

	HEALTHY LIFE EXPECTANCY years	YEARS IN POOR HEALTH years	TOTAL LIFE EXPECTANCY years
MEN			
RICHEST 10%	76	5	81
POOREST 10%	57	11	68
DIFFERENCE	19	6	13
WOMEN			
RICHEST 10%	78	6	84
POOREST 10%	61	15	76
DIFFERENCE	17	9	8

4 PROBLEMS

Gaps rather than slopes

Unsustained, ineffective interventions

Professionalisation of health inequalities

Denial of the inverse care law

Diamonds Are A Girl's Best Friend

A kiss on the hand may be
quite continental
But diamonds are a girl's best friend
A kiss may be grand
but it won't pay the rental
on your humble flat,
or help you at the automat
Men grow cold, as girls grow old
and we all lose our charms in the end
But square-cut or pear-shape
these rocks won't lose their shape
Diamonds are a girl's best friend

DECORATORS

BUILDERS

EXHIBIT ES-1. OVERALL RANKING

COUNTRY RANKINGS

Top 2*
Middle
Bottom 2*

	AUS	CAN	FRA	GER	NETH	NZ	NOR	SWE	SWIZ	UK	US
OVERALL RANKING (2013)	4	10	9	5	5	7	7	3	2	1	11
Quality Care	2	9	8	7	5	4	11	10	3	1	5
Effective Care	4	7	9	6	5	2	11	10	8	1	3
Safe Care	3	10	2	6	7	9	11	5	4	1	7
Coordinated Care	4	8	9	10	5	2	7	11	3	1	6
Patient-Centered Care	5	8	10	7	3	6	11	9	2	1	4
Access	8	9	11	2	4	7	6	4	2	1	9
Cost-Related Problem	9	5	10	4	8	6	3	1	7	1	11
Timeliness of Care	6	11	10	4	2	7	8	9	1	3	5
Efficiency	4	10	8	9	7	3	4	2	6	1	11
Equity	5	9	7	4	8	10	6	1	2	2	11
Healthy Lives	4	8	1	7	5	9	6	2	3	10	11
Health Expenditures/Capita, 2011**	$3,800	$4,522	$4,118	$4,495	$5,099	$3,182	$5,669	$3,925	$5,643	$3,405	$8,508

Notes: * Includes ties. ** Expenditures shown in $US PPP (purchasing power parity); Australian $ data are from 2010.
Source: Calculated by The Commonwealth Fund based on 2011 International Health Policy Survey of Sicker Adults; 2012 International Health Policy Survey of Primary Care Physicians; 2013 International Health Policy Survey; Commonwealth Fund *National Scorecard 2011;* World Health Organization; and Organization for Economic Cooperation and Development, *OECD Health Data, 2013* (Paris: OECD, Nov. 2013).

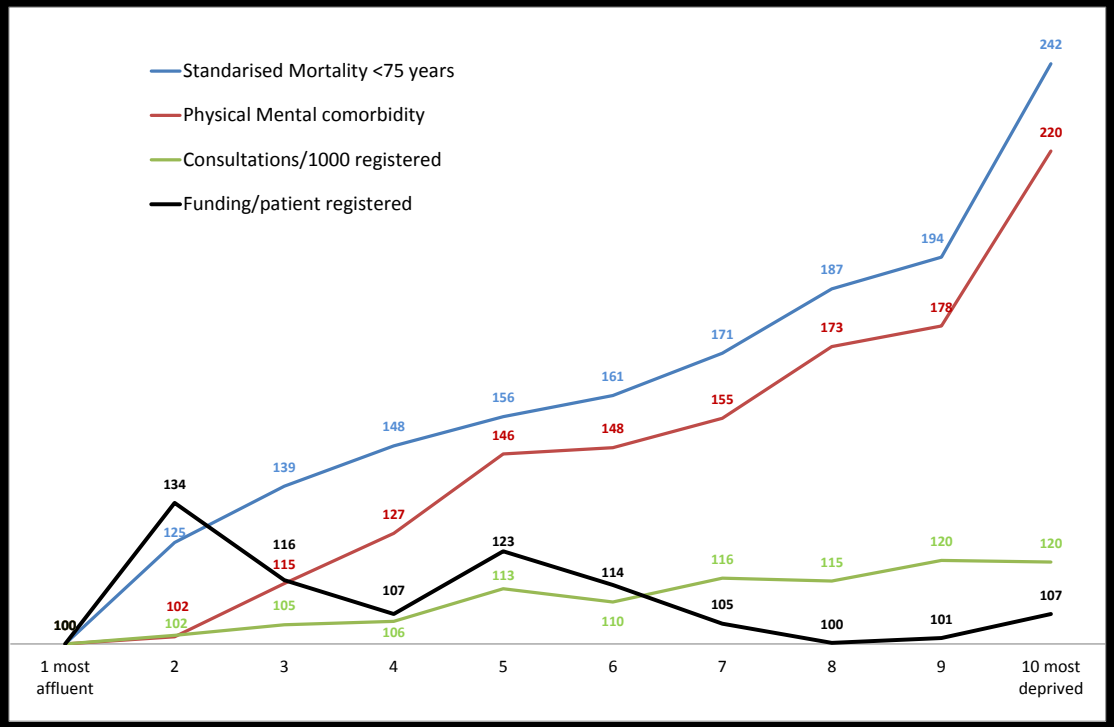
The NHS Act

1. Took money out of the consultation
2. Provided population coverage via the list system
3. Gave doctors the role of responding unconditionally to patients' needs
4. Established GPs as gatekeepers

