

50 Years of the Inverse Care Law Conference



On 26 May 2021, the Scottish Deep End Group¹ delivered a half day conference entitled "50 Years of the Inverse Care Law" to mark 50 years since The Lancet published Julian Tudor Hart's seminal paper describing The Inverse Care Law.² Tudor-Hart described it thus;

"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 The market distribution of medical care is a primitive and historically outdated social form, and any return to it would further exaggerate the maldistribution of medical resources."

A series of publications and an editorial to mark the 50th anniversary of the inverse care law were published in February 2021.³ The Inverse Care Law remains as relevant now as it was in 1971, and its importance has been brought sharply into focus during the pandemic. The last year has highlighted the devastating effects of Health Inequalities globally and the impact of market forces on healthcare, communities, and individuals.

This timely conference reflected on the Inverse Care law and the origins of the GPs at the Deep End and its work before moving on to reviewing progress in Health Inequalities and considering what still needs to be done. The conference featured presentations from internationally renowned speakers, including members of the Scottish Government. The event finished with an interactive Q&A panel session and participants were encouraged to submit questions for discussion. One hundred and eighty-seven people attended the conference. There was live tweeting during the event which can be found here <https://threadreaderapp.com/thread/1397544100446998531.html>

Carey Lunan, a Deep End GP in Edinburgh and Chair of the Scottish Deep End Steering Group (and former Chair of RCGP Scotland) opened and expertly chaired the meeting. Due to a technical hitch the planned order of the first two speakers was reversed, but the following summary presents the speakers in the order originally intended.

Graham Watt, Emeritus Professor of General Practice at the University of Glasgow, gave a comprehensive, heart-felt, and thought-provoking talk on "Julian Tudor-Hart, the inverse care law, and general practitioners at the Deep End", starting with his knowledge of Julian as mentor, colleague, and friend. Graham outlined Julian's 'big idea' that fuelled his life and work – which was that a general practitioner, working on a defined front on the war against misery and disease, could improve the health of a local population.

Julian was clear that while medical services were not the main determinant of mortality or morbidity, there was no excuse for the failure to match the greatest need with the highest standards of care. Thus, if the distribution of health care resources is not commensurate with need, inequity and

inequality will result, as some groups get the benefits of needs-based care while others don't. Julian 'walked the talk' by working and living in a small, highly deprived Welsh mining village, providing personal medical care to the entire village as well undertaking a ground-breaking series of research studies funded by the MRC. He was the first doctor-researcher in the world to show that by looking after every patient under his care (in this case in terms of blood-pressure control which he measured and responded to in 100% of his patients) he could show an improvement in mortality over a 20-year period (compared to a similar neighbouring village).

Graham then described the inverse care law as it exists in Scotland, as published by Graham and colleagues in the BJGP in 2015.⁴ Graham explained the origin of the Deep End Group in Scotland, highlighting the spread of the Deep End movement in recent years to a host of other sites in England, and a range of other countries around the world, which have given identity, voice, shared activity, shared learning and policy impact to a previously neglected group of general practitioners and, by proxy, the patients and communities they serve. He showed worked examples of the Scottish Deep End Project such as; extended consultations for selected patients; GP protected time; attached or embedded co-workers, including link practitioners, social care workers, financial advisors and alcohol nurses; enhanced multidisciplinary teams; a pioneer scheme for young GPs.³ He also pointed out that, to date, only link workers and financial advisors are currently being rolled out to all Deep End practices.

Graham discussed the potential of general practice and the fact that the primary motivation of most Deep End general practitioners is not to address the abstraction of inequalities in health but rather, to improve patient care, closing the gap between what they are able to do and what they could do with more time and resource. He believes that the 'exceptional potential' of individual general practices requires competence not only in clinical consultations but also on continuity of care, personalised to the patients' needs and wishes, and requires building two types of relationships: a compendium of patient narratives and a strong local health system based on the general practice hub. The potential of general practice as a coherent system depends on a range of supporting and connecting infrastructure including resources (pro rata based on need), information, educational opportunities, research and evaluation, and career opportunities.

He pointed out that if the NHS is not at its best where it is needed most, inequalities in health will widen. He presented four cogent reasons for beginning at the 'bottom of the slope' on inequalities:

- By improving outcomes for individual patients and delivering such care for all patients, population health can be improved and inequalities in health narrowed, reversing the inverse care law.
- For health service managers, stronger care in the community can prevent, postpone or lessen crises requiring emergency A&E attendance or hospital admission.
- Working in the Deep End is what many practitioners aspire to do; it is the direction they want their careers to take; and it is the collegiate culture they want to be part of.

