The Review

Time to make a difference

I sit on a man's back, choking him and making him carry me, and yet assure myself and others that I am very sorry for him and wish to ease his lot by all possible means — except by getting off his back.
(Tolstoy, *What then must we do?,* 1886)

After 15 meetings and reports, the Deep End Project has had some success, establishing an identity for the scattered front line of practitioners serving Scotland's 100 most deprived communities, and capturing their previously unheard experience and views. However, it is a sobering fact that the project has yet to make a material difference to the circumstances under which Deep End practitioners work. The remaining articles in this series focus on what needs to be done.

There is no single or short-term solution. A sustained and integrated package of measures is needed, combining at least six separate elements. First, Deep End practices need more time and capacity to address unmet need. Second, best use needs to be made of serial encounters over long periods. Third, practices need to be better connected with other professions and services, as hubs of local health systems. Fourth, there needs to be better connections between practices across the front line, following the example of the Deep End project. Fifth, the front line needs to be better informed and supported by NHS organisations. Sixth, leadership needs to be developed and supported at practice and at area level for all of these activities.

Additional time for Deep End practices is not sufficient, but it is essential. Very few of the very many reports and recommendations on health inequalities make any reference to the issue of time. If mentioned, the inverse care law is invoked as an Act of God, rather than a man-made policy which restricts access to care based on need. Experts on health inequalities have a collective visual field defect concerning this issue. The RCGP Scotland report *Time to Care* is an important exception.[1]

Of course, the most important policies for improving population health and narrowing health inequalities, concerning education, employment and the social environment, do not require one-to-one contact with the general population. But insofar as health polices require contact with the public, general practice is the main delivery system providing coverage, continuity, flexibility, sustainability, and trust.

General practice makes a difference partly via the mass delivery of evidence-based medicine, as per the Quality and Outcomes Framework, but also via the unconditional, committed, and continuing care provided for all patients, especially those with multiple morbidity and social problems. If such care is provided inequitably, greater improvements in health in better resourced areas lead to widening health inequality. Current arrangements are not a satisfactory option. They lead in the wrong direction.

The continued existence of the inverse care law is explained, not by the provision of good care in affluent areas and bad care in deprived areas, but by the difference between what practices in deprived areas are able to achieve and what they could achieve if properly supported. This difference is apparent on a daily basis to Deep End practitioners, but has largely escaped detection by epidemiologists and statisticians, trying to understand general practice and unmet need from afar.

The principal mechanisms of the inverse care law are firstly inadequate time within consultations to address the full burden of patients' problems and secondly, dysfunctional relationships between general practice and other local professions and services, leading to fragmentation of patient care.

Well coordinated care is needed most by patients with multiple health and social problems, including the 15% of patients who account for 50% of NHS activity. While a range of initial criteria may determine the need for integrated care (for example, cardiovascular disease risk, multiple morbidity, age, and vulnerable families), the key contribution of general practice (as opposed to specific care programmes) is personal, flexible, and continuing care for whatever combination of problems a patient may have.

Men and women in the most deprived tenth of the Scottish population have life expectancies 13 and 9 years shorter, respectively, than men and women in the most affluent decile. They spend twice as many years in poor health before they die (10.3 versus 5.5 years for men; 14.4 versus 6.0 years for women).[2] Yet the numbers of GPs serving such areas is the same.

The contribution of GPs to public health is via the sum of care provided for all patients. By addressing unmet need and improving the health of their patients, Deep End practitioners could do much more to prevent, reduce, and delay the effects of poor health.

Intellectual opposition to social injustice is only the beginning of understanding.[3] Reports and policies on inequalities in health need to address the inverse care law. More than 60 years on, the NHS could still show the world what universal coverage and needs-based services can achieve.

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On behalf of the Deep End Steering Group. This is the 9th in a series of articles from General Practitioners at the Deep End.

DOI: 10.3399/bjgp11X593910

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REFERENCES

1. Royal College of General Practitioners. *Time to care: health inequalities, deprivation and general practice in Scotland.* Edinburgh: RCGP, 2010.
2. The Scottish Government. *Long-term monitoring of health inequalities.* Edinburgh: Scottish Government, 2010. http://www.scotland.gov.uk/News/Releases/2010/10/26101757 (accessed 8 Aug 2011).
3. Hart JT. Relation of primary care to undergraduate education. *Lancet* 1973; **ii:** 778–780