Responses to the inverse care law in Scotland

Dr David Blane

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GP researcher, academic lead for the Deep End group

Key points

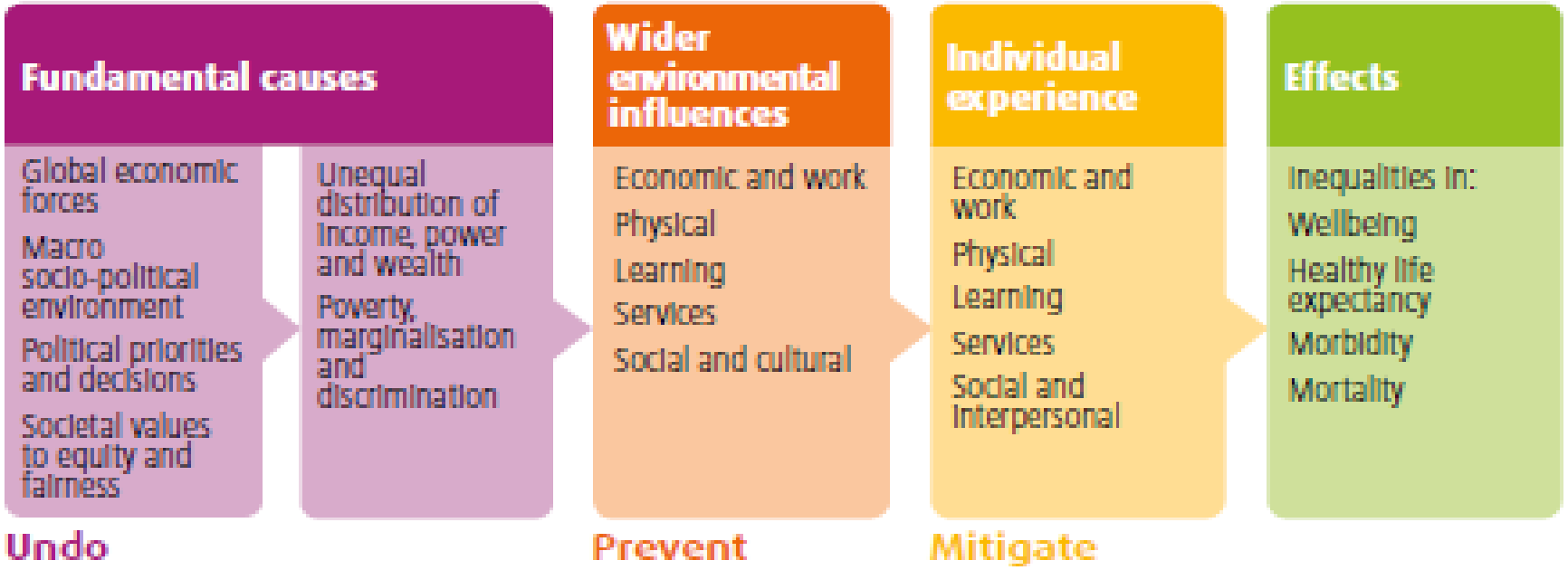
1. Most determinants of health (and health inequalities) lie outside the NHS, but the distribution of NHS resource is an important (and often overlooked) health determinant.

2. The (im)balance of primary/community vs secondary care impacts the gatekeeper function.

3. The inverse care law is not about good or bad care, but the difference between what can be done and what could be done if resources were distributed according to need (proportionate universalism).

Framework for understanding health inequalities

"…the conditions in which people are born, grow, live, work and age."

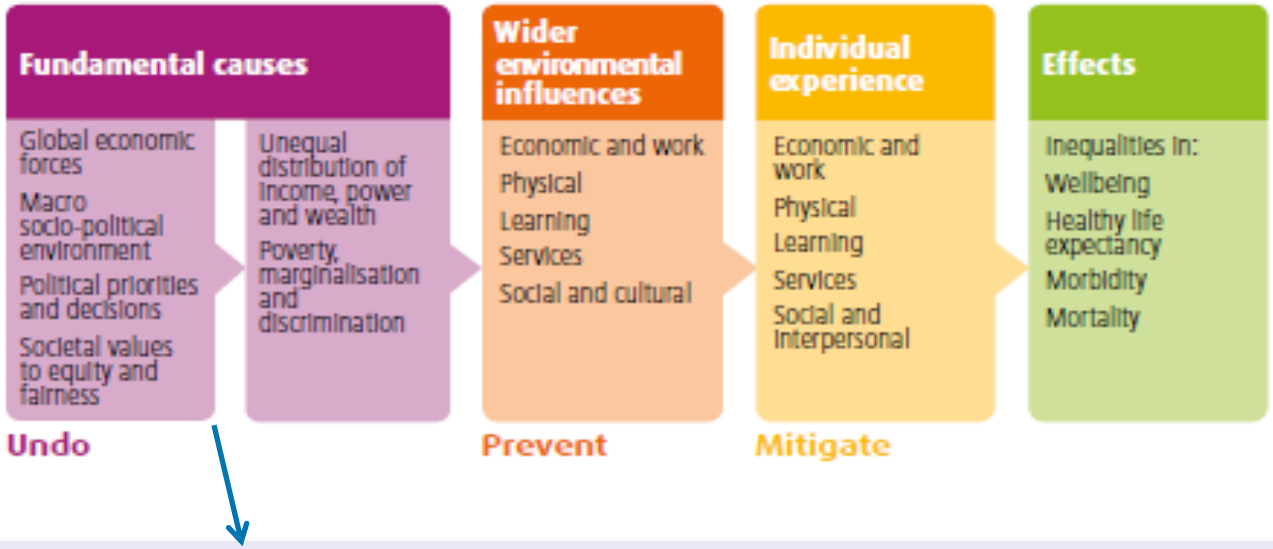


NHS Health Scotland (2016). Health inequalities: What are they? How do we reduce them?
http://www.healthscotland.com/documents/25780.aspx

Key actions - UNDO

Health inequalities:

What are they? How do we reduce them?



