

PROMOTING CHANGE IN HARDER TO REACH
AND DISADVANTAGED GROUPS

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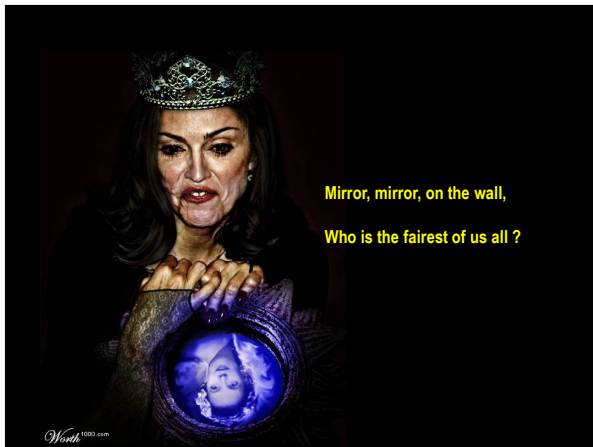
QUALITY FOR SOME

OR

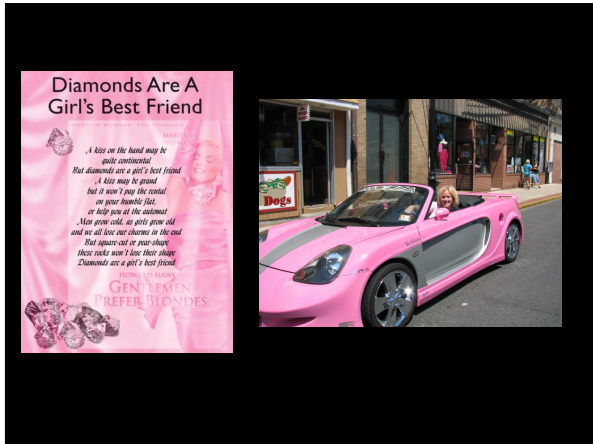
QUALITY FOR ALL

Illness is neither an indulgence for which people have to pay,
nor an offence for which they should be penalised,
but a misfortune,
the cost of which should be shared by the community

Aneurin Bevan

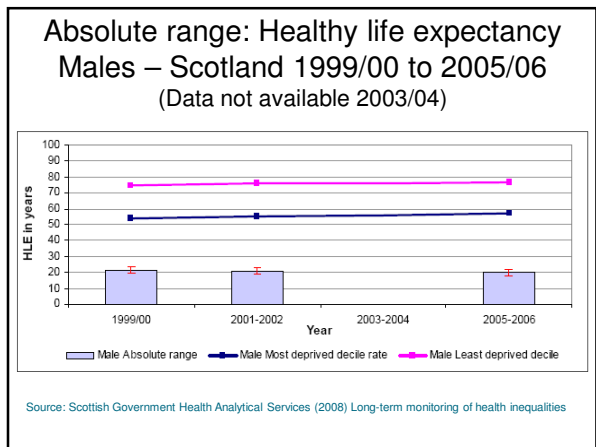
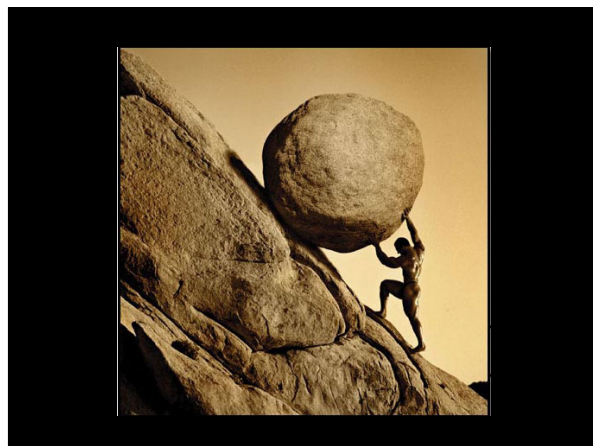


DIAGNOSIS	✓
TREATMENT	✓
DOSE	✗



UNIVERSAL COVERAGE IS ONLY THE START

UNCOORDINATED SUPPLY AND DEMAND WILL PRODUCE INEQUALITIES IN HEALTH



Scotland best in world at tackling health inequality, says medical chief

Scotland is the best in the world at tackling health inequality, says the chief medical officer for Scotland.

Dr. James Frith, the chief medical officer for Scotland, has said that Scotland is the best in the world at tackling health inequality. He said that Scotland has the lowest health inequality in the world, with the gap between the healthiest and the least healthy being the smallest.