IS THE NHS FAIR?

In providing emergency care	YES
In providing non-emergency care	NO
In providing primary care	NO

Percentage differences from least deprived decile for mortality, comorbidity, consultations and funding




The Herald

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GP funding is 'robbing the poor to pay for the rich'

By Eleanor Bradford
BBC Scotland Health Correspondent

30 November 2015 | Scotland

"Over 2 million Scots in the most deprived 40% of the population received £10 less GP funding per head per annum than over 3 million Scots in the most affluent 60%"

Out of Hours

Discretion is the better part of general practice

I shadowed a GP working in one of Glasgow's most deprived areas. She arrived at 7.20 am on a Monday morning to deal with 38 items of correspondence, all needing to be checked and prescriptions altered, a patient phoned, or arrangements made, before the day even started. The telephone calls to patients all began the same way: 'This is Dr xxxxx, Hello John, Hello Helen etc'.

As the on-call doctor on a busier day than usual, she completed seven house visits that morning, each taking 30 minutes. It took an hour to enter all the details back in the practice and make the necessary arrangements, leaving 5 minutes for lunch. A colleague who took over the on-call for the afternoon made three more home visits, dealt with 22 telephone consultations and six emergency appointments.

The afternoon surgery ran for 3 hours, and would have lasted longer if all the booked patients had attended. Problems addressed included: cancer, depression, agoraphobia, asthma, self-harm, bereavement, domestic violence, heart failure, alcohol abuse, dementia, social neglect, and so on, often in combination. She left for home after a 12-hour day, with 61 items of correspondence yet to deal with.

I didn't see any short or trivial consultations. There were no 'worried well' patients, but a worried doctor leaving no loose ends when dealing with a series of patients with complicated health issues and other problems, all of whom she knew well. One patient said 'Dr xxxxx" is the only person I can relate to'. Another came in grim-faced, avoiding eye contact, almost in tears, but left 15 minutes later, beaming a smile.

I was struck by the intensity of the day, every patient getting the same attention. The doctor was too busy to put on an act. 'We have to focus on every single patient and listen. A lot feel they bother us and we cannot fob them off by being stressed or not dedicating time'. The practice has learned from experience that it is unsafe to assume that if problems are serious, patients will consult in time.

There are three GP partners and none work 'full-time'. 'You cannot work fully concentrated for a whole day without recovery time'. The practice is wondering whether it might attract more students to their list to dilute the clinical load. Burn-out

> "'We have to focus on every single patient and listen. A lot feel they bother us and we cannot fob them off by being stressed or not dedicating time'."

is an ever-present hazard. The level of work is hard to sustain.

The consultations I observed showed a GP at the top of her game. Previous contact, shared knowledge, and trust were fundamental to what could be achieved in a short space of time. Despite the pressures of practice in a deprived area,[1] the GP was ambitious for what she could achieve with, and for, her patients.

One seldom gets the opportunity to observe a GP through a whole working day. What I saw in Glasgow reminded me of working with Julian Tudor Hart at Glyncorrwg in South Wales. He is best known for research on high blood pressure, but his daily practice and long-term achievements were characterised by his unconditional approach to all patients, whom he came to know well, whatever problems or combinations of problems they had. In the BBC documentary series on the NHS *Pioneers*, Mary Hart said 'Many people sentimentalise us, but we were just doing our job, for which we were paid, providing the NHS for our patients.'[2]

In an article with Paul Dieppe, Tudor Hart described the poisonous effects which can arise when, for whatever reason, health professionals become indifferent to what happens to the patient in front of them.[3] I remember him talking of the importance of finding something to like about every patient. There was no-one about whom there wasn't something to like.

In the 1950s, Collings described poorly-resourced areas of general practice as 'sufficient to turn a good doctor into a bad doctor in a short period of time.'[4] Such gross effects are less common today. A more subtle effect is whether practitioners set the bar high or low when dealing with patients.

ADDRESS FOR CORRESPONDENCE

Graham Watt
R308 Level 3, General Practice & Primary Care,
1 Horselhill Road, Glasgow G12 9LX, UK.
E-mail: graham.watt@glasgow.ac.uk

The incentives of the Quality and Outcomes Framework, involving only 12.7% of GP consultations,[5] have little to do with this aspect of practice. Professionalism and caring for patients are what matter, and both are at the discretion of individual practitioners.