Key actions

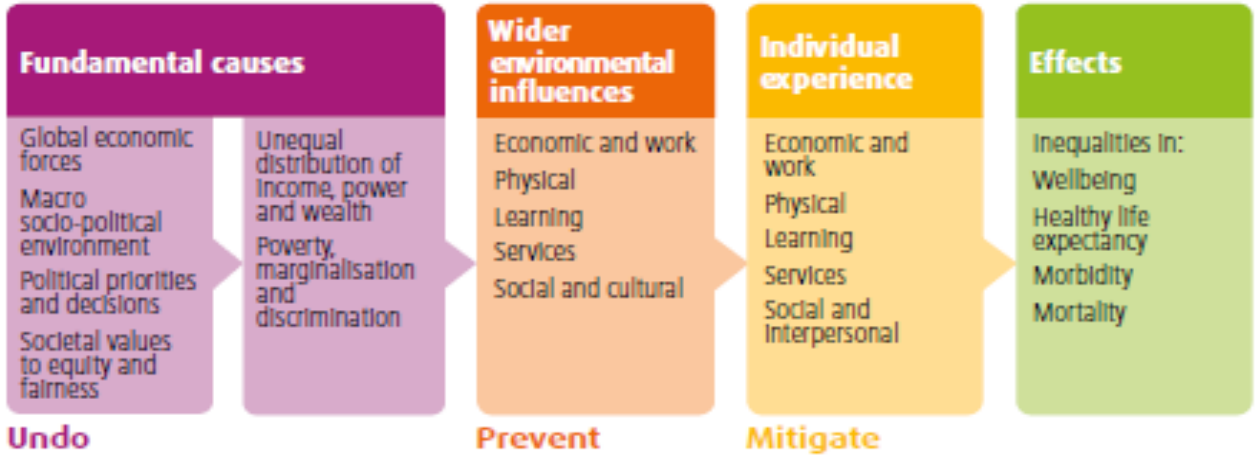
- Introduce a minimum income for healthy living.
- Ensure the welfare system provides sufficient income for healthy living and reduces stigma for recipients through universal provision in proportion to need (proportionate universalism).
- A more progressive individual and corporate taxation.
- The creation of a vibrant democracy, a greater and more equitable participation in elections and local public service decision-making.
- Active labour market policies (e.g. hiring subsidies/self-employment incentives, apprenticeship schemes) and holistic support (e.g. subsidised childcare, workplace adjustments for those with health problems) to create good jobs and help people get and sustain work.

NHS Health Scotland (2016). Health inequalities: What are they? How do we reduce them?
http://www.healthscotland.com/documents/25780.aspx

Key actions - PREVENT

Health inequalities:

What are they? How do we reduce them?



Key actions

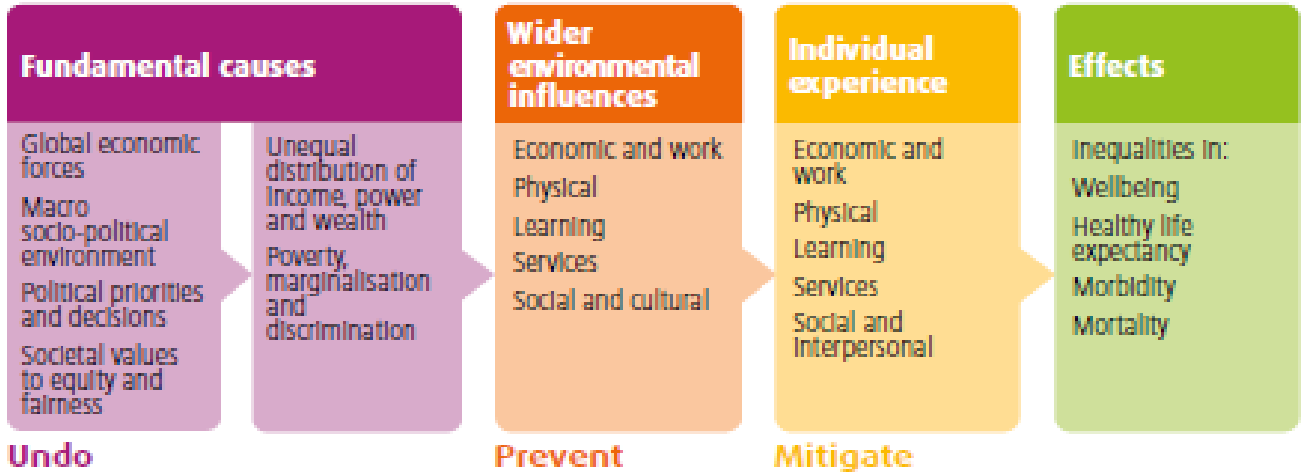
- Ensure local service availability and high quality green and open spaces, including space for play.
- Drink-driving regulations; lower speed limits.
- Raise the price of harmful commodities like tobacco and alcohol through taxation and further restrict unhealthy food and alcohol advertising.
- Protection from adverse work conditions (greater job flexibility, enhanced job control, support for those returning to work and to enhance job retention).
- Provision of high quality early childhood education and adult learning.

