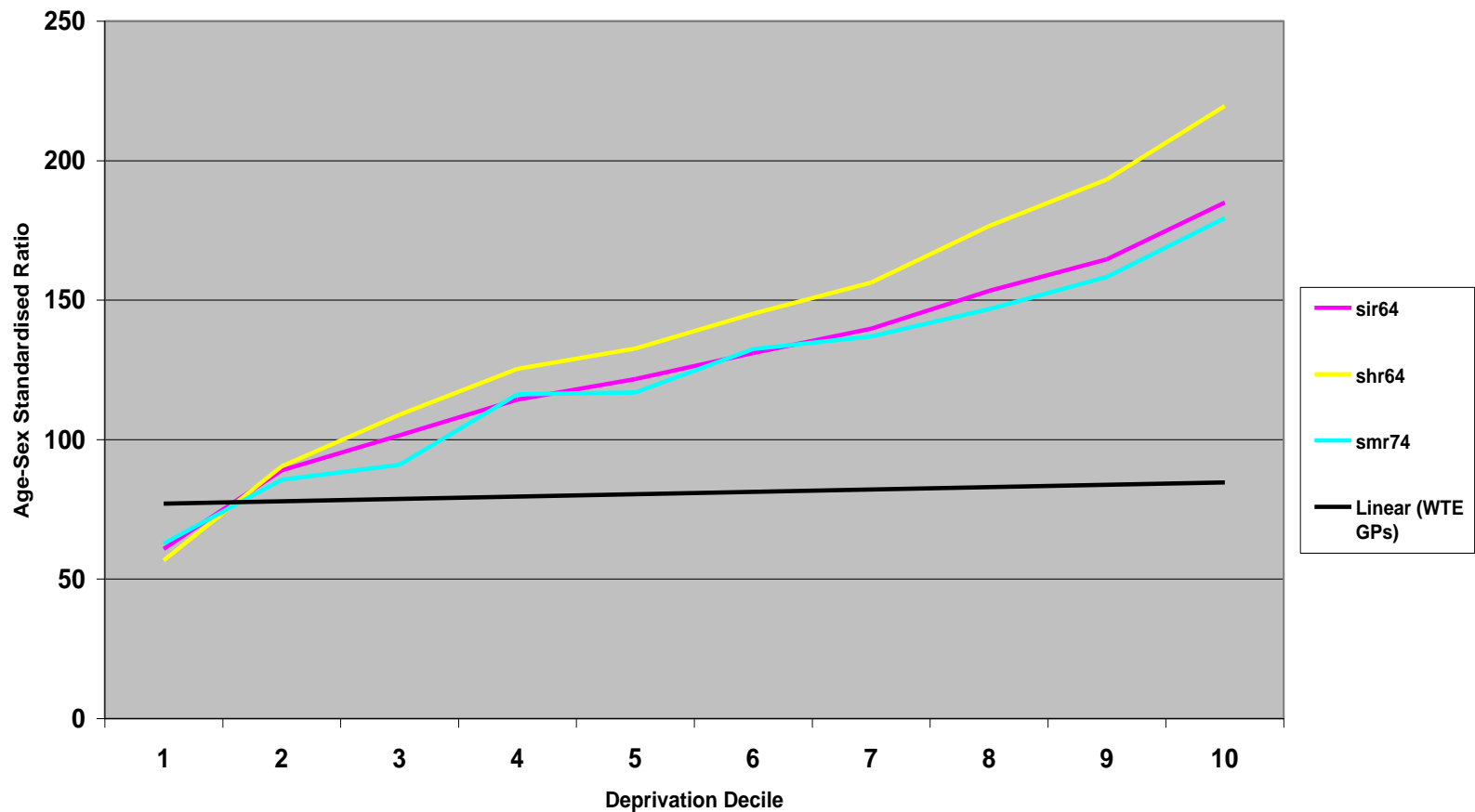


Mental health problems are strongly associated with the number of physical conditions that people have, particularly in deprived areas in Scotland



The Inverse Care Law

Age & Sex Standardised Census Health Measures by Greater Glasgow & Clyde
Deprivation Decile



The Inverse Care Law

- 'The provision of good medical care tends to vary inversely with the need for it in the population served.'
- www.juliantudorhart.org



Patients in deprived areas of Scotland do not feel enabled by GP encounters

In a study of over 3,000 GP consultations in the West of Scotland, patients in deprived areas (compared to patients in more affluent areas) had :

- More problems to discuss, which were more often **complex** (a mix of physical, psychological, and social);

Yet....