Graham ended his talk by saying this;

*"By excluding exclusions, keeping everyone on board, and building relationships, inclusive health care is a civilizing force in an increasingly dangerous, fragmented and uncertain world."*⁵

The second speaker was **Harry Burns**, Professor of Global Health and the University of Strathclyde and former Chief Medical Officer for Scotland. Sir Harry began by explaining his view that health inequalities are caused by a lack of wellbeing not too much illness. He gave a historical account of

health inequalities in Scotland, showing that Scotland's position as the 'sick man of Europe' (Scotland has the widest health inequalities in Western Europe) is a relatively new phenomenon, and Scotland's poor performance in international comparisons in terms of life expectancy only began in the 1950's and 1960's. Furthermore, Scotland's poor rating internationally is mainly explained by the wide inequalities that exists within Scotland, that is, by the very poor health of the most deprived sectors of the country. He went on to show how the widest inequalities in health in Scotland are in the younger age groups, peaking in people aged 30-40, and the leading causes of death in these younger age groups are things like violence, suicide, drug-related, and so on – as he put it 'socially-determined causes of disease and death'.

Harry described his interest in 'salutogenesis' and an assets-based approach to health and wellbeing, showing how stress affects the brain and the endocrine system. He gave some stunning examples of 'social experiments' which have shown how effective social approaches to care can be, when people are given autonomy, a sense of control, and helped to build trusting relationships. For example, in the 'Broadway Experiment', 15 people experiencing homelessness (rough sleepers) were given personalised support through a mentor and a personalised budget (up to £3,000). One year later, 11 of the 14 were living in permanent accommodation, some had found employment, and on average the spend out of the available £3,000 was only £800.⁶ An article in 'The Economist' concluded that 'the best way to spend money on the homeless might be to give it to them'.

Harry concluded by stating that there needs to be a serious change of attitude in public services, moving from a system that 'does things to people rather than with them' to one that is normative, gives strength and power to the citizens, and supports growth to enable solutions to emerge, and in so doing produces strong citizenship and stronger communities. He commended the Deep End GPs for their important role in this work.

Catriona Morton was the third speaker of the day. Catriona is a Deep End GP in Edinburgh, the current Deputy Director of the RCGP Scotland, and a former Chair of the Lothian Medical Committee and GP Sub-Committee and remains a member of the Scottish GP Committee of the BMA. Catriona has been an active member of the Deep End since its very first meeting 10 years ago. Catriona spoke about her experiences of the inverse care law at the 'coalface' of general practice as a front-line GP in a very deprived area.

Her opening statement was her belief that the GP as an expert medical generalist in deprived areas has a key role in reducing or mitigating health inequalities. She referred to the importance of the new Scottish GP contract, with GP practices working in clusters, and GPs leading an expanded multidisciplinary team. She gave a comprehensive overview of the literature in health inequalities, drawing on a wide-range of published evidence and making a compelling case for an end to the inverse care law – which is of course not a law but a policy anomaly of the NHS. She demonstrated the core importance of mental health in early life as a predictor of future poor health and multimorbidity, drawing on a range of work published in the Lancet⁷ and elsewhere.

Catriona illustrated these academic papers by case histories of some of her own patients. She described the realities of accessing a healthy diet in poor areas, and the problems of managing patients with diabetes, who develop the condition much younger in her practice than in other practices in more affluent parts of Edinburgh. She described system problems that exist, with many referred patients not able to attend hospital appointments and thus missing out on specialist care and increasing the workload on the GPs. She also presented Andrea Williamson's work on missing appointments in primary care, which also rises with deprivation and is predictive of increased mortality. She went on to describe many things which could be done differently to improve the outcomes of her patients if resources were matched with (unmet) need.

Indeed, the key theme running through Catriona's talk was the issue of unmet need - the essence of the inverse care law. From first-hand experience as a Deep End GP, from numerous examples of patients whose lives could have been vastly improved if only resource matched need.

Catriona ended by pointing out the workforce crisis in general practice, and the worrying trend across all the 4 nations of the UK of rising numbers of hospital consultants yet falling numbers of GPs, a situation she called 'an inverse medical care law all of its own'.⁸ She called for a new kind of practice, designed to meet unmet need in deprived areas, thus reversing, once and for all, the inverse care law.