NHS Health Scotland (2016). Health inequalities: What are they? How do we reduce them?
http://www.healthscotland.com/documents/25780.aspx

Key actions - MITIGATE

Health inequalities:

What are they? How do we reduce them?



Key actions

- Training to ensure that the public sector workforce is sensitive to all social and cultural groups, to build on the personal assets of service users.
- Link services for vulnerable or high risk individuals (e.g. income maximisation welfare advice for low income families linked to healthcare).
- Provide specialist outreach and targeted services for particularly high risk individuals (e.g. looked after children and homeless).
- Ensure that services are provided in locations and ways which are likely to reduce inequalities in access (i.e. link to public transport routes; avoid discrimination by language).
- maintain a culture of service that is collaborative and seeks to co-produce benefits, including health and wellbeing, through work with service users.

NHS Health Scotland (2016). Health inequalities: What are they? How do we reduce them?
http://www.healthscotland.com/documents/25780.aspx

GATEKEEPING

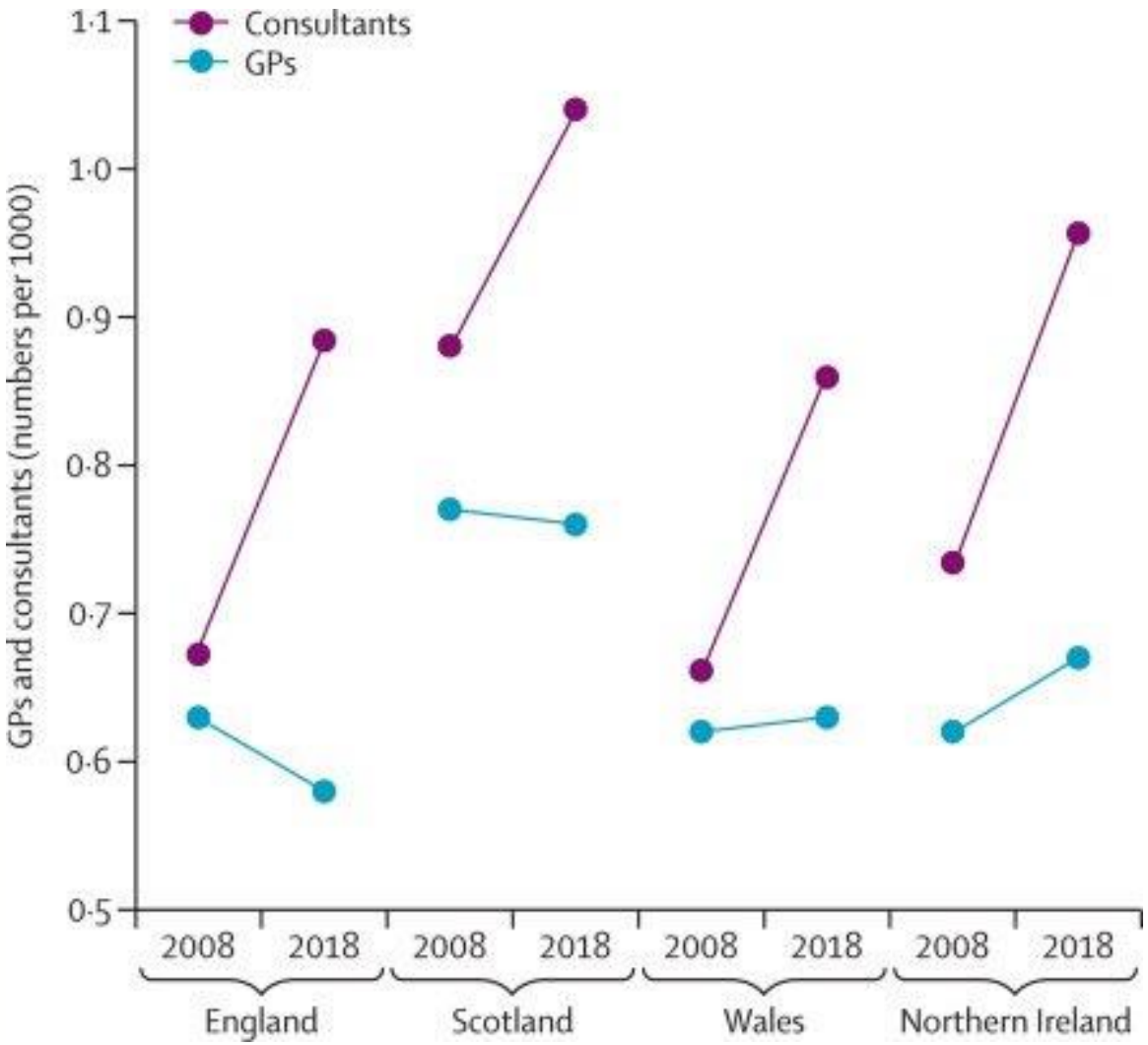
87 : 13

86 : 14

85 : 15

84 : 16

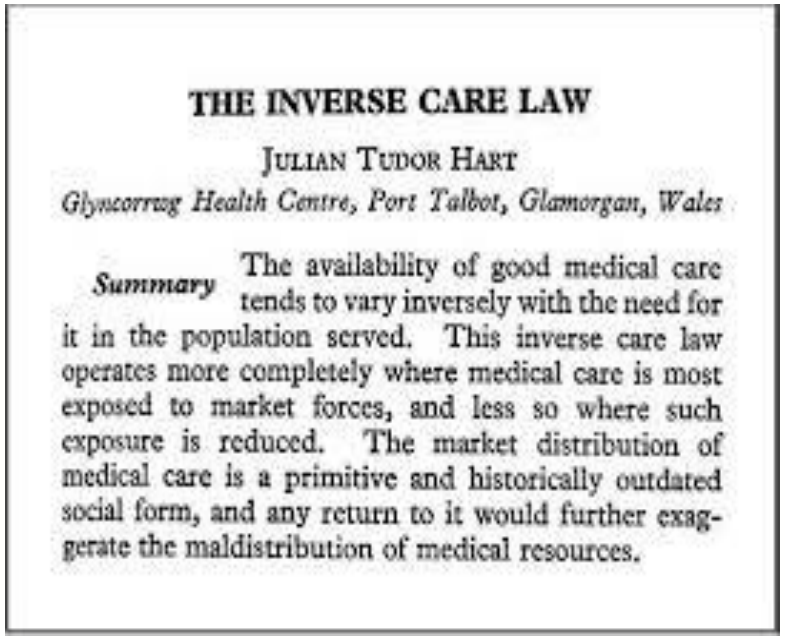
Supporting the GP workforce



Anderson et al. *"Securing a sustainable and fit-for-purpose UK health and care workforce"*, Lancet May 2021

https://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736(21)00231-2.pdf

JULIAN TUDOR HART, THE INVERSE CARE LAW



THE INVERSE CARE LAW

JULIAN TUDOR HART

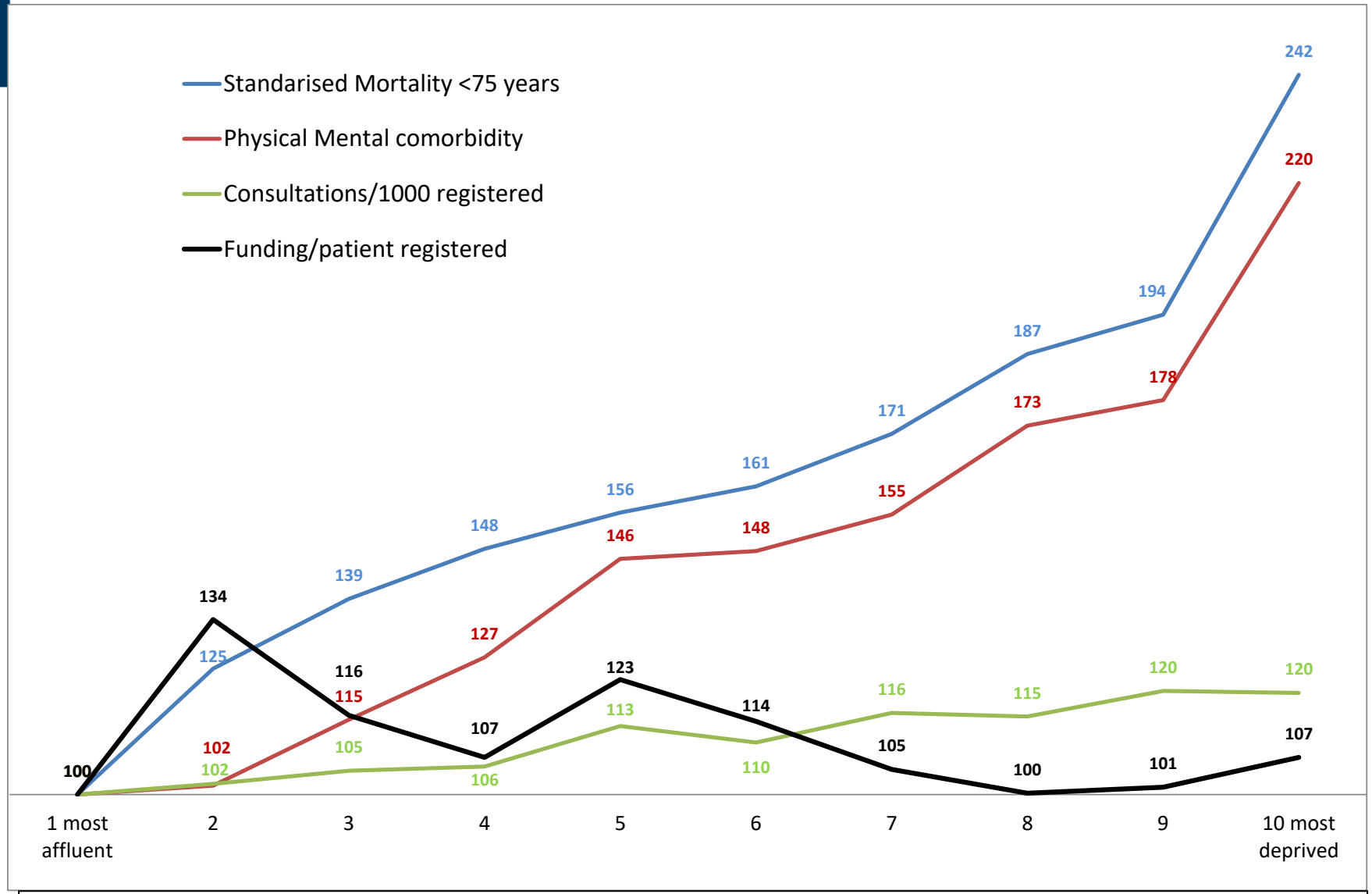
Glyncorrwg Health Centre, Port Talbot, Glamorgan, Wales