Dr. Frith said that this is due to a combination of factors, including a high level of social inequality, a high level of income inequality, and a high level of health inequality. He said that Scotland has the lowest health inequality in the world, with the gap between the healthiest and the least healthy being the smallest.

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STRATEGIES TO REDUCE INEQUALITIES

Without population contact

Fiscal measures
 Legislation
 Mass media

With population contact

Single contacts
 Serial contacts



BARBARA STARFIELD ON PRIMARY CARE

1. Health services with strong primary care systems are more efficient (with better outcomes and lower costs)
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 APROPRIATE health services

PRIMARY CARE CONTRIBUTIONS TO HEALTH IMPROVEMENT

- Preventive advice and procedures for well people
- Reversing risks in people who are otherwise well
- Screening for asymptomatic disease
- Preventing disease complications
- Enabling patients to live well with illness and disability
- Reducing distress and disability
- Palliative care for end stage disease

GOOD COVERAGE RATES

90%
 80%
 70%
 60%

POPULATION CONTACT OF GENERAL PRACTICE

Routine coverage

90% over 5 years

QOF targets for 2007/08 (n = 62)

- 35 (56%) required 90% coverage
- 12 (19%) required 80% coverage
- 9 (15%) required 70% coverage
- 4 (6%) required 60% coverage
- 2 (3%) required 50% coverage

HARD TO REACH PATIENTS ?

or

HARD TO REACH PRACTICES ?



CAN PRIMARY HEALTH CARE DO ANYTHING TO REDUCE HEALTH INEQUALITIES ?

1. The combination of evidence-based, effective interventions
PLUS
whole population coverage
CAN
improve population health
2. BUT
by inequitable delivery of effective interventions, health care
CAN
widen health inequalities
3. In theory, primary health care serving poor areas
COULD IMPROVE POPULATION HEALTH, AND NARROW INEQUALITIES
by increasing the volume, coverage and quality of care provided

THE INVERSE CARE LAW

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

Julian Tudor Hart

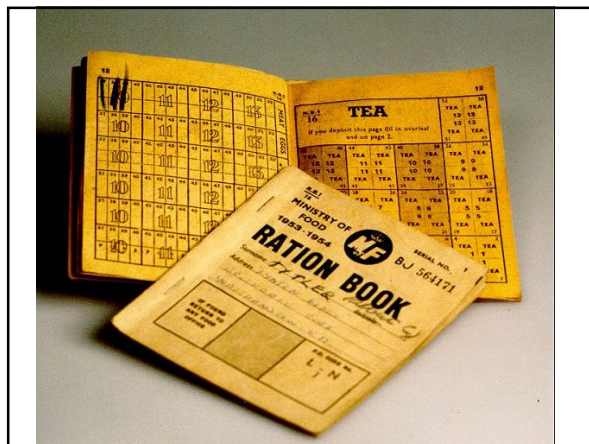
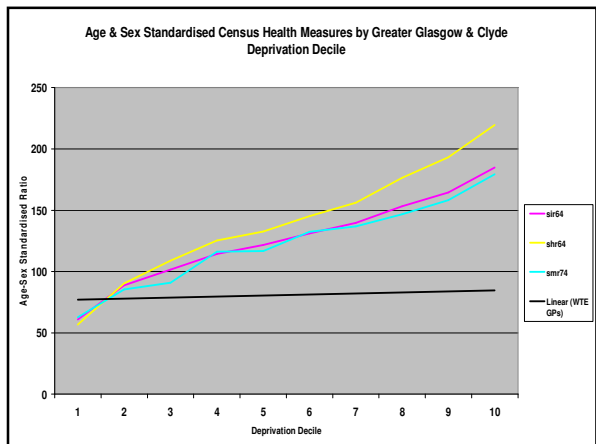
Lancet 1971