- Consultations were **shorter**
- Patients with complex problems were **less enabled**
- GPs were more **stressed**

General practitioners and practice nurses in deprived areas struggle to support people with multimorbidity

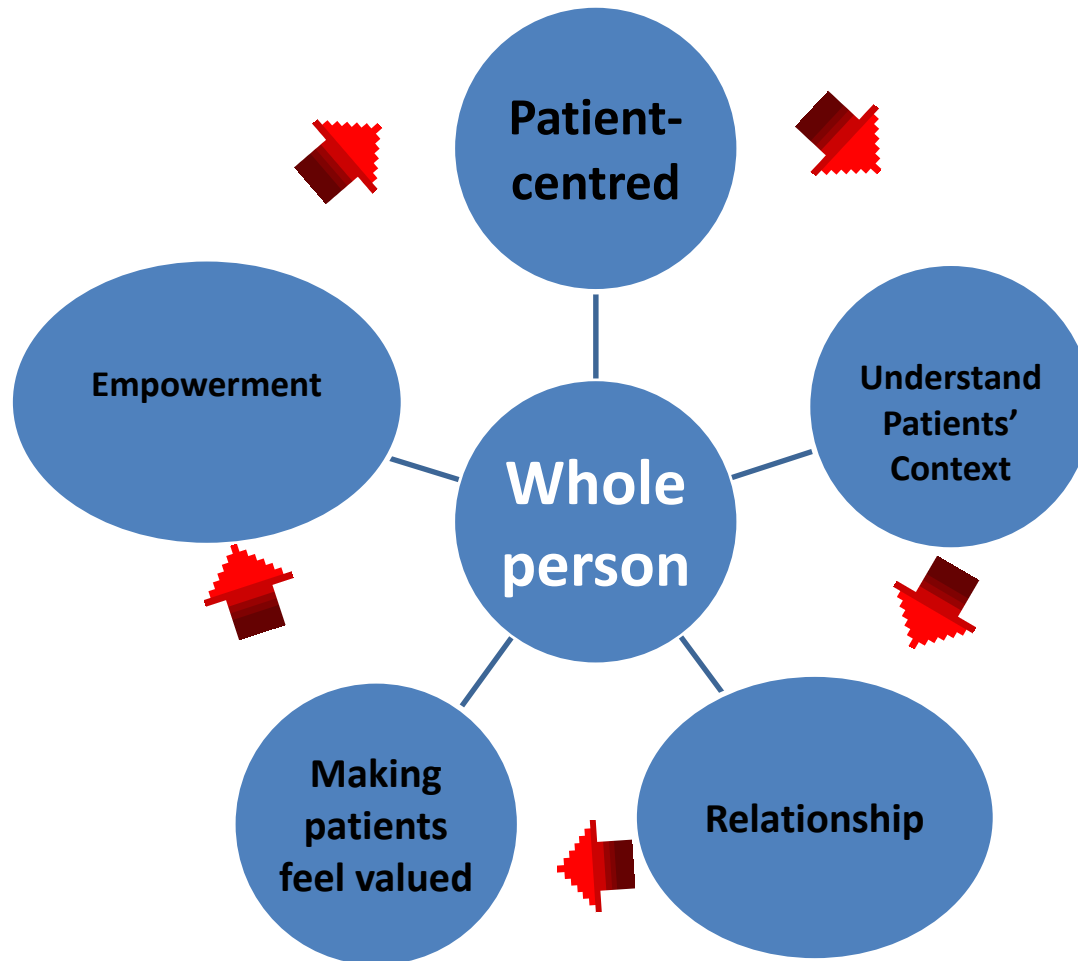
“Demoralising”

