GPs at the Deep End: beyond the inverse care law

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Declaration of interest

• Not a sociologist
• White Scottish, male
• ‘Deep End’ GP and...
  sleep deprived!
Overview

• The inverse care law
• Realities of ‘Deep End’ general practice
• Who are ‘GPs at the Deep End’ and what have they done?
• Where do we go from here?
  – Medical education (e.g. widening access)
  – Postgraduate training (e.g. structural competency)
  – Scope and discretion (e.g. community engagement and advocacy; new GP contract...)
NHS Health Scotland (2016). Health inequalities: What are they? How do we reduce them?
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The impact of general practice

NOT ONLY

Evidence-based medicine (QOF, SIGN)

BUT ALSO

Unconditional, personalised, continuity of care, provided for all patients, whatever problems they present.

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The market distribution of medical care is a primitive and historically outdated social form, and any return to it would further exaggerate the maldistribution of medical resources.”

Inverse care law

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

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

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

Inverse care law today

GENERAL PRACTITIONERS AT THE DEEP END
‘Deep End’ context

ISSUES AFFECTING DEEP END COMMUNITIES

- Unemployment
- Benefits sanctions
- Cuts to services
- Drugs and alcohol
- Child protection
- Asylum seekers
- 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

Context (2) – ‘premature multimorbidity’

WHERE ARE THE ‘MOST DEPRIVED’ POPULATIONS?

**BLANKET DEPRIVATION**
50% are registered with the 100 “most deprived” practice populations
(from 50-90% of patients in the most deprived 15% of postcodes)

**POCKET DEPRIVATION**
50% are registered with 700 other practices in Scotland
(less than 50% in the most deprived 15% of postcodes)

**HIDDEN DEPRIVATION**
200 practices have no patients in the most deprived 15% of postcodes
Deep End achievements?

2009 – first time that ‘Deep End’ GPs had been convened and consulted in the history of the NHS…

- Identity
- Engagement
- Profile
- Voice

Phase 1: Meetings
Phase 2: Publications, Presentations and Profile
Phase 3: Opportunities, Influence, Resources
Phase 4: Implementation, Lobbying

Projects: LINK Workers, Care Plus, Bridge, Benefits, Alcohol, Housing, Pioneer Scheme

REPORT 20: Deep End Proposals – engagement with Government

What can NHS Scotland do to prevent and reduce inequalities in health?

3rd National Meeting, 2016
Horizon scanning; Meeting with Young Practitioners, 2015

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4 Areas of activity

1) Evidence / Experience

2) Advocacy

3) Service development

4) Professional development
1) EVIDENCE

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
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 health 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 in very deprived areas
27. Improving partnership working between general practices and financial advice services in Glasgow: one year on
2) ADVOCACY

DEEP END REPORTS 16, 21, 25 and 27
Patients need referral services which are:

- Local
- Quick
- Familiar

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

“your problem is our problem”
3) SERVICE DEVELOPMENT

GOVAN SOCIAL AND HEALTH INTEGRATION PARTNERSHIP (SHIP)

Additional clinical capacity (2 salaried GPs between 4 practices)

2 attached social workers

2 attached community link practitioners

Support for monthly multidisciplinary team meetings

Protected time for GP leadership

DEEP END GP PIONEER SCHEME

Day release scheme

Shared learning
4) PROFESSIONAL DEVELOPMENT

1. Engaging with patients
2. Promoting GP tenacity
3. Drugs and alcohol
4. Safeguarding children
5. Asylum seekers/migrant health
6. Multimorbidity
7. Poverty
8. Vulnerable adults
9. Evidence-Based Medicine (EBM) and unhealthy populations
10. Previous sexual abuse
11. Homelessness

REACH programme → Medical students → GP trainees → GPs
COMMON CAUSE?

1) To develop a compelling competing narrative based on the importance of generalist clinical practice (i.e. unconditional, personalised continuity of care for all patients, whatever problems they have)

2) To highlight the persistence and significance of the inverse care law
POSSIBLE EXPLANATIONS FOR THE WEAKENING OF GENERALISM

Traditional disdain

The most important work of generalists is “out of sight, out of mind”

Effective generalist care is hard to document as it mainly results in non-events

The most powerful and influential institutions tend to be specialist-based

Most research and evidence is specialist-based

Practice-based research is complicated by small numbers and many sources of variation

The arguments that bigger and better general practice is the solution to pressure on A&E departments, health care fragmentation and widening health inequality tends to be rhetorical rather than evidence-based
SIX ESSENTIAL COMPONENTS

1. Extra TIME for consultations (INVERSE CARE LAW)

2. Best use of serial ENCOUNTERS (PATIENT STORIES)

3. General practices as the NATURAL HUBS of local health systems (LINKING WITH OTHERS)

4. Better CONNECTIONS across the front line (SHARED LEARNING)

5. Better SUPPORT for the front line (INFRASTRUCTURE)

6. LEADERSHIP at different levels (AT EVERY LEVEL)
DISCRETIONARY ASPECTS OF GENERAL PRACTICE

How broadly to identify the problems that general practice can help (e.g. the medical model or more widely).

How high to “set the bar” in terms of the short, medium and long term objectives of patient care.

The length of a normal working day (with average resources, practices can only increase the numbers of patients seen by shortening consultations or lengthening the working day).

The number and type of practice staff to employ.

Whether to provide extra-contractual letters for patients seeking support for benefit applications and appeals.

Whether to invest time in developing links with local community resources for health.

Whether to take part in optional activities, including teaching, training, research or development projects.

Whether to pursue a leadership role in representing general practitioners, or in developing the local health system.

Whether to take part in advocacy, fighting against the conditions and policies which cause poor health in patients.

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“...only those GPs fluent in discussing structural causes of health inequalities discussed obligations to change local systems via strengthening community linkages and to influence higher level policies related to the SDH. This suggests that while there is a degree of what Metzl and Hansen deem ‘structural competency’ amongst some GPs working in disadvantaged areas, the scope remains to deepen this competency more broadly.”

Babbel et al. How do general practitioners understand health inequalities and do their professional roles offer scope for mitigation? Constructions derived from the deep end of primary care Critical Public Health 2017; DOI: 10.1080/09581596.2017.1418499
Summary

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

• Challenging context
  – Increasing workloads, social/medical complexity
  – More part-time, portfolio careers

• Where do we go from here?
  – Medical education (e.g. widening access)
  – Postgraduate training (e.g. structural competency)
  – Scope and discretion (e.g. community engagement and advocacy; new GP contract...)
  – **Protected time** for both service and professional development
  – **Shared learning** within and between practices
Thank you for listening...
Any questions?

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