The next speaker was **Stewart Mercer**, Professor of Primary Care and Multimorbidity, and former Director of the Scottish School of Primary Care who described his work with Graham Watt and others, on the research evidence on the inverse care law in Scotland. He began by describing his early interest on the importance of empathy in health care, which led to the development and validation of the Consultation and Relational Empathy (CARE) Measure.

In 2007, Stewart and Graham demonstrated how the inverse care law operates in general practice in deprived areas. This showed that patients in deprived areas (compared with those in affluent areas) had more problems they wished to discuss with the GP (and these problems were more often complex) but received shorter consultations, resulting in lower patient enablement and higher GP stress. A second study, in which routine consultations were videoed and outcomes followed up at one month, also showed that consultations in deprived areas tended to be less patient-centred and the outcomes worse than in affluent areas. These studies demonstrate the corrosive effect on doctors and patients of a system that does not match health care need with resource.

He went on to describe the epidemiology of multimorbidity in Scotland and how it is socially patterned –with more multimorbidity in deprived areas which develops some 10-15 years earlier than in affluent areas. Analysis of the consultation video study showed that patients with multimorbidity in affluent areas get substantially longer consultations than non-multimorbid patients (in affluent areas) which are more patient-centred and more empathic. These differences, however, are not seen in deprived areas – all patients get the same due to the pressures of the inverse care law.

The key question from all of these findings is whether reversing the inverse care law experimentally could be shown to lead to better consultations and better outcomes. This was explored in the CARE Plus study, which was a primary care-based complex intervention involving substantially longer consultation for selected multimorbid patients in Deep End practices, with training and support for the GPs and self-management support for the patients. In a phase two exploratory cluster randomised controlled trial, patients who received CARE Plus showed higher quality of life and wellbeing compared to the control group, and the intervention was highly cost-effective. The series of studies described by Stewart can be found on this blog of the International Multimorbidity Research Community.⁹

Stewart concluded his talk by suggesting the areas of research that are of critical importance as Scotland moves forward with a new GP contract and the integration of health and social care; he also highlighted the disparity between the funding available to do such work in England (through the NIHR School of Primary Care Research) compared with Scottish School of Primary Care.

The next speaker was **Darren McGarvey** who is a Scottish rapper (known as Loki), hip hop recording artist, columnist and social commentator. He is author of the best-selling book *Poverty Safari: Understanding the Anger of Britain's Underclass*,⁹ which was in the Sunday Times Top Ten bestseller, was winner of the Orwell Prize 2018, and was named the most 'Rebellious Read of the 21st Century' in a Scottish Book Trust poll. Darren was part of the Poverty Truth Commission that was hosted in

Glasgow in 2009 and has presented eight programmes for BBC Scotland exploring the root causes of anti-social behaviour and social deprivation. Darren grew up in a deprived area of Glasgow and understands first-hand the blight that poverty has on people, families and communities.

Darren spoke to the conference on the theme of social connection, reading from passages of his new book *The Social Distance Between Us: How Our Remote Politics Wrecked Britain*, which is due to be published by Random House in 2022. He began by recounting an experience of sitting with his child in a shopping mall, where a natural beach scene had been built from entirely artificial sources and went on to expand on how our basic need for connection with nature and other human beings is being increasingly denied to us, as our environments and our interactions become more and more artificial. He gave a comprehensive account of the vital importance of social connections, beginning in the womb and continuing across the life-course. He described in vivid detail the juxtaposition of his experience of community in Birnam, a small affluent Scottish village in Perthshire - in which the sense of trust and community was palpable and visible in the neatness and cleanliness of the streets, shops and hotels and positive interactions between the local inhabitants - with Possilpark in Glasgow, ranked as the most deprived community in Britain. He describes how long-term deprivation and lack of investment following post-industrialisation has destroyed the sorts of social connectedness seen in Birnam, resulting in social isolation and withdrawal, with people turning to alcohol or drugs to fill the void of lack of social connection. This is not just the lack of investment in housing, education, and jobs but the loss of community assets and social networks that were bound up in people – the characters who helped define, shape, and support the community, the families and neighbours who knew and trusted each other over generations and looked out for each other. As Darren explained;

“Social networks are like naturally occurring wi-fi that people log onto from the moment we are born. Without these networks we cannot fully develop.”