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 return to it would further exaggerate the maldistribution of medical resources.

"The availability of good medical care tends to vary inversely with the need for it in the population served".

Julian Tudor Hart, The Lancet, 27th February 1971

Inverse Care Law today = “lack of time to address needs”



McLean G, Guthrie B, Mercer SW, Watt GC. ***General practice funding underpins the persistence of the inverse care law: cross-sectional study in Scotland?*** BJGP 2015; 65(641): 799-805.

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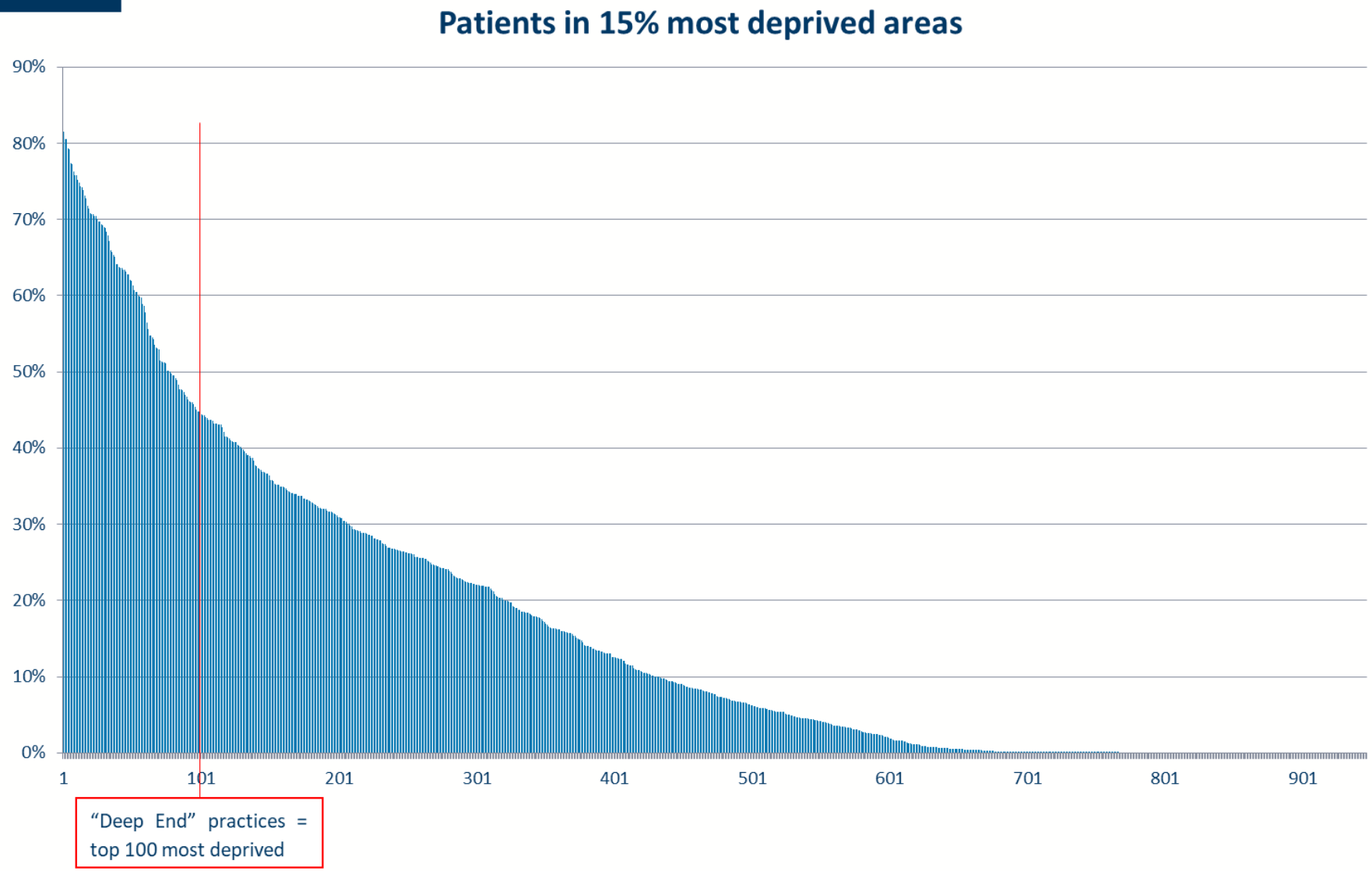
GPs at the Deep End = “blanket deprivation”