Consultation rates are used as crude measures of practice activity and proxy indicators of health need. Such data convey nothing of the duration, content, quality, or consequences of consultations, and their use sustains the inverse care law.[6] What I saw in 1 day in one practice in one part of the country goes unrecorded in the scheme of things, reflects poorly on the NHS commitment to equitable resource distribution, but spoke volumes for the professionalism of one GP.

Graham Watt,
Norie Miller Professor of General Practice,
University of Glasgow, Glasgow.

DOI: 10.3399/bjgp15X685357

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Ubiquitous, endemic complexity

The value of previous encounters

Empathy and trust

The "worried doctor"

Setting the bar high

Every patient matters

BJGP, June 2015

RELATIONSHIPS ARE THE SILVER BULLETS OF GENERAL PRACTICE AND PRIMARY CARE

BRIEF ENCOUNTERS

SERIAL ENCOUNTERS

SCHEHEREZADE

TELLING 1001 TALES

10% of patients with 4 or more conditions accounted for

34% of patients with unplanned admissions to hospital and

47% of patients with potentially preventable unplanned admissions

Payne R, Abel G, Guthrie B, Mercer SW.

The impact of physical multimorbidity, mental health conditions and socioeconomic deprivation on unplanned admissions to hospital: a retrospective cohort study.

CMAJ 185 (e-publication ahead of print): E221-E228, 2013, doi:10.1503/cmaj.121349