“Exhausting”

“I feel like a wrung-out rag at the end of consultations”

“If you’re too caring ... you’ll crack up in a place like this. Our boundaries lie where they are because they have to at the moment”

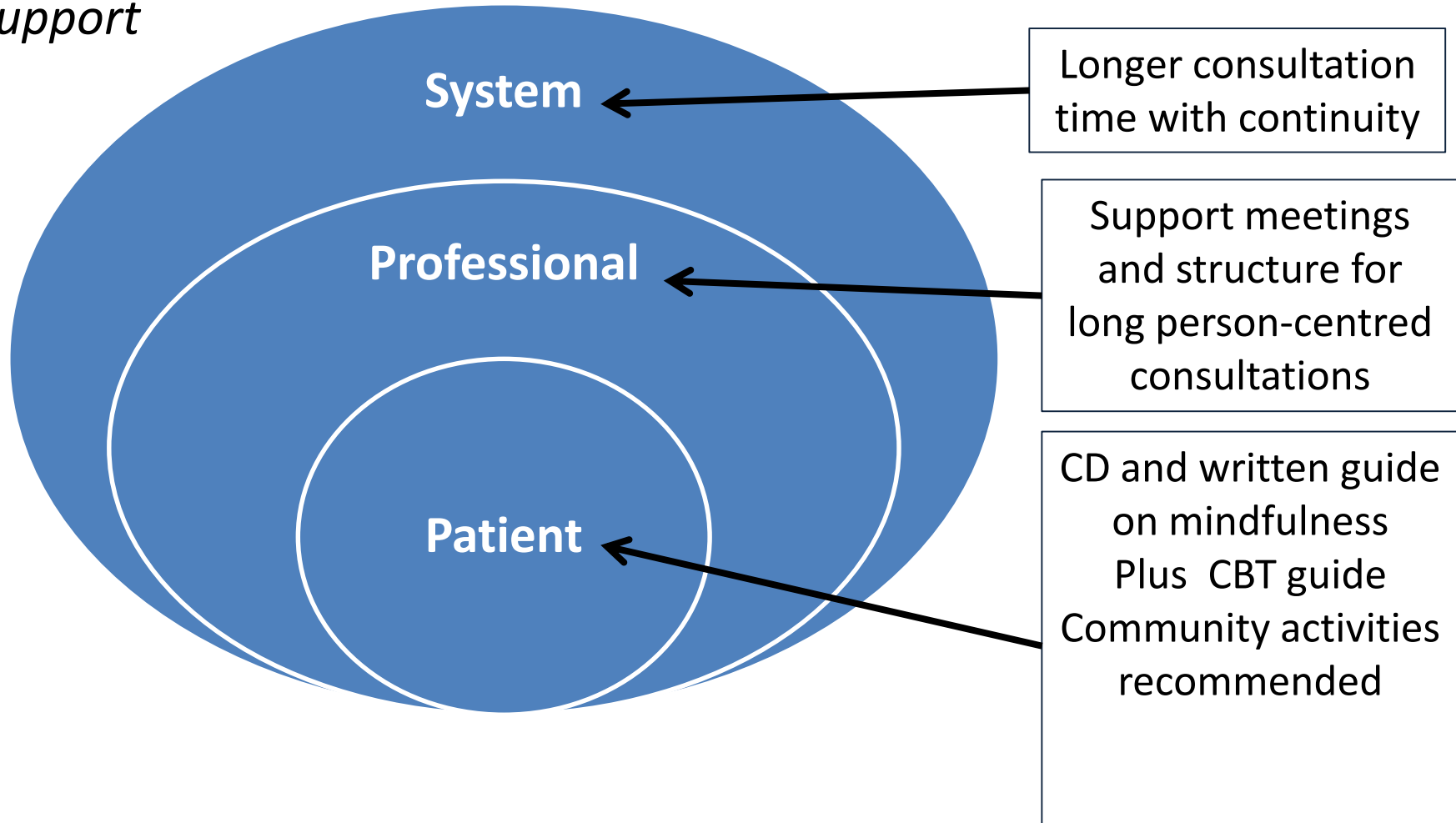
Developing – whole system, whole person approach