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"Deep End" issues

ISSUES AFFECTING DEEP END COMMUNITIES

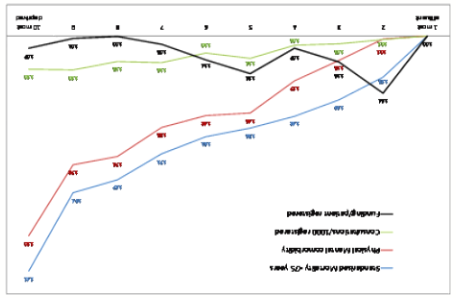
- Unemployment
- Benefits sanctions
- Cuts to services
- Drugs and alcohol
- Child protection
- Migrant health
- Vulnerable adults
- Bereavement

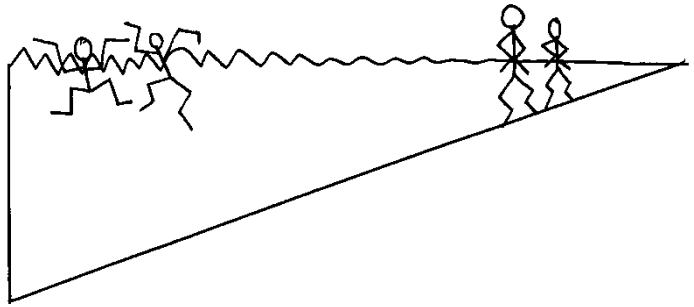
KEY POINTS ABOUT DEEP END ENCOUNTERS

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

Mercer S, Watt G. (2007) ***The inverse care law: clinical primary care encounters in deprived and affluent areas of Scotland.*** Ann Fam Med, 5(6): 503–510.
Mercer SW, Jani BD, Maxwell M, Wong SYS and Watt GCM. (2012) ***Patient enablement requires physician empathy: a cross-sectional study of general practice consultations in areas of high and low socioeconomic deprivation in Scotland***. BMC Family Practice, 13, p. 6

GENERAL PRACTITIONERS AT THE DEEP END





GPs at the Deep End

Deep End activities

1) Advocacy
2) Evidence
3) Service development
4) Professional development

THE HERALD TUESDAY 15.05.2012 PAGE 9 NEWS

Doctors warn austerity is damaging patients' health

GPs in deprived areas see sharp rise in social issues

STEPHEN NAYSMITH
SOCIETY EDITOR

"So many people who are clearly unfit for work are being assessed as capable of work after a cursory assessment"

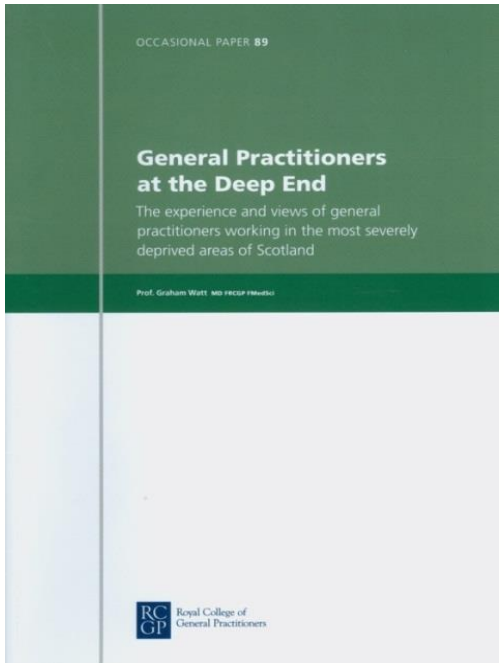
ON THE FRONTLINE: GPs Margaret Craig, left, and Petra Barnsdale are part of the Deep End group of GP practices. Picture: Colin Mearns

Cases of concern

Patients and doctors in the report are anonymous to protect confidentiality.

Large city hospitals 'are hubs for MRSA'

E.ON to freeze its prices



www.gla.ac.uk/deepend

Lessons from Links Worker Programme

- High % of consultations related to social adversity:
- poverty and financial problems
- experiences of violence, trauma, addictions, housing issues, etc.
- **Lack of time / barriers to accessing community resources**