GATEKEEPING

87 : 13

86 : 14

85 : 15

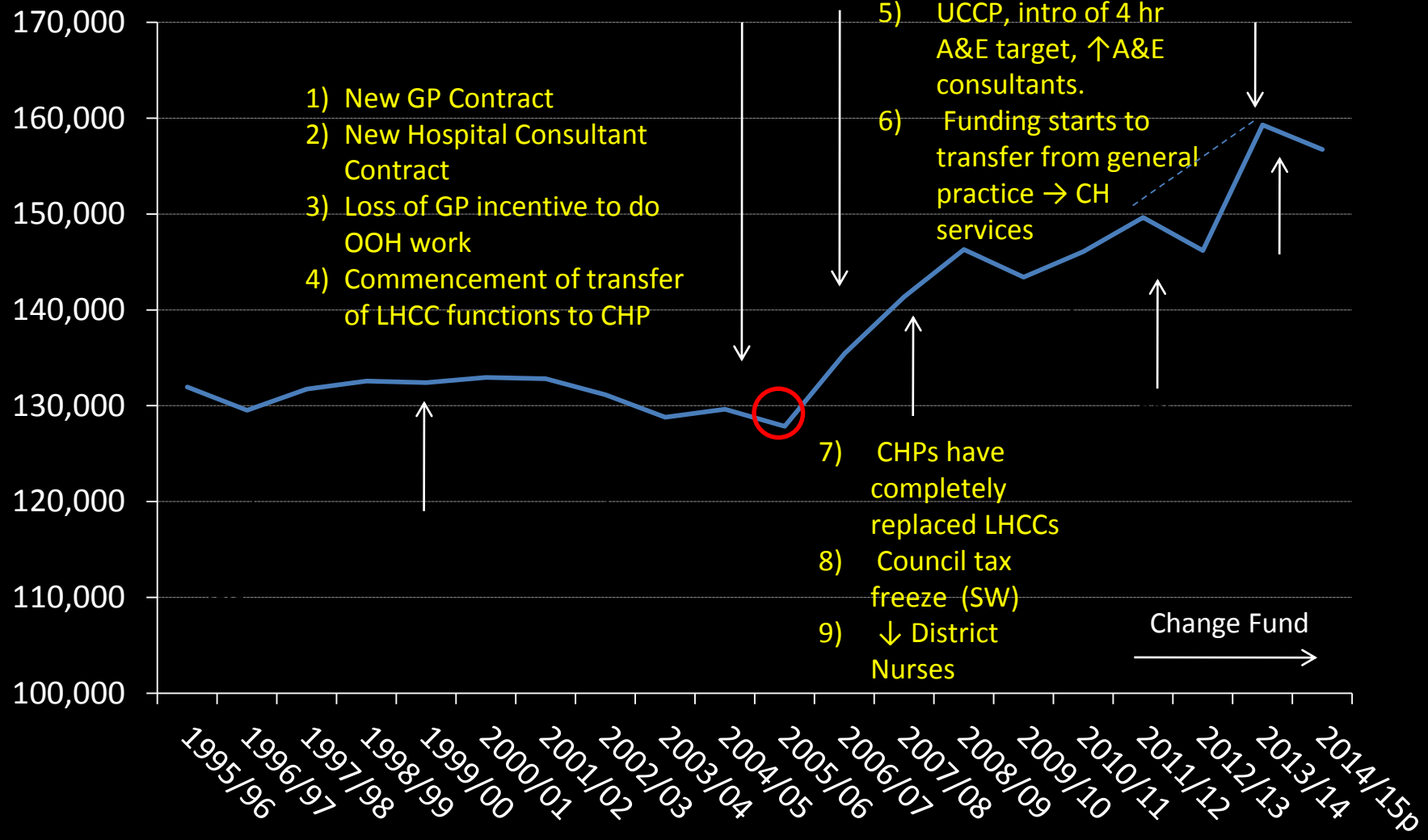
84 : 16

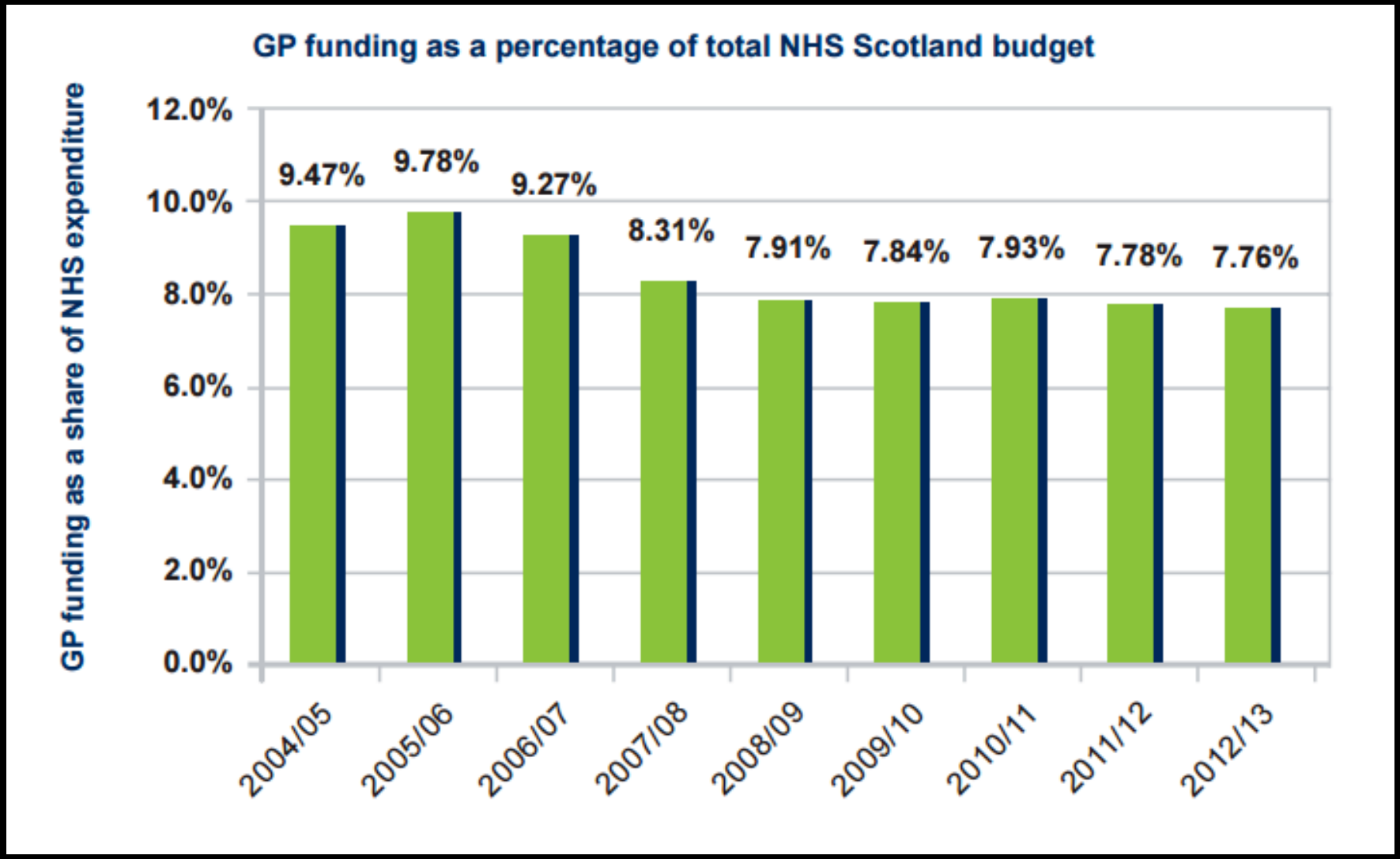
THE SECRET OF GATEKEEPING

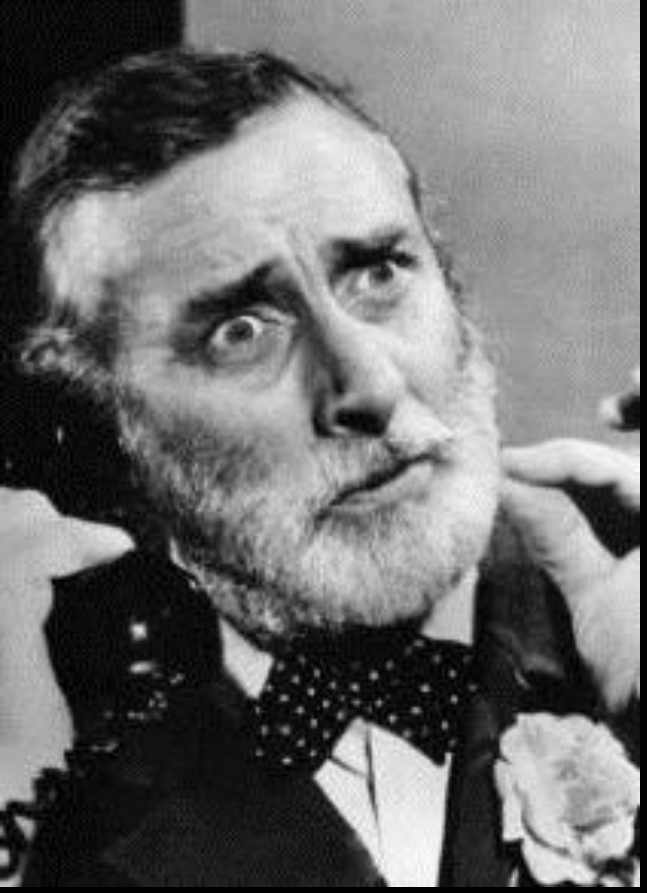
THERE IS NO GATE (at least, to unscheduled care)

ONLY A GATEWAY (that patients can go through at any time)

Number of emergency admissions (all specs, all ages, all stays) at GG&C sites, 1995/6 - 2014/15. Source: SMR01 data from J Gomez.