3 EXPLANATIONS OF INVERSE CARE

Financial barriers

Interest groups

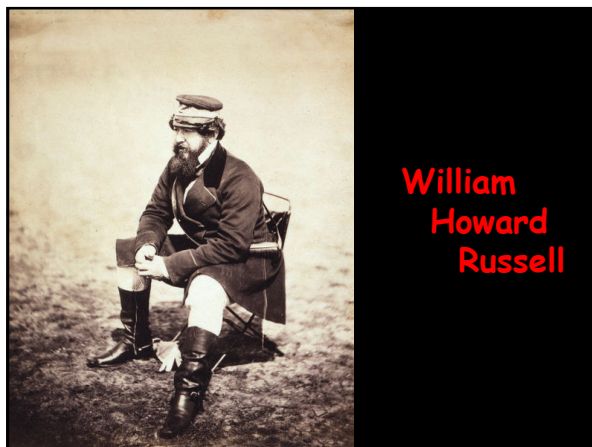
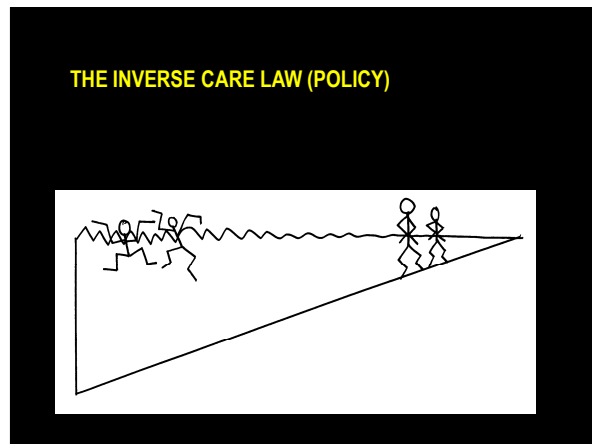
NHS policy



CHD CASELOAD PER WTE GENERAL PRACTITIONER

Quintile of Deprivation	No of cases with at least one CHD diagnosis	WTE GP	CHD cases per WTE GP
1	6543	100.9	65
2	6399	97.9	65
3	9262	121.7	76
4	8455	110.8	76
5	9378	111.2	84

SOURCE : GREATER GLASGOW LES DATA



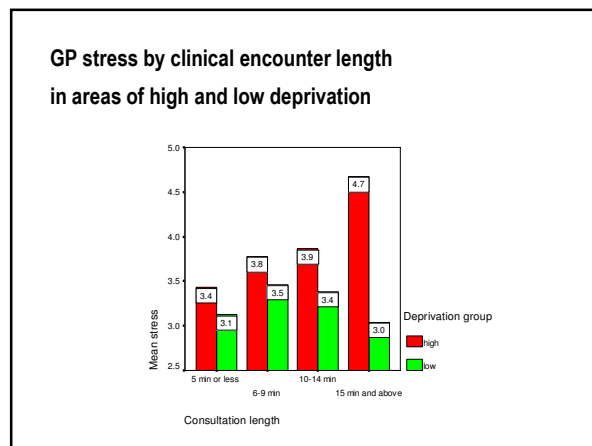
UNDERSTANDING THE INVERSE CARE LAW

Mercer SW Watt GCM

How does the inverse care law operate?
 An in-depth characterisation of the clinical encounter in primary care in areas of high and low deprivation in Scotland

Annals of Family Medicine 2007;5:503-510

- FEATURES OF CONSULTATIONS IN DEPRIVED PRACTICES**
- Higher demand
 - Shorter time available
 - Greater psychological and physical morbidity
 - More multimorbidity
 - Less enablement reported by patients with complex problems
 - Greater GP stress

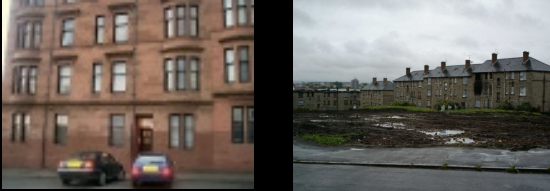


Patient ENABLEMENT Instrument (PEI)
 As a results of your visit to the doctor today, do you feel you are

- Able to cope with life
- Able to understand your illness
- Able to cope with your illness
- Able to keep yourself healthy
- Confident about your health
- Able to help yourself

Consultation and Relational EMPATHY Instrument (CARE)
 How was the doctor at

Making you feel at ease	Letting you tell your story
Really listening	Being interested in you as a whole person
Fully understanding your concerns	Showing care and compassion
Being positive	Explaining things clearly
Helping you to take control	Making a plan of action with you



Mercer SW Fitzpatrick B Gourlay G Vojt B McConnachie A Watt GCM

More time for complex consultations in a high deprivation practice is associated with increased patient enablement and reduced GP stress

British Journal of General Practice 2007;57:960-966

PRACTICAL ISSUES

What is a "complex" patient ?

How to deploy additional consultation time ?