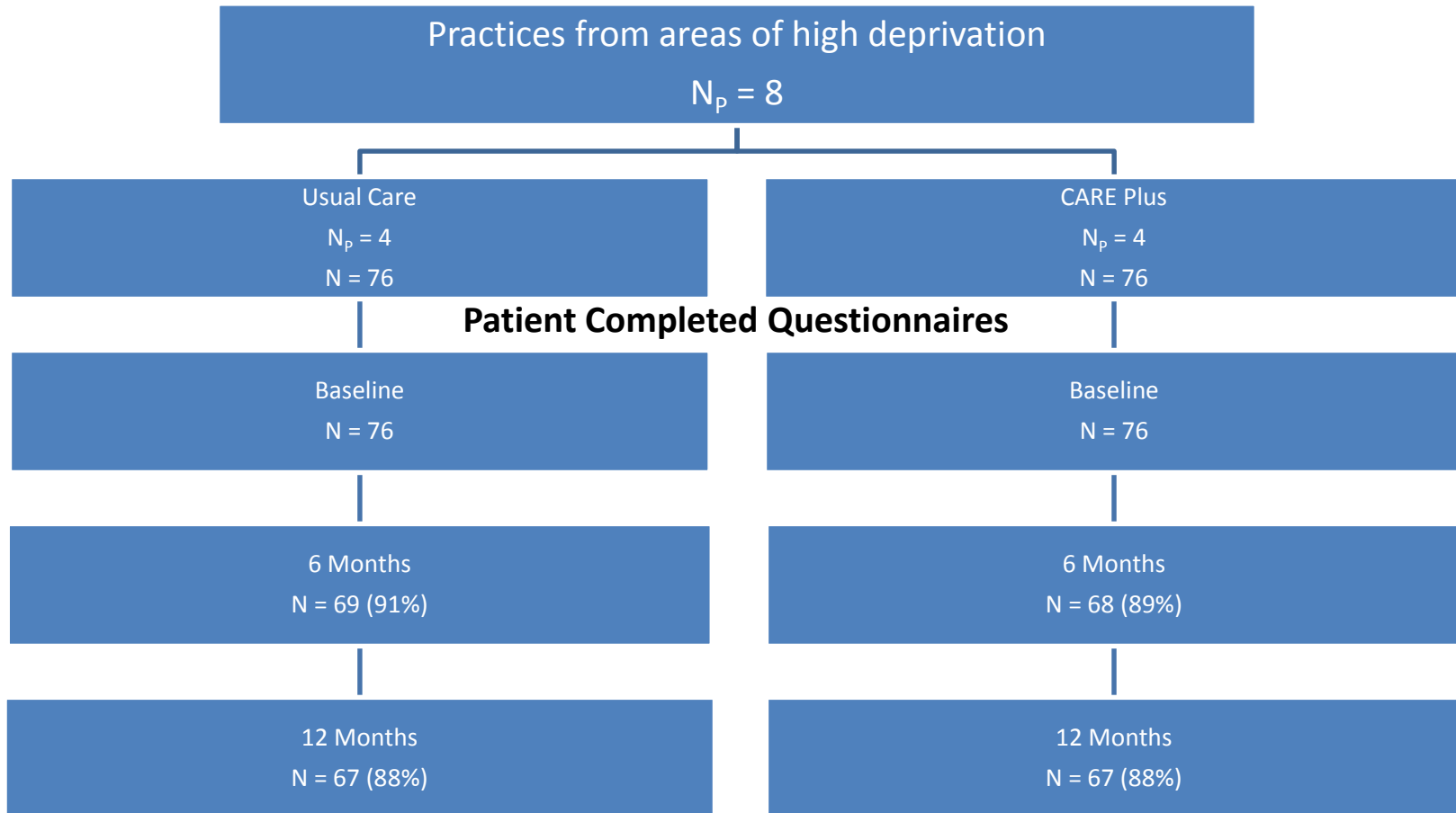
- Time
- Continuity
- Support and training for professionals
- Self-management support for patients