GP funding as a percentage of total NHS Scotland budget
GP funding as a share of NHS expenditure
12.0%
10.0%
8.0%
6.0%
4.0%
2.0%
0.0%
9.47%
9.78%
9.27%
8.31%
7.91%
7.84%
7.93%
7.78%
7.76%
2004/05
2005/06
2006/07
2007/08
2008/09
2009/10
2010/11
2011/12
2012/13



I'VE JUST INVENTED A MACHINE THAT DOES THE WORK OF TWO MEN.

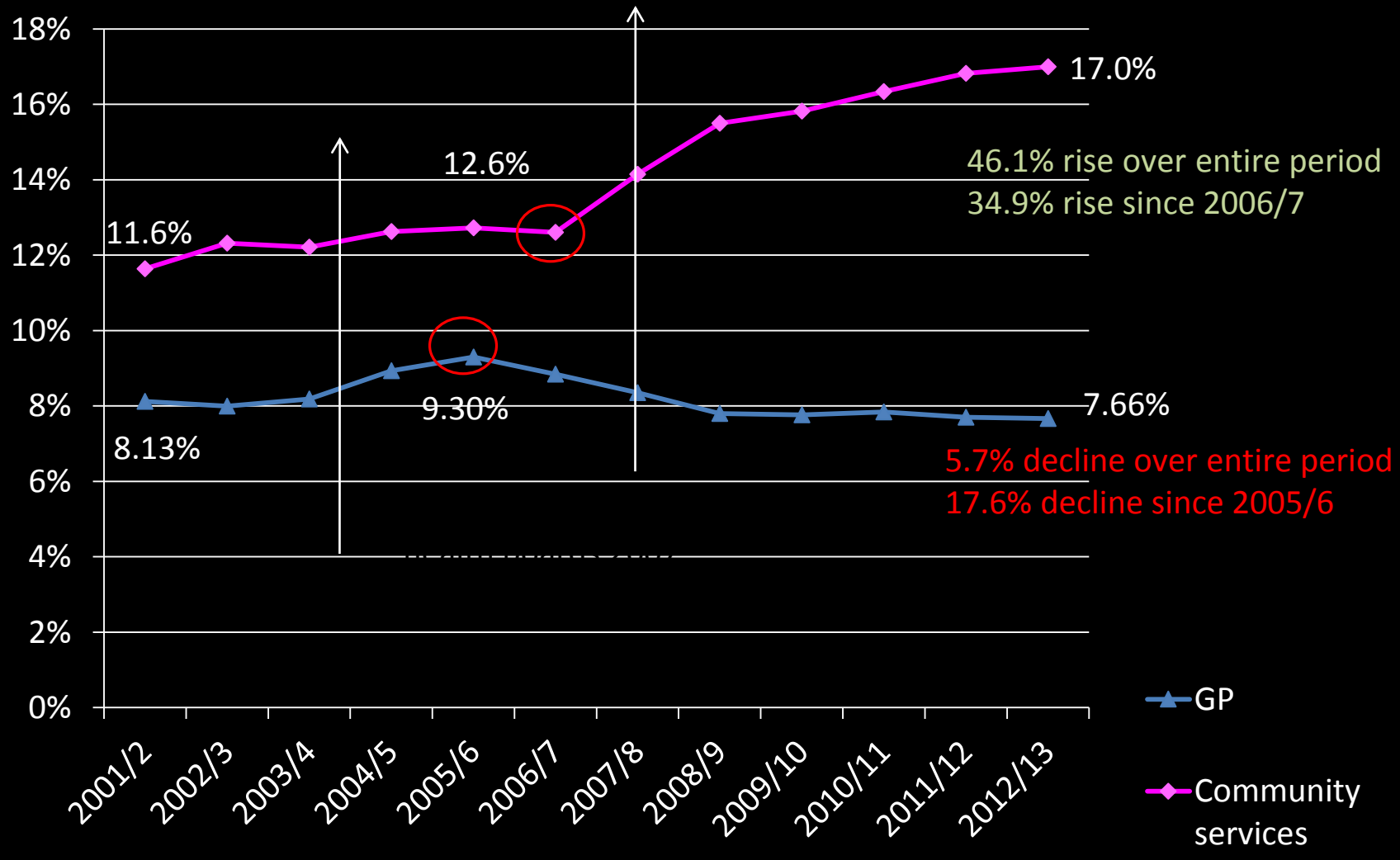
UNFORTUNATELY, IT TAKES THREE MEN TO WORK IT