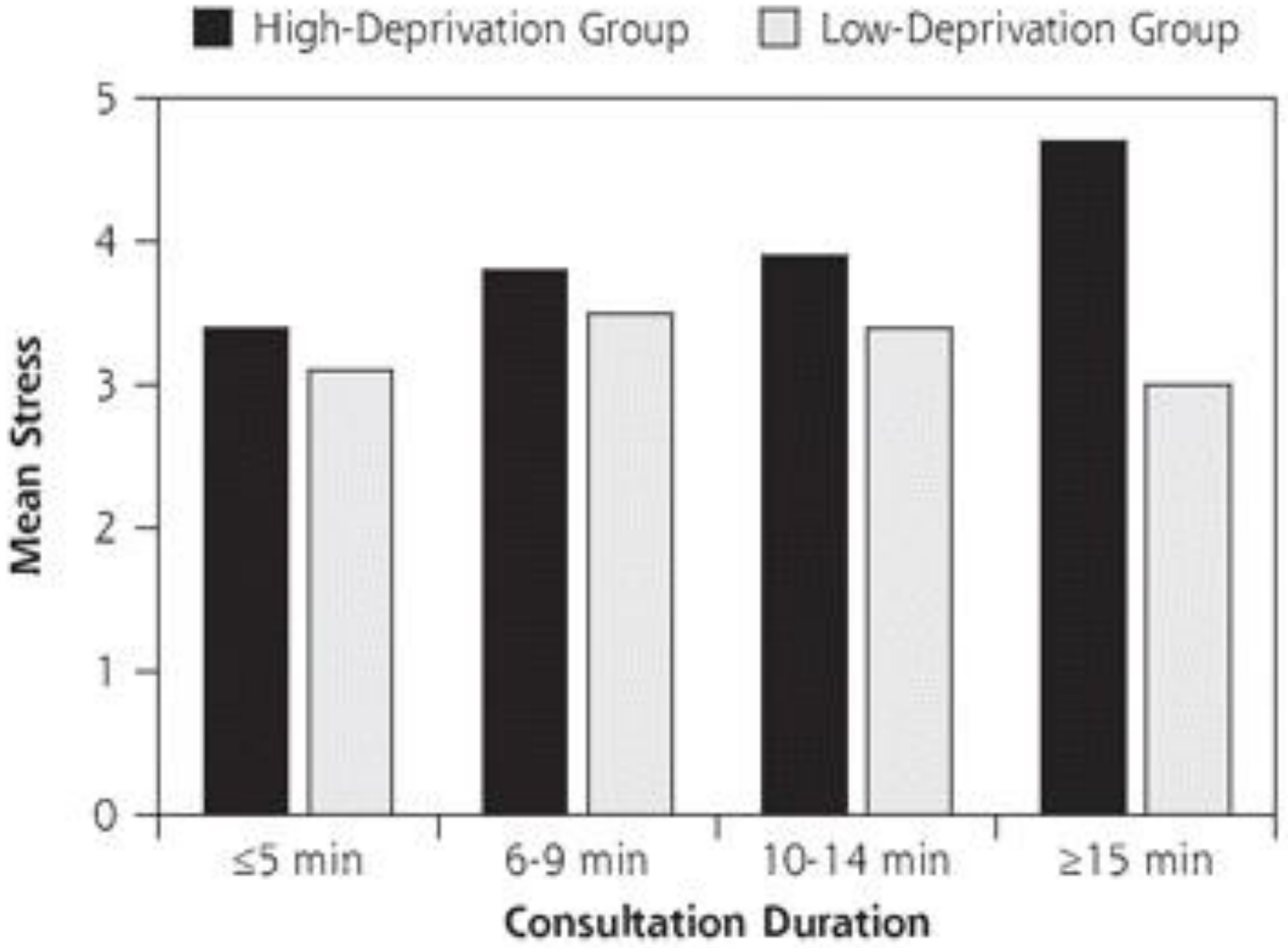
- Pilot in 7 practices in 2014
- (8 practices in comparison group)
- *Lead GP: Dr Peter Cawston*

Lessons from Links Worker Programme

- "Key ingredients"/capacities to develop in primary care teams:

1. Team wellbeing
2. Sharing learning
3. Awareness of social context
4. Intelligence/knowledge management
5. Signposting
6. Problem solving
7. Network building

GP stress → "less empathy = less enablement"



Mercer S, Watt G. ***The inverse care law: clinical primary care encounters in deprived and affluent areas of Scotland.*** Ann Fam Med. 2007; 5(6): 503–510.

Lessons from Advice Worker Project

- Area profile:
- Strong links btw debts & MH/addictions
- 26% report limiting disability
- Advice worker from GEMAP
- Expert knowledge on housing, social security, financial (e.g. debt) management
- Half-day per week in each practice
- "Embedded", not just co-located

- Pilot in 2 practices from 2015-17
- *Lead GPs: Dr Ronnie Burns & Dr Gillian Dames*

Lessons from Advice Worker Project

University of Glasgow

www.gcph.co.uk

The Deep End Advice Worker Project:

embedding an advice worker in general practice settings

Jamie Sinclair

Glasgow Centre for Population Health

September 2017

276 referrals were made to an advice worker based in the two practices

85% of referrals had never previously accessed GEMAP's services (despite these services having been available in the area for 15 years.)

74% of referrals were made by a GP (this is a good rate of GP engagement for this type of project)

165 people (65% of referrals) engaged with the service

68% stated they had a mental health condition

58% self-reported a long-term health condition

2 in 3 were tenants of registered social landlords

2017/18: 9 practices & 665 referrals

Lessons from Advice Worker Project

University of Glasgow

www.gcph.co.uk

The Deep End Advice Worker Project:

embedding an advice worker in general practice settings

Jamie Sinclair

Glasgow Centre for Population Health

September 2017

GPs at the Deep End | gemap | Glasgow City HSCP | Wheatley Group | NHS Greater Glasgow and Clyde | Glasgow

Of the 165 people which engaged with the service:

£850,000 worth of financial gain was secured through supporting people to access social security payments