CARE PLUS: a whole-system approach

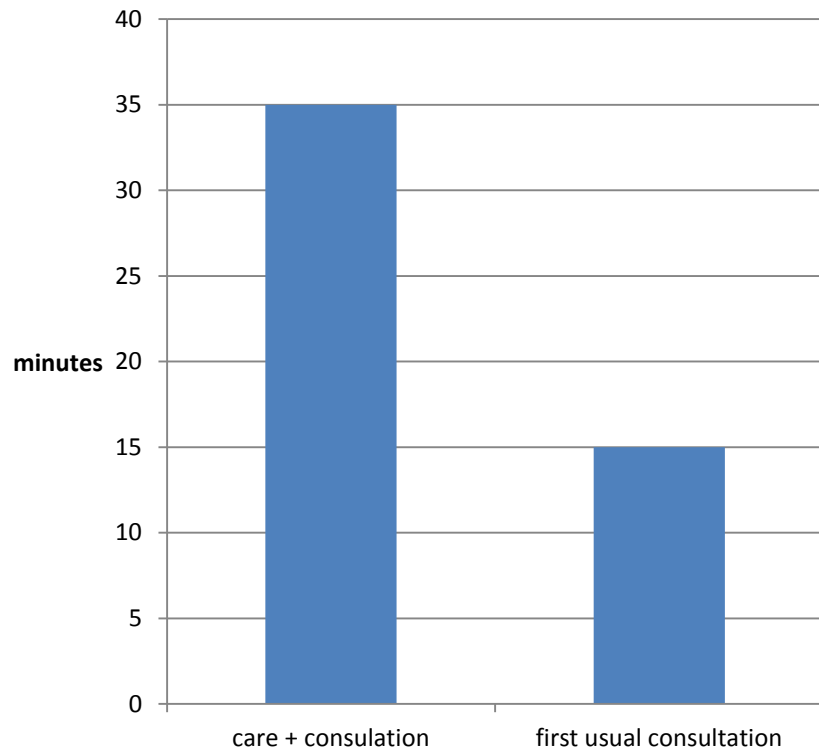
Time, continuity, person centredness and self-management support



Would GPs and patients participate in a RCT?