SPIKE MILLIGAN

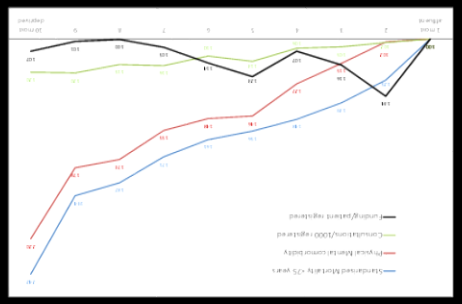
TOO MANY HUBS

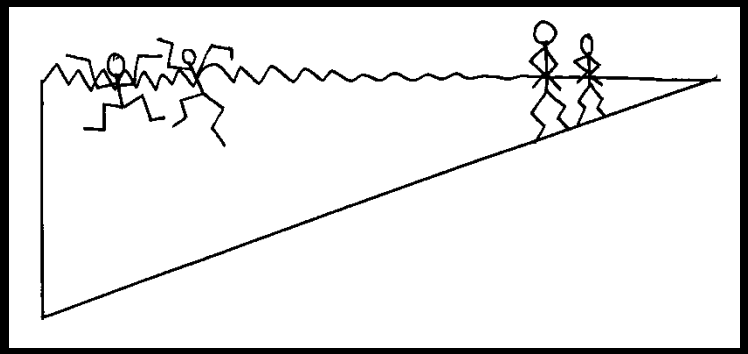
HEALTH CARE AS A PINBALL MACHINE

Percentage of total national territorial board NHS funding spent on general practice vs community services, 2001-2013. Source: ISD Scotland website funding data.