Darren went on to describe the importance of informal social control that arise as a natural consequence of social networks and social connections. Such informal controls allow positive affirmations of helpful behaviours, unlike formal social controls (such as policing) which are externally imposed and are often perceived as negative. These three factors are central to a community's capacity to adhere and to prosper. Darren went on to propose that the prosperity seen in affluent communities is not simply a result of higher income, better education, better health, etc (though these are important) but also – crucially – to social connections and social networks. Darren believes that the re-building of social connections is crucial to the development of resilience in deprived areas and can enable such communities to fight back against the social injustices they face.

The final speaker was **Naureen Ahmad**, from the Scottish Government. Naureen is Head of General Practice Policy Division, and Policy Lead for Health Inequalities at the Scottish Government. Naureen began by stating her personal commitment to tackling health inequalities, and her personal and family experiences of health inequalities, coming from a Black and Ethnic Minority background. Naureen also passed on an apology from Dr Gregor Smith, the Chief Medical Officer, who had planned to speak at the conference but changes in his diary at short notice prevented him from doing so. Naureen noted that Gregor's first report as CMO published earlier this year included reference to the inverse care law and the work of Julian Tudor Hart.

Naureen re-stated the importance of the social determinants of health in underlying inequalities, and the need to address those, but also highlighted the role of health care and health care professionals in helping to reduce health inequalities. She also described the unequal effects of the covid-19 pandemic in Scotland, hitting those living in deprived areas the hardest. She went on to describe the Scottish Government's commitment to do more to tackle inequalities in general, building on the work

of Sir Michael Marmot and others. This includes plans to tackle childhood poverty, further protection and safeguarding for the more vulnerable groups, and expansion of mental health services. The Government, she said, must embed inequality and a human-rights approach in everything they do to address structural inequalities.

Naureen described the things the Scottish Government is doing to support primary care, which she described as being at the 'heart of the healthcare ecosystem'. She outlined the ambitions of the new Scottish GP contract, to support prevention and self-management of long-term conditions. She referred to the Primary Care Health Inequalities Short-Life Working Group which has been set up by the Scottish Government to take an in-depth look at the things that need to be done to help primary care take a more active role in tackling health inequalities. She also referred to the £3 million being invested to roll out the welfare rights programme to GP practices in deprived areas and the roll-out of the Deep End Link Worker Programme. She referred to the ongoing discussions with the Scottish General Practice committee of the BMA, and ways in which GP workload can be reduced. She also announced plans to reduce racial inequality, as a response to the covid-19 working group that was established early in the pandemic, and the efforts underway to improve vaccine uptake in minority ethnic communities. She finished her talk by restating the questions asked by the CMO in his recent report:

- What will we do to tackle inequalities in everyday practice?
- What will do to ensure more equitable access to the services we provide?
- How can we help the people we care for, by promoting agency and providing access to the services they need – which often sit beyond health care?

Naureen's talk was then followed by a panel discussion.

Summary of Panel Discussion

For the panel discussion, we were joined by Becks Fisher, GP and Senior Policy Fellow at the Health Foundation. Questions from the audience were fed in through the course of the afternoon via the Slido app. They were analysed for recurring themes, and the most frequently presenting and pertinent questions were presented to the panel. Some questions were amalgamated for write-up for ease of reading.

Question 1: How do we resource and enable the primary care workforce to be able to do this kind of work?

Catriona highlighted the need to rebalance the 'inverse medical care' law, with a recent Lancet paper showing a disproportionate growth across the UK in the secondary care workforce in comparison with the primary care workforce. See; [https://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(21\)00231-2/fulltext](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(21)00231-2/fulltext)

Becks spoke of the need to 'level up' general practice to achieve levelling up of health, and also of the significant funding disparity in NHS England between practice in the most and least deprived areas (7% difference when adjusted for need). She expressed concerns that without addressing the underlying inequity, any interventions will simply further worsen health inequalities. Building the workforce required is a significant challenge and needs tackled in multiple ways – from undergraduate through to postgraduate teaching and training, with financial investment.

Naureen reflected that Phase 2 of the GMS contract may address workforce issues

Catriona stated that more GPs overall are needed to achieve this, and that the recommendations from the Gilles report need to be embedded to increase undergraduate exposure. Focused expansion of the multidisciplinary team is important, but GPs have ongoing key roles in supervision and mentorship. Highlighted the Deep End Pioneer Scheme and its proven benefits on recruitment and retention, with a focus on new ways of working.