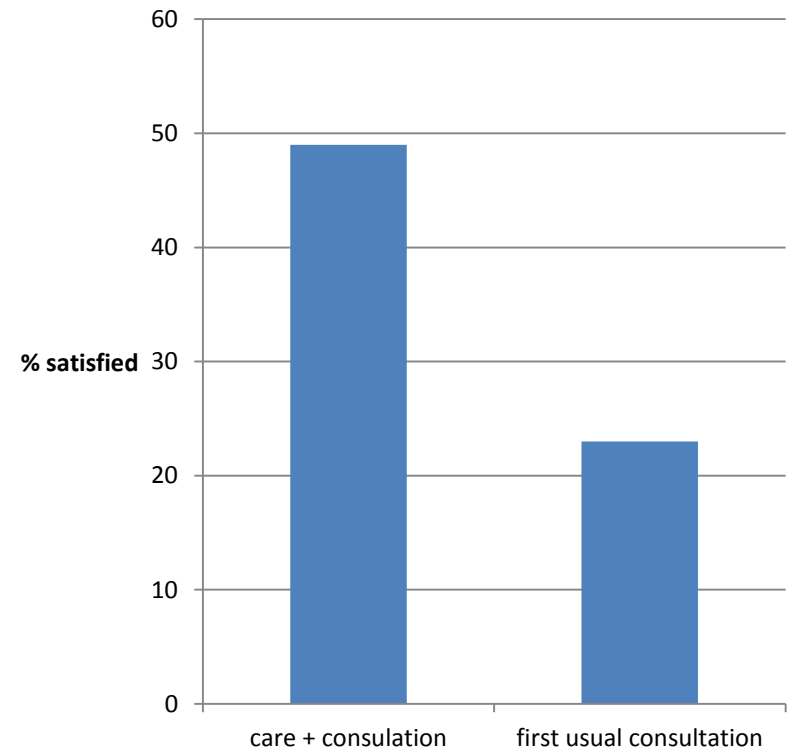


Time spent in first index consultation



P<0.0001

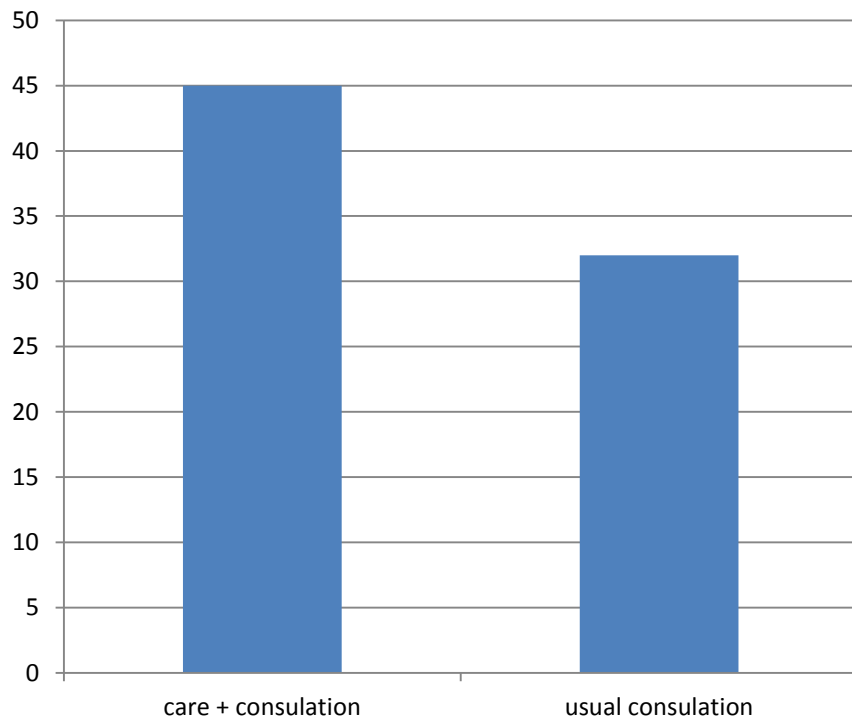
Satisfied with time spent in first index consultation



P<0.0005

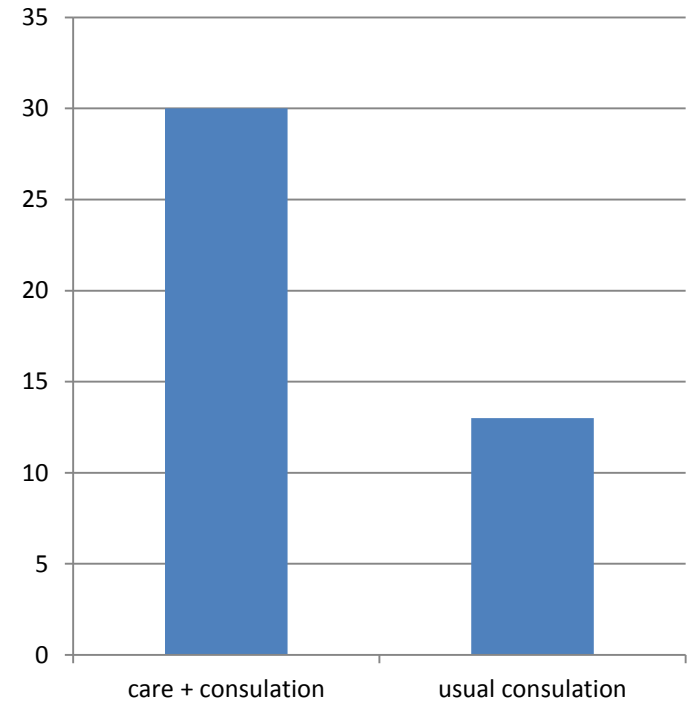
Are consultations 'better'?

care measure (% max score)