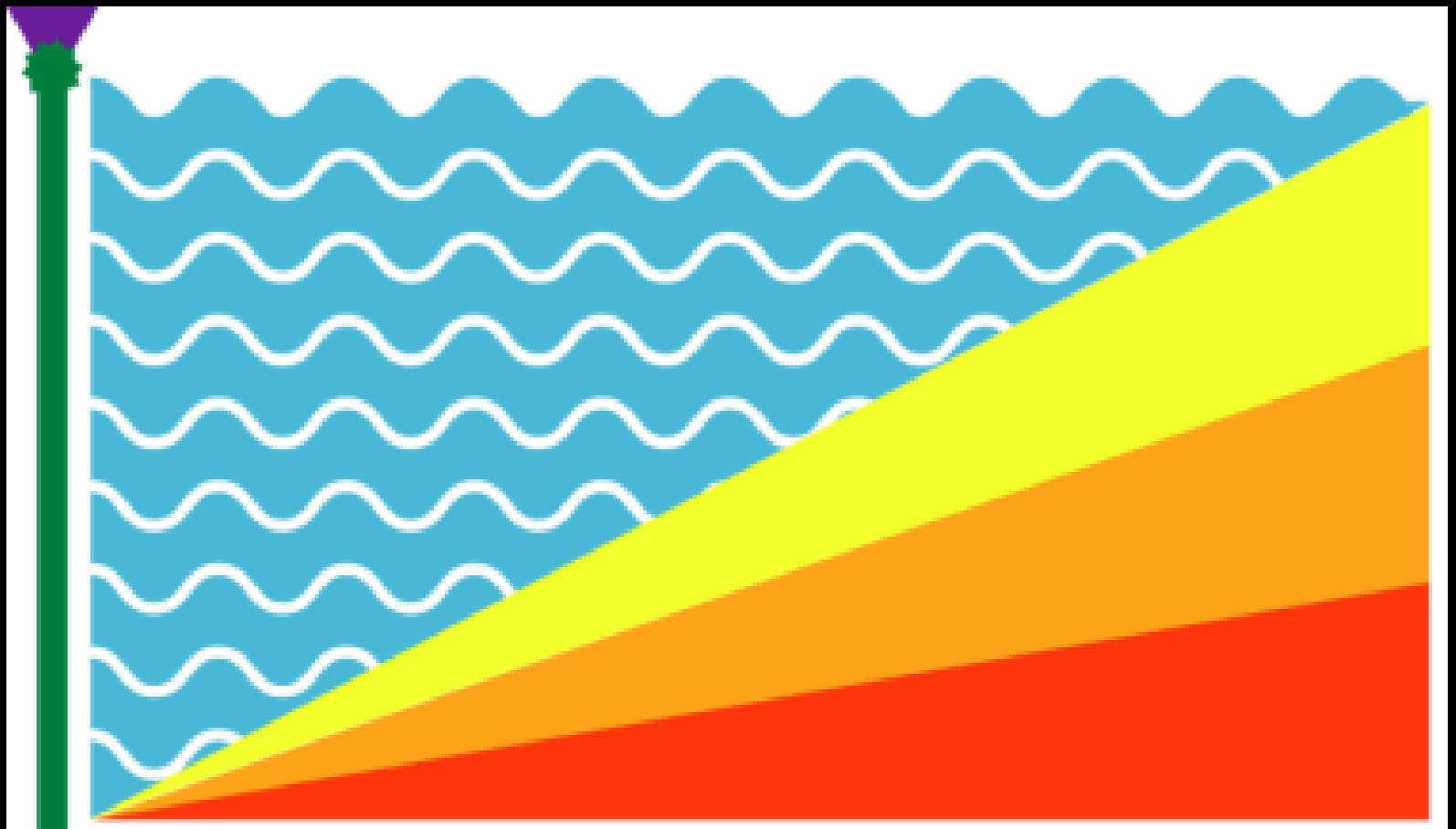


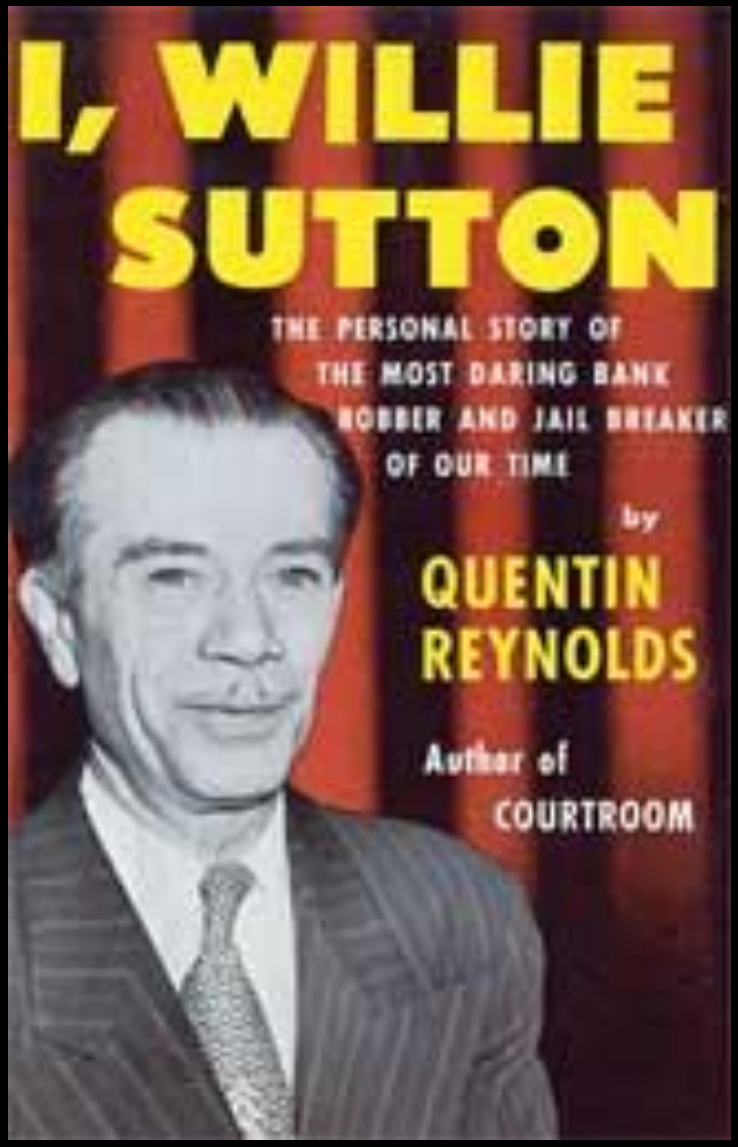
GENERAL PRACTITIONERS AT THE DEEP END





GPs at the Deep End


GPs at the Deep End



QUESTION

WHY DO YOU ROB BANKS ?