Key themes:

- Prioritise the growth of the GP workforce within wider medical workforce planning
- Utilise all levers across the career spectrum, undergraduate to postgraduate level
- Allocate additional GP workforce proportionately, according to population need

Question 2: How do we start to change the way that people feel about seeing other members of the wider MDT, to enable these new models of care?

Stewart reflected that one of the potential dangers of expanding the MDT is that care is fragmented, and continuity is eroded. Continuity is proven to improve health outcomes. New teams need protected time to learn together and build relationships to ensure they function well. GPs do have a leadership role in these teams, unique in having a generalist medical education (referenced Michael West work on compassionate leadership). These new models of care remain relatively untested, it is not a matter of simple delegation, and it presents significant challenges in areas of unmet need “if you open a new lane on a motorway, it will simply fill up”. Reflections by **Stewart and Graham** were offered on the success of the Deep End Govan SHIP project, which resourced protected time for effective multi-disciplinary working, and enabled recruitment into a deprived practice area.

Catriona highlighted the work of RCGP Scotland in calling for a National Conversation about sustainable NHS use, to ensure that the NHS can be at its best where it is needed the most

Key themes:

- Delegation to wider MDTs risks fragmentation of care unless careful mitigation
- Continuity of care improves health outcomes
- Protected time needed for new teams to learn, build relationships and function well
- A National Conversation about sustainable NHS use is needed

Question 3: How do we co-produce healthcare systems that meet the needs of the communities they serve?

Darren reflected on the ‘fatalism’ that can be present within communities, giving example of the rising number of drug deaths in Scotland as a specific example. He stated that there are often significant disconnects between those with lived experience and those in positions of authority. He recommends making better use of the experience of independent recovery communities and emphasised the need for humility and honesty in practitioners to build trust, with an openness to admit when the answers are not known.

Graham recommended a better understanding of the additional costs of undertaking research in more deprived populations. Julian Tudor Hart’s early work showed the value of research and the importance of empowering local teams to ensure high community engagement and facilitation in the model of

‘social contracts’. He reflected that modern approaches to research ethics where individual rights are considered before collective groups have made this approach more difficult

Harry emphasised that the key to working effectively within communities is to ask them what they need and shared the example of the work undertaken in Beacon and Old Hill estate in Falmouth. (see Guardian article; <https://www.theguardian.com/society/2000/nov/15/communities.housingpolicy>)

Becks stressed the need to change the language and the approach around engagement, from one of ‘can I help you?’ to ‘can you help me?’. The importance of ensuring that we are listening to understand rather than simply listening to hear, being prepared to ‘share power with’, rather than ‘have power over’ - and considering what our communities can teach us. She referenced the work of the Poverty Truth Commissions as good examples of this; <https://tfn.scot/news/poverty-truth-commission-becomes-a-movement-for-change>

Naureen stressed that there is political will to ensure meaningful community engagement. The Scottish Government short life working group on Health Inequalities in Primary Care has actively consulted with the Drumchapel patient group in the development of its recommendations

Key themes

- Challenge traditional power hierarchies
- Engage local teams in research
- Consult with communities: listen to understand

Question 4: How do we support general practice to engage meaningfully with their communities and use their wider spheres of influence, when current workload is so high, levels of trust are low, and there is little willingness to work proactively with vulnerable communities?

Stewart observed that GP Clusters have the potential to do more with more support, especially around data availability, and time. This could include more of a proactive outreach model to link with their local voluntary and third sectors to facilitate collaborative working, to support co-production of service design and delivery, flexed according to local population needs.

Graham reflected that JTH referred to the ‘correction of social ignorance’ in the undergraduate curriculum: humility, listening, watching, learning, rather than assumed knowledge. He stressed the importance of sharing positive stories of pioneering GPs, and of more proactive seeking of random patient experience and feedback. New ways of working need actively supported within general practice to support them in this; ‘learning system’ rhetoric and policy alone is not enough, needs support on the ground, and the building of inter-professional relationships

Catriona highlighted the need for the widening participation agenda, to build a more representative workforce. she also emphasised the need for more exposure to general practice placements during undergraduate training. She felt that the requirement to adopt a more digital service in general practice had adversely impacted on our ability to get to know our patients and their communities.