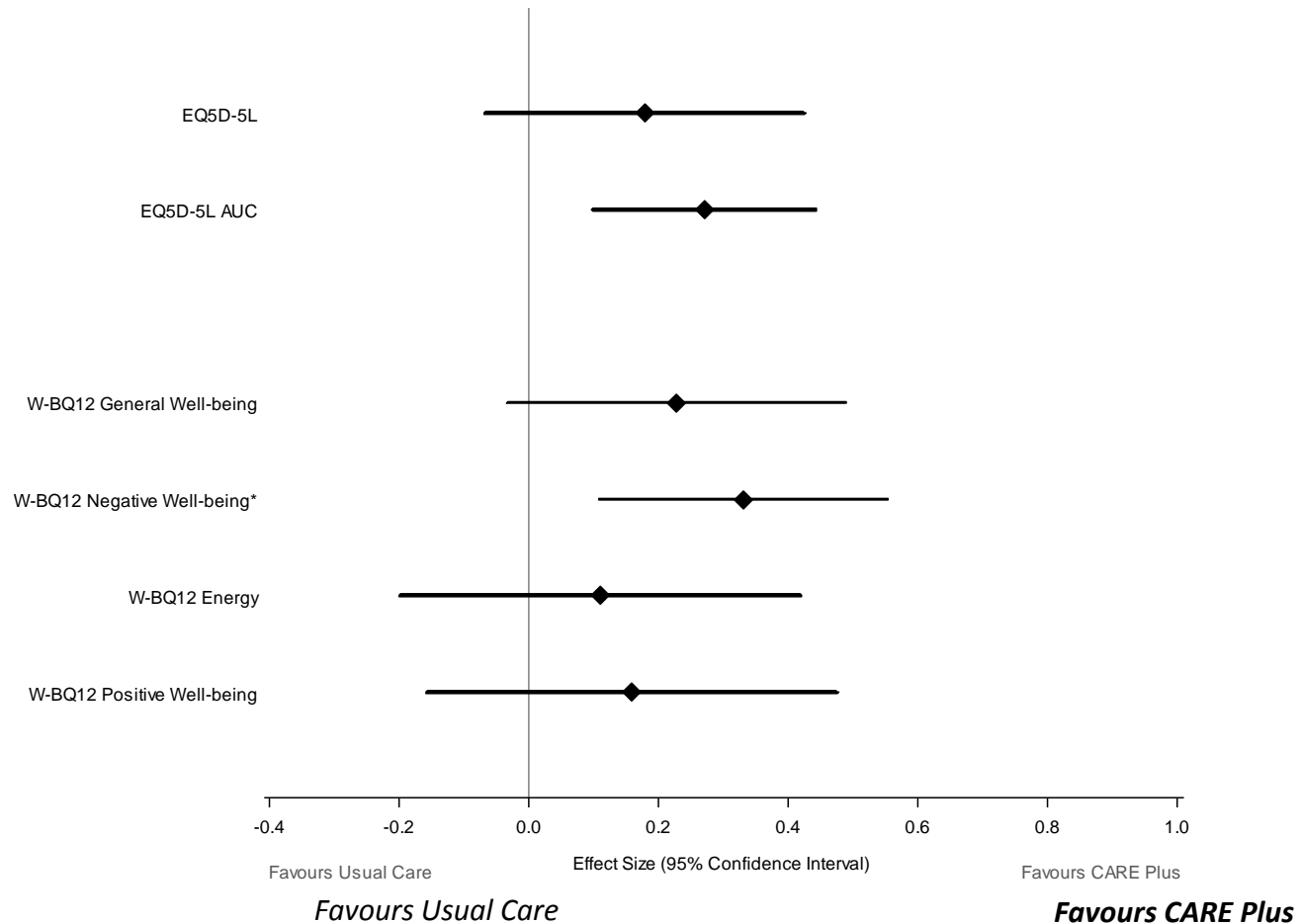
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PEI (% 'enabled')

