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DOI: 10.3399/bjgp12X649043

GPs at the Deep End

These 12 articles[1] and Watts'[2] concluding editorial have been inspirational, and for us, like others,[3] have helped validate our experience over a professional lifetime of serving in a deprived post-war peripheral council estate where there were 'very few easy cases'.[4] We recognise each characteristic cited by Watts, as being a true reflection of issues faced by all patients at the Deep End, and the teams who serve them.

Watts *et al* convincingly make the case, again, for additional healthcare resources to deal with the number, severity, and complexity of health and social problems at the Deep End, that are difficult to address with standard resources and in standard consultation times.[5] Despite the shorter life expectancies, and many more years in poor health before death, endured by Deep End patients, any additional healthcare resources directed to Deep End populations do not reflect the additional, potentially preventable, morbidity and premature mortality.

An answer to this mismatch of need and resource is to engineer longer consultation times in deprived areas, either with doctors, or with nurses able to handle the complexity of multiple morbidity, and this model would fit the opportunistic nature of the work. This requires political will and professional support, rather than opposition.[6] It is telling that the *Black Report*, in 1980, was released in small numbers on a Bank Holiday weekend, and that this important series of articles from GPs at the Deep End has, to date, generated only three letters to this journal. The blind spot to which Watts refers is real. His point that Tudor Hart's Inverse Care Law is a man-made construct, that restricts access to care based upon need, is well made. The point, as he says, is not that poor areas get bad GPs while rich areas get good ones, but that good GPs in poor areas are prevented from maximising what they could do by failure of provision of the resource that would give the deprived 'an average chance of health'. The issue is not doctor workload, but resource to reach all the potentially treatable morbidity.

Twenty-one years ago we wrote a series of articles for this journal (they appeared in *Connexions*) about the need to target resources to the 'forgotten areas of deprivation' to give our patients an 'average chance of health'.[7] Over 65 years, between us, of service within socio-economic deprivation, it was our clear experience that advocacy on behalf of the health resource needs of patients, needs to be a constantly repeated teaching theme. Resource providers start out not understanding, learn in dialogue, then move on and the educational process has to start all over again.

The mutual support that Deep End group participants have experienced is relevant for Deep End workers everywhere. The involvement of policy advisers from the Scottish Government Health Directorate is important. We look forward to hearing more about the trajectory of this initiative. As Watt says: 'addressing the Inverse Care Law is not rocket science', but it is vital to the health of deprived patients. Would that a similar group could establish itself south of the border.

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Patients' views of pay for performance in primary care

In the results section of their research into 'patients' views of pay for performance in primary care'[1] Hannon and colleagues state that, 'the majority of patients were surprised to hear their practice received bonuses for doing "simple things"'. This is a fundamental misconception. The money intended for potential QOF payments was taken out of the guaranteed/secure income to practices and is then paid only on achievement of certain agreed targets. And no one is going achieve 100% so not all the money was ever going to be paid back. Thus QOF payments are in no way 'bonuses': overall the scheme is of pay deductions for not achieving the desired targets. In fact in our practice, payments for QOF achievements equal, in very rough and ready terms, half of partners drawings, so in a very real sense if we don't achieve we don't get paid. Let patients understand the system as 'pay for performance', OK, but, please, not as bonuses.

But things are worse than that. In order to make sure that the targets are achieved GPs often have to create new systems, new clinics, or anyway do more work, and this costs the practice something, hopefully at least paid for by the QOF-related income. Yet now some QOF targets are being 'retired' on the grounds that change has been secured, achievement is the norm. We are expected to carry on with the work needed to carry on the achievement, yet suddenly it is not being specifically funded any longer. The only way for this not to be a net financial loss to a practice is to make 'efficiency savings' somewhere else, or simply stop doing something else. Moreover new targets introduced will mean more new work, and cost.

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