One effect of serial university research assessment exercises has been to concentrate resources in centres of excellence and for these centres to concentrate on smaller numbers of research areas.

As universities become knowledge factories, producing particular types of knowledge, the question arises of how well the public is being served.

Whatever the excellence of medical knowledge, professional skills and health policies, these are often irrelevant to the needs of patients, incompletely applied, or deployed in ways that provide poor value for money.

Health systems around the world are struggling to find ways of coping with ageing populations, endemic multimorbidity, service fragmentation, resource constraints and widening inequality.

We will increasingly need well-researched local solutions to these internationally prevalent problems.

Graham Watt
The UK’s Research Excellence Framework 2014
A tool with many uses, including, now, assessment of the usefulness of research
British Medical Journal, 27th November 2012

What research on inequalities in health might actually make a difference?

RESEARCH IMPACT

“any effect on, change or benefit to the economy, society, culture, public policy or services, health, the environment or quality of life, beyond academia”

One example for every 10 researchers submitted

Chosen from the last 20 years
Absolute range: Healthy life expectancy
Males – Scotland 1999/00 to 2005/06
(Data not available 2003/04)

PUBLIC HEALTH POLICIES

1. No contact with the public
2. Single contacts
3. Serial contacts

DECORATORS  BUILDERS
### Prevention of Inequalities in Health?

### Narrowing of Inequalities in Health?

<table>
<thead>
<tr>
<th></th>
<th>Healthy Life Expectancy (years)</th>
<th>Years in Poor Health (years)</th>
<th>Total Life Expectancy (years)</th>
</tr>
</thead>
</table>
| **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    |
BARBARA STARFIELD ON PRIMARY CARE

1. Health services with strong primary care systems are more efficient.
2. Social differences in health are greater for manifestations of illness severity (including mortality) than for occurrence of illness.
3. The major impact of health services is on the severity and progression of ill health.
4. Equity of access to health services, by itself, is not a useful strategy in industrialised countries. What matters is use of appropriate health services.

NOT ONLY (12%)
Evidence-based medicine (QOF, SIGN)
BUT ALSO (88%)
Unconditional, personalised, continuity of care.
INVERSE CARE LAW

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

The inverse care law is a policy of NHS Scotland which restricts care in relation to need.

Not the difference between good and bad care, but between what general practices can do and could do with resources based on need.

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GENERAL PRACTITIONERS AT THE DEEP END

THE INVERSE CARE LAW
Not the difference between good and bad care, but between what general practices can do and could do with resources based on need.
The challenge of universal coverage - 1948 and now
THE NEW SOUTHERN GENERAL HOSPITAL

CASTLES IN THE AIR

The problems of a hospital based health service
In 1949, Glasgow recorded its highest incidence of respiratory TB since notification had commenced in 1910. After almost 40 years experience of treating the disease and the expenditure of millions of pounds, the people of Glasgow had got precisely nowhere with respect to respiratory TB. Why was this so?

Although no effort was spared to cut costs, it has been shown that the institutional treatment of respiratory TB in Glasgow was largely a waste of time, money and effort before the introduction of effective chemotherapy.

Neil Mcfarlane

Having blundered into the sanatorium solution, vested interests including many owners of private sanatoria, ensured that the State remained committed.

It was the misdirection of government intervention which was responsible for Glasgow’s unique experience of the disease. Glasgow got hospitals when it needed houses.

Neil Mcfarlane

Institutional treatment, although expensive, was the cheapest and easiest solution to the problem of TB. It provided, perhaps unwittingly, a smokescreen behind which the social conditions which predisposed to infection were obscured.

Medically it was a complete failure, politically it was a great success. Something was seen to be done. The 1911 National Insurance Act took TB right out of the political arena and it was never to return.

Neil Mcfarlane
THE RISE OF NON-COMMUNICABLE DISEASES

FIVE PRIORITY INTERVENTIONS FOR NCDS
1. TOBACCO USE
2. DIETARY SALT
3. OBESITY, UNHEALTHY DIET AND PHYSICAL ACTIVITY
4. HARMFUL ALCOHOL INTAKES
5. CARDIOVASCULAR RISK REDUCTION
The epidemiology of multimorbidity in a large cross-sectional dataset: implications for health care, research and medical education

Karen Barnett, Stewart Mercer, Michael Norbury, Graham Watt
Sally Wyke, Bruce Guthrie

LANCET 12th May 2012

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
Most people with any long term condition have multiple conditions in Scotland

There are more people in Scotland with multimorbidity below 65 years than above
It's hard work having multiple morbidity
It can be dangerous having multiple morbidity
There is little guidance for multiple morbidity

TOO MANY BITS

I'VE JUST INVENTED A MACHINE THAT DOES THE WORK OF TWO MEN.
UNFORTUNATELY, IT TAKES THREE MEN TO WORK IT

SPIKE MILLIGAN

HOW TO AVOID FRAGMENTATION?
WHO NEEDS INTEGRATED CARE?

Potentially anyone but mostly the 15% of patients who account for 50% of general practice workload.
Listen to the patient
He is telling you the diagnosis

SIR WILLIAM OSLER

Listen to the patient
She is telling you her treatment goals

PROFESSOR JAN DE MAESENEER

LOOKING AFTER 100% OF THE POPULATION
THE POWER OF RANDOM SAMPLING
(excluding exclusions)

Health practitioners need to ask
not only “What do I do?”
but also “What am I part of?”

Don Berwick
Head of US Medicare and Medicaid
RESOURCE POOR

PEOPLE RICH

RESOURCE RICH

PEOPLE POOR

UNDERSTANDING AND PRODUCING SOCIAL CAPITAL

Centralisation
Specialisation
Privatisation

Primary Care

Diseases
RCTs
Education
Research

Patients
Multimorbidity
Hard to reach patients?

or

Hard to reach practices?

David is 14 months old. His 18 year old mum Sarah has had anxiety problems since her older brother hung himself four years ago. She started college but left when she fell pregnant shortly afterwards. Sarah does not get on well with her mother, whom she accuses of drinking and "shoving about" since her brother died. Her mum says she is "mental" and a "teenage brat". Sarah relies heavily on her own gran Margaret. Aged 50 she has moderately severe COPD (emphysema) and continues to smoke. Margaret has had several chest infections recently and is struggling to cope with Sarah's strange behaviour and a lively toddler for whom she is the main care giver.

For David the next two years, as he learns to walk, talk and interact, will have a huge effect on the rest of his life. Early years interventions such as parenting classes may be important, but on their own will fail to change his life opportunities. He will need supportive neighbours, a good nursery and adequate family income, but also optimal COPD nurse reviews, responsive alcohol and mental health services, good communication with social work, persistent contraceptive advice and smoking cessation support. In none of these areas is there adequate coordination or feedback from one to another.

At the hub of these lies the primary care team, offering unconditional care and the possibility of trusting relationships over the span of David's life.