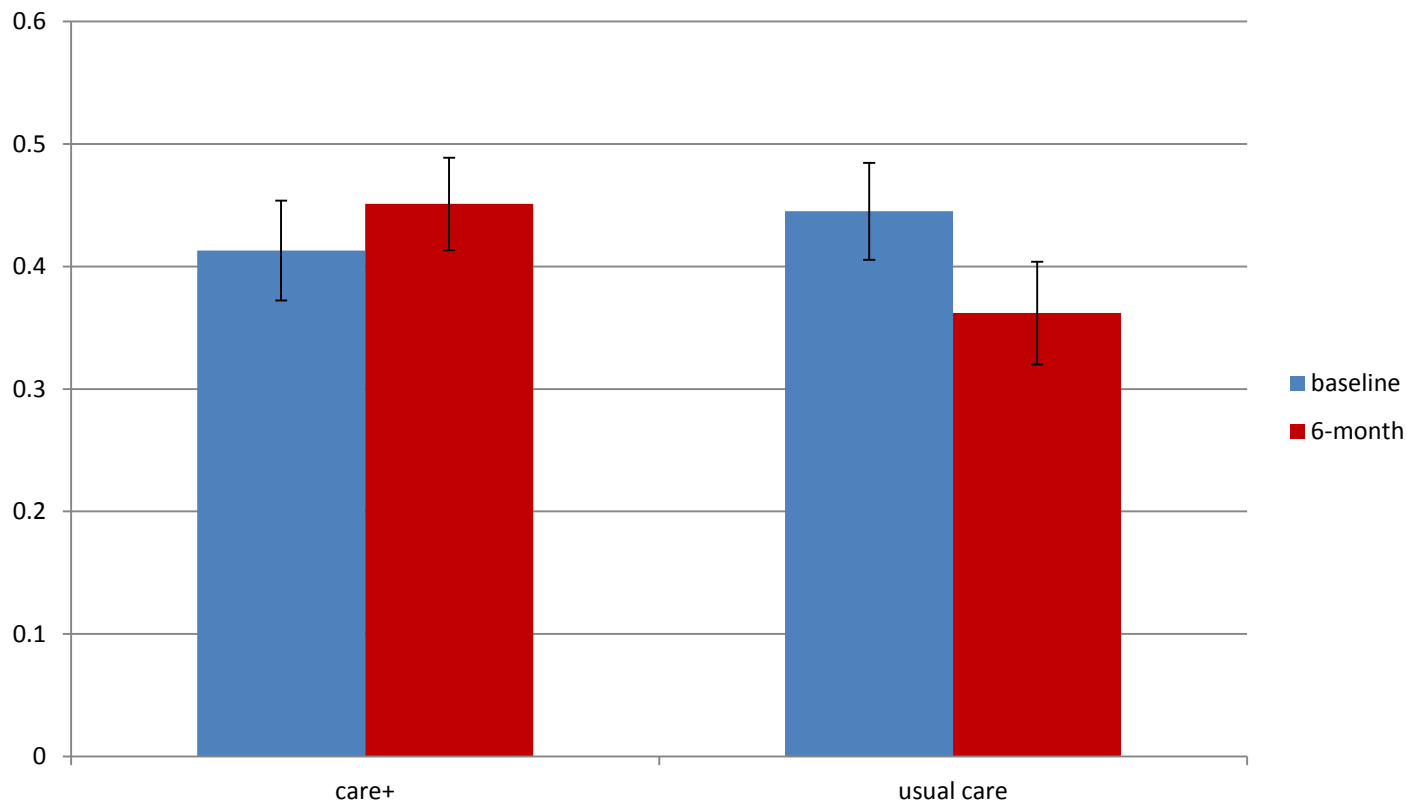


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Patients in the CARE Plus group had improvements in quality of life and wellbeing at 12 months



CARE Plus prevents decline in QOL (EQ5-DL)



Effect size = 0.35

CARE Plus is also very cost-effective

- Cost-effective:
 - Cost < £13,000 per QALY
 - NICE currently supports a cost of £20,000 per QALY

Summary

- Health inequalities continue to widen
- Multimorbidity is a major challenge
- It is socially patterned, occurring earlier in deprived areas
- Because of the inverse care law, GPs struggle to meet patients complex needs in deprived areas
- 'Reversing' the inverse care law experimentally appears to improve outcomes in a very cost-effective way