

## Debate & Analysis

# What can the NHS do to prevent and reduce health inequalities?

### PROPOSALS FROM GPs AT THE DEEP END

A new set of papers from GPs at the Deep End imagines how the NHS should address the inverse care law, reduce the consequences of inequalities in health for individual patients, and narrow social differences in life expectancy.<sup>1</sup>

The principal causes of inequalities in health lie outside the health service, which is why policies to prevent health inequalities must address the wider social determinants of health, starting in childhood. However, it is insufficient to focus on the prevention of future inequalities in health. It is also necessary to reduce existing inequalities in health, and to prevent them getting wider. In practice, these approaches are complementary (Box 1).

The high prevalence of vulnerable families in deprived areas is one aspect of the general challenge facing the NHS in very deprived areas, which is to increase the volume, quality, and range of services provided for patients. Improving health, reducing premature hospital admissions, and narrowing health inequalities will be by-products of this simple objective.

#### The inverse care law

The inverse care law is a man-made policy which restricts needs-based health care. The flat distribution of GPs, in contrast to the steep social gradient of health needs, combined with often dysfunctional links between general practice and other parts of the NHS, are principal causes of the inverse care law, providing not only a partial explanation of 20 years of failure in addressing inequalities in health, but also

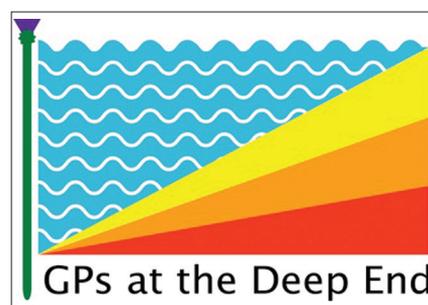
a major obstacle as the NHS searches for ways of delivering integrated care for the increasing numbers of people with multiple health and health-related problems.

The inverse care law is not explained by good medical care in affluent areas and bad medical care in deprived areas, but by the difference between what primary care teams are able to do in deprived areas and what they could do if they were better supported.

In a recent study of 60 representative Scottish general practices, 10% of patients with four or more comorbid physical conditions accounted for 34% of patients with unplanned admissions to hospital and 47% of patients with potentially preventable unplanned admissions to hospital.<sup>2</sup> The study vividly shows the combined effect of deprivation, physical multimorbidity, and mental illness on unplanned hospital admissions, including admissions that could potentially be prevented if general practice in deprived areas were adequately resourced.

It is recognised that many health improvement initiatives may have widened inequalities in health as a result of differential uptake by different social groups. The same perverse process applies to routine health care in deprived areas, where the NHS underachieves in reducing the severity and delaying the progression of health problems.

GPs at the Deep End would welcome an end to short-term health improvement initiatives, employing a screening approach, emphasising the start of processes rather than their continuation, and invariably achieving incomplete coverage and follow-



up (describing patients as 'hard to reach'). General practice has coverage and continuity but lacks the time and links to make effective use of contact it already has.

Modern health care improves population health not only via the mass delivery of evidence-based medicine, as incentivised by the Quality and Outcomes Framework (QOF), but also via the unconditional continuity of coordinated care provided for all patients, especially for patients with multiple problems, whatever combination of problems they may present.

However, only 12% of patient encounters in general practice concern QOF conditions.<sup>3</sup> Data from 314 Scottish general practices show that for all QOF conditions, patients with only that condition and no other comprise a small minority of patients.<sup>4</sup> Clearly, the QOF provides too narrow a focus to address the multiple problems of patients with multimorbidity.

The principal achievements of the Deep End project so far have been to connect GPs working in very deprived areas and to capture and communicate their experience and views. Building on 18 Deep End Reports ([www.gla.ac.uk/deepend](http://www.gla.ac.uk/deepend)), the steering group has developed a package of proposals to improve health and narrow inequalities (Box 2).

Additional time for GP consultations is essential but not enough. The Deep End proposals also address how general practices can work more effectively with other professions, services and organisations, using the intrinsic contact, coverage, and continuity of general practice as the hub of local health systems. In general, the NHS has too many hubs and not enough integrated working with patients at the centre. The intrinsic features of general practice make it the natural hub of care for most patients.

### Box 1. Prevention and treatment in one family

David is 14 months old. His 18-year-old mum Sarah has had anxiety problems since her older brother hanged himself 4 years ago. She started college but left when she became pregnant shortly afterwards. Sarah does not get on well with her mother, whom she accuses of drinking and 'always shouting' since her brother died. Her mum says she is 'mental' and a 'teenage brat'. Sarah relies heavily on her own gran Margaret. Aged 50 years, 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 often strange behaviour and with a lively toddler for whom she is the main care giver.