Key themes:

- More of a potential role for GP Clusters – need better data support and more time
- Proactive outreach models into communities to co-produce
- Proactive outreach models to local voluntary sector to work collaboratively
- Practical support at the frontline in new ways of working
- Correct social ignorance and retain humility
- Strive for a representative workforce – widen access to medical school

Question 5: Continuity of care reduces morbidity and mortality. Continuity is of even greater importance in more deprived communities with earlier onset disease and a need for relationships of trust. How do we guard against the rise of 'mega practices' and the possible fragmentation of care?

Stewart reflected that with an increasingly less-than-fulltime workforce, personalised continuity of care is often not possible – or necessary – for all patients. Those who are known to benefit the most include people with complex multimorbidity and mental health issues. It is well recognised that there are higher levels of complexity in Deep End practices and the mega practice model of healthcare would be likely to further worsen health outcomes for those with the most complex needs.

Becks shared that the Health Foundation is currently evaluating the impact of Primary Care Networks (PNs) on continuity of care and recognised that there is a careful balance to be achieved between growing the MDT to address a workforce issue – and fragmenting continuity. She stressed the need to prioritise continuity of care for those who need it the most.

Catriona highlighted the potential of the Alaskan NUKA model of care, which focuses on continuity, case management and community-identified needs. She recognised that some patients will prioritise access over continuity.

Key themes:

- Continuity of care reduces morbidity and mortality
- Continuity of care should be prioritised for those who benefit the most

Question 6: This conference marks the 50th Anniversary year of the Inverse Care Law. What would be your one wish or idea to reverse it?

Graham: Fund primary care research and redress the balance of generalist/specialist priority

Harry: Adopt an improvement science approach to share and scale-up the evidence base

Catriona: A new kind of general practice with defined outcomes, evaluation and dedicated resource e.g., through a new enhanced service

Stewart: Sustained political will to support primary care across the board and especially in deprived areas which either requires a transfer of funding – or additional funding

Naureen: Addressing the implementation gap

Becks: Proportionate universalism. Create a funding formula that adjusts for both unmet and under-met need and consider the political levels and levers within our profession to allow the formula to be implemented. Equitable, not equal, allocation of funding and workforce, proportionate to need.

Summary and Recommendations

Summary

The inverse care law remains a significant problem in Scotland, some 50 years after it was first described. It is at its most visible in primary care in deprived areas ('Deep End' practices) where the high levels of complex multimorbidity in the population (spanning mental, physical, and social problems) is not matched with the resource required for equitable healthcare. Research has shown that patients living in such areas commonly consult GPs with more complex problems than patients living in more affluent areas, but receive shorter, less-patient-centred consultations by healthcare professionals who are overly stressed and stretched due to the inverse care. There is a significant gap between what GPs and others in primary care are able to do at present and what they could do with more time and resource.

Health inequalities, like all inequalities, are primarily due to the unequal distribution of wealth and power across society – the social determinants of health. This is not just the lack of investment in housing, education, and jobs but the loss of community assets and social networks. Tackling these structural and relational determinants of health are crucial in the fight against health inequalities. However, healthcare is also a social determinant of health, as it provides effective, evidence-based treatments for a range of common mental and physical diseases affecting public health. If the NHS is not at its best where it is needed most, inequalities in health will inevitably widen.

The Deep End Group in Scotland (now spreading to a host of other sites in England, and a range of other countries around the world) has given identity, voice, shared activity, shared learning and policy impact to a previously neglected group of general practitioners and, by proxy, the patients and communities they serve. The GP as an expert medical generalist in deprived areas has a key role in reducing or mitigating health inequalities. However, there is a workforce crisis in general practice, with a worrying trend across all the 4 nations of the UK of rising numbers of hospital consultants yet falling numbers of GPs - an inverse medical care law. We need a new kind of practice, designed and supported to meet unmet need in deprived areas, thus reversing, once and for all, the inverse care law.

The Scottish Government has stated that it is committed to reducing health inequalities. The new Scottish GP contract, still under negotiation, has a focus on clusters of practices working together, with an expanded multidisciplinary team, offers an opportunity to begin to tackle the inverse care law. Ongoing research on the inverse care law and evaluation of the new GP contract and other initiatives is crucial, but funding for this type of 'middle-ground' research is limited in Scotland compared with England.