ANSWER

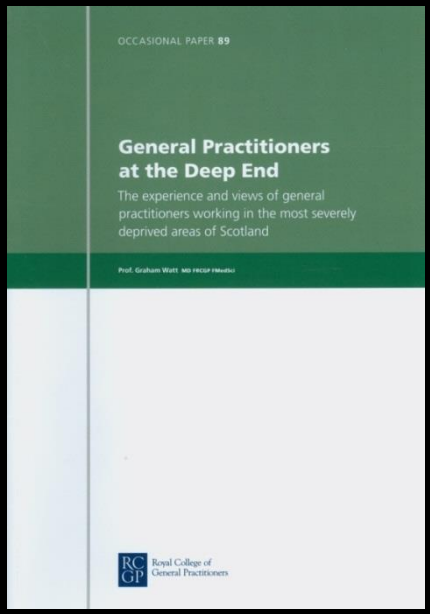
BECAUSE THAT'S WHERE THE MONEY

WILLIE SUTTON

DEEP END REPORTS

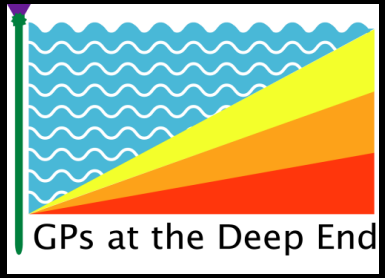
1. First meeting at Erskine
2. Needs, demands and resources
3. Vulnerable families
4. Keep Well and ASSIGN
5. Single-handed practice
6. Patient encounters
7. GP training
8. Social prescribing
9. Learning Journey
10. Care of the elderly
11. Alcohol problems in young adults
12. Caring for vulnerable children and families
13. The Access Toolkit : views of Deep End GPs
14. Reviewing progress in 2010 and plans for 2011
15. Palliative care in the Deep End
16. Austerity Report
17. Detecting cancer early
18. Integrated care
19. Access to specialists
20. What can NHS Scotland do to prevent and reduce heath inequalities
21. GP experience of welfare reform in very deprived areas
22. Mental health issues in the Deep End
23. The contribution of general practice to improving the health of vulnerable children and families
24. What are the CPD needs of GPs working in Deep End practices?
25. Strengthening primary care partnership responses to the welfare reforms
26. Generalist and specialist views of mental health issues

GPs at the Deep End



www.gla.ac.uk/deepend

SIX ESSENTIAL COMPONENTS



1. Extra TIME for consultations

2. Best use of serial ENCOUNTERS

3. General practices as the NATURAL HUBS of local health systems

4. Better CONNECTIONS across the front line

5. Better SUPPORT for the front line

6. LEADERSHIP at different levels

A NEW BUILDING PROGRAMME FOR INTEGRATED CARE

PATIENT STORIES

LOCAL HEALTH SYSTEMS

MACHINES THAT DO THE WORK OF TWO MEN

The essence of General Practice

An invitation to create the future

INVENTING THE WHEEL

HUB

Contact
Coverage
Continuity
Comprehensive
Coordinated
Flexibility
Relationships
Trust
Leadership

SPOKES + RIMS

Keep Well
Child Health
Elderly
Mental Health
Addictions
Community Care
Secondary Care
Voluntary sector
Local Communities

INTEGRATED CARE DEPENDS ON MULTIPLE RELATIONSHIPS

MESSAGE FROM THE DEEP END

Patients need referral services which are :-

Local
Quick
Familiar

i.e.
Attached workers who will work flexibly and quickly according to the needs of patients and practices

“your problem is our problem”

A machine that does the work of two men but takes one person to work it

UNANSWERED QUESTIONS

Who else can manage risk, uncertainty and complexity ?

Do strong local health systems keep patients out of hospital ? How ?

Are “integrated” local health systems “people rich” or “people poor” ?

How do serial contacts (all the NHS contacts a patient has) add up, in terms of building knowledge and confidence ?

What do “self help” and “self management” mean for patients who lack knowledge, confidence and agency ?

How to engage with patients who are hard to engage ?

What is the “treatment burden” imposed on patients, especially those with multimorbidity ,by fragmented and dysfunctional services ?

How to apply evidence, when so little of it is based on patients with complicated multimorbidity ?

Reverse the underfunding of general practice

Address the inverse care law

Develop strong local health systems based on practice hubs

Mitigate the effects of health inequalities

Remove the NHS as a social determinant of widening inequality