For David the next 2 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 workers, persistent contraceptive advice, and smoking cessation support, to name a few. At the hub of these lies the primary care team, offering unconditional care and the possibility of trusted relationships over the span of David's life.<sup>1</sup>

*"If the NHS is not at its best where needs are greatest, inequalities will continue to widen. Sixty-five years on from the foundation of the NHS, this is the current test of its founding values."*

The Deep End proposals are not a blueprint that can be 'switched on'; they are an agenda requiring a long-term commitment to joint working in general practice and primary care. For example, policies to encourage self-help and self-management often imply that this is a minimal intervention, which quickly transforms patient behaviour. The reality is that reversing years of low expectations can be a long haul, 'initially face to face, eventually side by side'. In a study of 3000 GP consultations in the west of Scotland, an essential ingredient was patient perception of practitioner empathy.<sup>5</sup> While practitioner empathy was often reported by patients without enablement, patient enablement was never reported without practitioner empathy. 'Co-production' implies long-term relationships between patients and practitioners who know each other well, building knowledge and confidence from a succession of challenges and problems.

Resources are a central issue, and a fundamental test of political will to address the inverse care law, but there is also a challenge in how the NHS deploys its considerable resources to best effect. The principles of co-production, including mutuality and trust, apply not only to long-term relationships between patients and practitioners, but also to relationships between general practices and other

services, and between leaders working at every level of the NHS.

Most of the above issues are not confined to Deep End practices but apply to most general practices, differing only in degree. It is axiomatic that many of the Deep End proposals should be applied not only in very deprived areas but also, pro rata, across the country.

The Deep End agenda looks forward. Increasingly, the challenge facing health services is to develop effective, affordable, and sustainable ways of helping people with multiple problems to live well with their conditions, and to avoid or postpone complications. Neither patients nor the NHS can afford partial, fragmented, inefficient care, yet this has been the direction of travel. For most patients, joined-up care begins and ends in general practice. The challenge is greatest in very deprived areas. If the NHS is not at its best where needs are greatest, inequalities will continue to widen. Sixty-five years on from the foundation of the NHS, this is the current test of its founding values.

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<http://www.gla.ac.uk/researchinstitutes/healthwellbeing/research/generalpractice/deepend/>

## Box 2. Deep End proposals

- Additional time for consultations with patients, including targeted appointments for the neediest patients.
- Support for serial encounters and the productive use of long-term relationships.
- Attachment of staff from area-based services (social work, mental health, addictions, and child health) to general practices or groups of practices, on a named basis.
- A national enhanced service for practices to address the needs of vulnerable families.
- Development of a lay link worker role connecting practices and patients with community resources for health.
- Support for training and leadership development within and between practices and linked to locality planning.
- Protected time for practices to share experience, information, learning, and activity on a cluster basis, following the example of the Scottish Primary Care Collaborative.
- A new partnership between leadership at the top and bottom of the NHS, based on mutual understanding, accountability, and respect.
- Evaluation and research based on and informing the person-centred work of general practice, especially in very deprived areas.
- A greater focus by all central NHS agencies on the support of general practices serving very deprived areas, beginning with an audit of what these agencies currently do in very deprived areas.

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## Provenance

Freely submitted; not externally peer reviewed.

## Further reading

RCGP Occasional Paper 89: *General Practitioners at the Deep End: the experience and views of general practitioners working in the most severely deprived areas of Scotland* including 13 articles from the *BJGP*, can now be downloaded free of charge from <http://www.ncbi.nlm.nih.gov/pmc/issues/221894/>

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## REFERENCES

1. General Practitioners at the Deep End Steering Group. *What can NHS Scotland do to prevent and reduce health inequalities? Proposals from General Practitioners at the Deep End.* [http://www.gla.ac.uk/media/media\\_271030\\_en.pdf](http://www.gla.ac.uk/media/media_271030_en.pdf) [accessed 7 Aug 2013].
2. Payne RA, Abel GA, Guthrie B, Mercer SW. The effect of physical multimorbidity, mental health conditions and socioeconomic deprivation on unplanned admissions to hospital: a retrospective cohort study. *CMAJ* 2013; DOI:10.1053/cmaj.121349
3. Information Services Division. *Practice Team Information (PTI). Annual update (2011/12). 27 November 2012.* <http://www.isdscotland.org/Health-Topics/General-Practice/Publications/2012-11-27/2012-11-27-PTI-Publication-Report.pdf> [accessed 7 Aug 2013].
4. Barnett K, Mercer SW, Norbury M, et al. Epidemiology of multimorbidity and implications for health care, research and medical education: a cross-sectional study. *Lancet* 2012; **380(9836)**: 37-43.
5. Mercer SW, Jani BD, Maxwell M, et al. Patient enablement requires physician empathy: a cross-sectional study of general practice consultations in areas of high and low socioeconomic deprivation in Scotland. *BMC Fam Pract* 2012; **13**: 6.