Recommendations

As Graham Watt stated in his talk, the potential of general practice as a coherent system depends on a range of supporting and connecting infrastructure including resources (pro rata based on need), information, educational opportunities, research and evaluation, and career opportunities. To achieve this potential, we make the following recommendations.

1. The top priority is to tackle the inverse care law by allocation of additional funding to Deep End practices on a proportionate universalism basis. This could be through an enhanced service arrangement.

2. GPs working in deprived areas should also have protected time for practice and personal development (such as was provided by the Deep End Pioneer Scheme), as well as support for their own health and wellbeing. This could include, for example, access to a dedicated clinical psychologist service, formation of reflective learning groups (such as Balint groups), and/or other approaches such as mindfulness.
3. Ways of promoting continuity of care and long-term therapeutic relationships with patients with complex care needs. Continuity of this nature is of central importance to both patients and staff. This is of course an important issue across all general practice but is most pressing in Deep End practices where complex care need is highly concentrated. A learning cycle is required on what models work, who they work best for, and what outcomes. This needs funded evaluation followed by support for implementation.
4. A further key issue is the number of medical graduates who choose general practice and who then work in areas of high deprivation, i.e., the pipeline from undergraduate to GP. It is vital that health inequalities and inclusive healthcare is a key part of teaching medical undergraduates, but it is unclear how much these feature in curricula at present. We recommend that an audit of the undergraduate and postgraduate curricula is conducted and a survey of students and trainees of how adequately they feel their existing curricula prepare them for clinical practice in deprived areas or with patients from vulnerable groups.
5. Dedicated funding for such 'middle-ground research' and evaluation should be provided by the Scottish Government to the Scottish School of Primary Care, at a level commensurate with that of the English School of Primary Care Research.
6. Establishment of Health Equity GP leads within practices or clusters in deprived areas, who would act as collaborative leaders and have a proactive outreach role including the establishment of patient engagement forums based on existing good practice. They would work within and between Clusters and HSCPs, acting as 'brokers and boundary spanners' to facilitate collaborative working in tackling health inequalities.¹⁰

Carey Lunan

Lynsay Crawford

Stewart Mercer

References

1. The Scottish Deep End Project
<https://www.gla.ac.uk/researchinstitutes/healthwellbeing/research/generalpractice/deepend/> ([back](#) to text)
2. The Inverse care law: [https://doi.org/10.1016/S0140-6736\(71\)92410-X](https://doi.org/10.1016/S0140-6736(71)92410-X) ([back](#) to text)
3. The Lancet. Fifty Years of the Inverse Care Law:
[https://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(21\)00505-5/fulltext](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(21)00505-5/fulltext) ([back](#) to first citation) ([back](#) to second citation)
4. General practice funding underpins the persistence of the inverse care law: cross-sectional study in Scotland: <https://bjgp.org/content/65/641/e799> ([back](#) to text)
5. The Exceptional Potential of General Practice, by Graham Watt. CRC Press, 2018, ISBN 9780429764592 ([back](#) to text)

6. Providing personalised support to rough sleepers. <https://www.jrf.org.uk/report/providing-personalised-support-rough-sleepers> (the document has been moved or removed and so the link has been removed. At time of editing, the cited document was available from [this source](#) – however, this is an archived source, so may not be permanently available.) ([back](#) to text)
7. Kivimäki, Mika et al. Association between socioeconomic status and the development of mental and physical health conditions in adulthood: a multi-cohort study. The Lancet Public Health, 2020, Volume 5, Issue 3, e140 - e149. <https://www.thelancet.com/journals/lanpub/article/PIIS2468-2667%2819%2930248-8/fulltext> ([back](#) to text)
8. Anderson, Michael et al. Securing a sustainable and fit-for-purpose UK health and care workforce. The Lancet, 2021, Volume 397, Issue 10288, 1992 – 2011 [https://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(21\)00231-2/fulltext](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(21)00231-2/fulltext) ([back](#) to text)
9. Mercer SW. The CARE Plus study. CIRMO; <https://crmcspl-blog.recherche.usherbrooke.ca/?p=1325> ([back](#) to text)
10. Long, J.C., Cunningham, F.C. & Braithwaite, J. Bridges, brokers and boundary spanners in collaborative networks: a systematic review. BMC Health Serv Res 13, 158 (2013). <https://doi.org/10.1186/1472-6963-13-158> ([back](#) to text)