Successful applicants received an annual average of just under **£7,000**

The project identified and is now managing **£155,000** worth of debt

1 in 5 people referred were supported with a housing issue

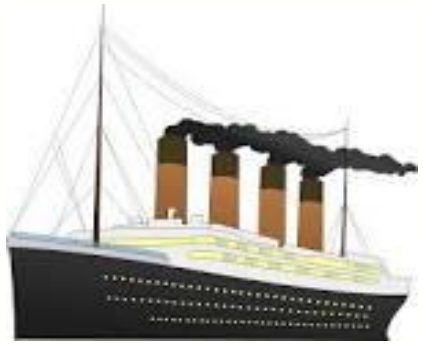
Around half of people were referred to additional forms of community support such as mental health, fuel poverty and carers' support

Over 85 individual forms of cost reduction support were provided

This includes helping to reduce fuel costs and secure free bus passes

2017/18: £25 return for every £1

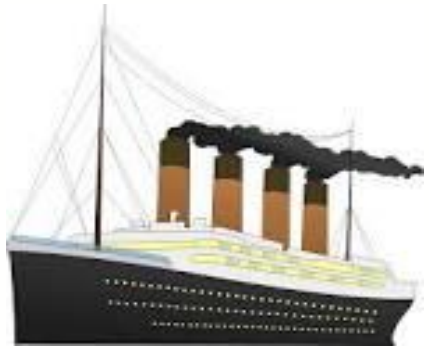
Govan SHIP Programme



- **Social and Health Integration Partnership**
- Aim to improve collaboration / integration between GP, social work and health services (primary, community and acute), also engaging with community and third sector organisations

- Started in 4 practices in 2015
- *Lead GP: Dr John Montgomery*
- *Project Manager: Vince McGarry*

Govan SHIP Programme



- **“Key ingredients”:**

- Aligned Social Workers
- Structured Multi-Disciplinary Team Meetings
- Early career GP locums
- Additional time for GPs
  - Extended consultations
  - Polypharmacy reviews
  - Case Review
  - Outward facing / planning

“Key ingredients” of the Pioneer scheme

- **Additional** clinical capacity.
- **Released time** of experienced GPs for service development.
- **Protected time** for Fellows for tailored day-release curriculum and service development.
- **Peer support.**
- **Engagement with others**, including students, policy makers.
- **Shared learning** across practices.
- **Shared ethos and values**.

Blane DN, Sambale P, Williamson AE, Watt GCM (2017). ***A change model for GPs serving deprived areas.*** Ann Fam Med, 15(3): 277

Impact of the Pioneer Scheme?

- **Impact for Fellows**
  - Better support than locums
  - Part of the team (well established teams)
  - Regular employment / CPD needs met
  - Time to undertake projects
  - Deep End experience / leadership roles

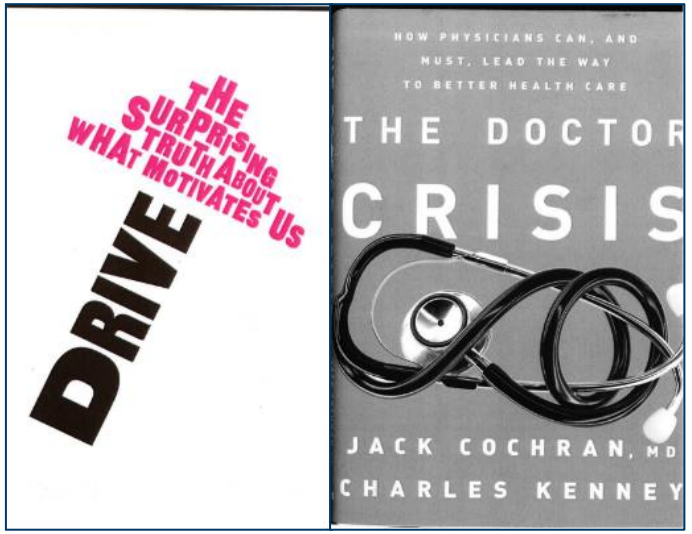
- **Impact for Patients**
  - Less stressed / burnt out GPs
  - Extended appointment time
  - Time for ACP / visits / case management
  - Quality improvement positive impact on patient care

- **Practice impact**
  - Increased morale
  - Increased job satisfaction
  - Team meetings

Attracting practitioners

Individual Factors

Autonomy
Mastery
Purpose



System factors

Leadership
Collegiality and shared learning
Accountability

WP 1: Since 1990, which policies have attempted to tackle the inverse care law in general practice in England?

For each policy what were the mechanisms used, targets set etc. How did they relate to other policies at the time?

WP 2: What were the results of these policies?

Were they implemented? What were the outcomes? Evidence of impact (of individual policies or groups of policies)?

WP 3: Development of evidence-based policy recommendations

Scope of their analysis

- National government policies since 1990 that have explicitly targeted the **'supply side'** of general practice in areas of deprivation in England
- Drawing on available data (identified through lit search):
  - On **policies and implementation**, eg govt white papers, DoH/NHSE guidance, select committee papers
  - On **impact**, eg academic papers, official stats, national evaluations, assessments from relevant stakeholders

- Analysis on: **workforce**; **premises**; commissioning and contracting; **funding**

Summary

1. If the NHS is not at its best where it is needed most… health inequalities will widen.

2. The (im)balance of primary/community vs secondary care impacts the gatekeeper function.

3. Learning from DE projects is promising…
   - “Proportionate universalism” – targeting needs
   - Protected time for service and professional development
   - Shared learning within and between practices
   - Joint working with others (and team wellbeing!)

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Thanks for listening!
Email: david.blane@glasgow.ac.uk

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