CONCLUSIONS

- Evaluation of one initiative in an area of extreme deprivation
- Extended consultation length for complex consultations resulted in modest increases in patient enablement
- General reduction in GP stress
- Increased enablement in non-complex patients
- Further work required

STRENGTHS OF PRIMARY MEDICAL CARE

- CONTACT
- COVERAGE
- CONTINUITY
- COMPREHENSIVENESS
- COORDINATION
- RELATIONSHIPS
- TRUST
- FLEXIBILITY
- LEADERSHIP

WEAKNESSES OF PRIMARY MEDICAL CARE

- LACK OF RESOURCE (TIME)
- CAN'T DO EVERYTHING
- DOMINANT REACTIVE PATTERN OF CARE
- LOW EXPECTATIONS ?
- ISOLATION
- LACK OF SUPPORT SYSTEMS
- LACK OF VOICE AND INFLUENCE

CHALLENGE 1

HOW TO COMBINE

THE STRENGTHS OF PRIMARY MEDICAL CARE

**WITH THE STRENGTHS OF OTHER HEALTH
IMPROVEMENT SERVICES**

Not the whole solution, but an important part

CHALLENGE 2

THE DISAGGREGATED NATURE OF GENERAL PRACTICE



**The
General
Practice
Armada**

Some Numbers...PRIMARY CARE IN GLASGOW

- 270 GP Practices
- 860 GPs
- Total GMS related spend 08/9 £158m
- Annual net prescribing spend in 08/9 £220m
- 230 Practice Managers
- Over 450 Practice Nurses
- 200+ Health Care Support Workers

CHALLENGE 3

SHORTAGES OF INFORMATION AND EVIDENCE

THE BLIND LEADING THE BLIND



CHALLENGE 4

INTEGRATING VERTICAL POLICIES

IN A HORIZONTAL SERVICE

(within consultations
surgeries, practices and localities)

**THE 100 MOST DEPRIVED
GENERAL PRACTICES IN SCOTLAND**

THE MOST DEPRIVED 10% OF THE SCOTTISH POPULATION

The problem of concentration

50% are registered with the 100 "most deprived" practice populations

The problem of dilution

50% are registered with the other 900 practices in Scotland

THE 100 MOST DEPRIVED PRACTICES

43% of male deaths and 24% of female deaths occur under 70

85 practices are in Glasgow

(5 in Edinburgh, 5 in Inverclyde, 2 in Dundee, 2 in Ayrshire, 1 in Renfrewshire)

Average practice has 3.6 WTE general practitioners

20 practices are single-handed

QOF POINTS 2007

	TOTAL	CLINICAL	NON-CLINICAL
Most affluent practices	984	645	339
Mixed practices	979	643	336
Most deprived practices	977	641	335

ADDITIONAL ACTIVITIES

Undergraduate teaching	45
Postgraduate teaching	27
Research (SPCRN)	66
Primary Care Collaborative (SPCC)	67

PRINCIPLES OF ENGAGING WITH PRIMARY MEDICAL CARE

MUTUAL RESPECT

CANNOT BE LED FROM OUTSIDE

BUILD ON CORE ACTIVITIES AND STRENGTHS

NO ADDITIONAL WORK WITHOUT ADDITIONAL RESOURCE

THE TIME THAT IS MOST VALUABLE IS THAT OF EXISTING LEADERS WITHIN GENERAL PRACTICES

HOW CAN PRIMARY CARE WORK BETTER TOGETHER ?

SHARING ACTIVITY

SHARING EXPERIENCE

SHARING INFORMATION

SHARING EVIDENCE

PRODUCING NEW EVIDENCE

SPEAKING WITH ONE VOICE

WHAT CAN PRIMARY MEDICAL CARE DO DIFFERENTLY ?

MORE TIME WITH PATIENTS
BETTER USE OF EXSTING RESOURCE
BETTER LINKS WITH HEALTH IMPROVEMENT
BETTER LINKS WITH OTHER NHS PRIMARY CARE SERVICES
BETTER COLLABORATION WITH LOCAL AUTHORITY SERVICES
BETTER COLLABORATION WITH VOLUNTARY SERVICES AND LOCAL COMMUNITIES
BETTER LINKS WITH THE REST OF THE NHS, INCLUDING OUT OF HOURS, ELECTIVE REFERRALS AND HOSPITAL SERVICES

WHAT SUPPORT SYSTEMS ARE NEEDED

PROTECTED TIME
INFORMATION
ADVICE
CONTINUING PROFESSIONAL DEVELOPMENT
TRAINING
PRIMARY CARE COLLABORATIVE
PARTNERSHIPS

AND HOW TO GET THEM ?

THE CULTURE OF POWER

or

THE POWER OF CULTURE

**PROMOTING CHANGE IN HARDER TO REACH
AND DISADVANTAGED PARTS OF PRIMARY CARE**

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