**Health, Social Care and Sport Committee**

**Health Inequalities Inquiry**

**April 2022**

RCGP Scotland welcomes the opportunity to respond to this consultation. As the membership body for GPs in Scotland, our response is focussed on the role of general practice in mitigating health inequalities. However, we fully recognise that wider public health, structural and societal changes are key to addressing the root causes of health inequalities.

1. **What progress, if any, has been made towards tackling health inequalities in Scotland since 2015? Where have we been successful and which areas require more focus?**

* The starkest measures of health inequalities, including life expectancy, are not narrowing, and the evidence is that the opposite is true, even prior to Covid. Improvements in life expectancy for the poorest have stalled, and even reversed.
* We recognise that many of the key determinants of health inequality relate to inequalities in wealth and power, education and employment. There are key policy areas in relation to these which are reserved to UK Government and as such ultimately outwith the immediate control of Scottish Government. However, with regards to key devolved policy areas such as health, we believe that we have not seen the widespread, systemic implementation of models of healthcare service delivery which tackle health inequalities. We believe this should be a key area of focus for the Scottish Government.
* General practice delivers universal, local, comprehensive, holistic care, and provides powerful mitigation for health inequalities. It must be seen as the cornerstone of organising and delivering care to the most deprived and needs to be considered and resourced in that context. However, it is difficult to link success to particular interventions as the required data is lacking, and this is a highly complex area with many potential attributions. We would support the collection and analysis of data around immediate measures such as health service usage (not only number of consultations), chronic disease parameters and mental wellbeing of patients in both primary and secondary care.   
    
  While general practice data lags behind that held on the rest of healthcare, we recognise the commitment from Scottish Government, and accompanying work, to improve the workforce and workload data held on the general practice. Any action to increase the data held on general practice is to be welcomed, however with regards to measuring health inequalities we do have concerns that simply counting the number of consultations will not fairly represent the complexity contained within each consultation. GPs in deprived settings have higher consultations rates, but shorter consultation times (driven by higher demand), deal with higher levels of co-existing physical and mental ill-health, care for patients with shorter lives lived in poorer health (early-onset multiple morbidities), lower health literacy, with patients reporting lower enablement scores and patients reporting higher burnout and stress[[1]](#endnote-1)[[2]](#endnote-2)
* We welcome increased focus and recognition at a national level on the need to take action on health inequalities. We also recognise and welcome recent work at a national level on the role of primary care in mitigating health inequalities, with the GP practice model being ideal with its continuity of care, universal coverage and local access. This work has been promoted by GPs at the Deep End group, supported by the Scottish Government’s Primary Care Division, particularly with the approaches of its Health Inequalities Short Life Working Group (SLWG). RCGP Scotland have been pleased to be represented on this group. We are supportive of the SLWG’s final recommendations and would encourage these to be adopted and taken forward in full by the Scottish Government.
* While we recognise there is a greater recognition at a national level of the need to tackle health inequalities, we feel that these are supported by few specific actions or dedicated resources at the grass roots level, and that is the area which now requires dedicated and urgent focus.
* We note the three current cross-portfolio priorities (children, climate and communities, fair work). In 2015 the then Scottish Parliament Health and Sport Committee reported that *“There was agreement in the roundtable that although health inequalities had been a stated priority of every Scottish administration since devolution, they would not be reduced without action to reduce inequalities in every other policy area and across every portfolio”[[3]](#endnote-3).* In view of Scotland’s poor record on health inequalities (the worst in Europe), perhaps this should be considered as a fourth cross-portfolio priority area.

1. **What are the most effective approaches to tackling health inequalities and how successful is Scotland in pursuing such approaches?**

* The public health evidence is that the most powerful determinants of health inequalities relate to societal ones: wealth, land and other ownership, corporate and organisational power, educational opportunities, and so on. We agree with the analysis offered in the Scottish Parliament’s Health and Sport Committee’s report on Health Inequalities, published in 2015[[4]](#endnote-4), and note that the status for some of these areas has worsened since then, and deteriorated yet further during the pandemic. There is now clear evidence for an adverse Covid impact which disproportionately affects the poor affecting health outcomes, mental health, educational achievement, and loss of savings, amongst others.

The WHO estimates that in public health terms addressing non-communicable diseases (NCDs) in youth and middle age is the key to improving prospects[[5]](#endnote-5): NCDs are the building blocks of multimorbidity. Cardiovascular and respiratory disease, cancer and diabetes responsible for most deaths (80% globally). The WHO now recognises socioeconomic deprivation (including mental health and the environment) as an independent risk factor for mortality risk and impaired physical functioning, with comparable impact to that of smoking, alcohol and obesity[[6]](#endnote-6). These factors comprise what Michael Marmot calls the *“causes of the causes of health inequalities*”. NCD prevention and management are strongly rooted in general practice care, and we need more resource-intensive approaches to addressing those health inequalities. There are many ways we could approach this, but they require differential investments in deprived general practice and primary care teams, and we have not seen that anywhere near the required scale.

* Access to healthcare is increasingly recognised as a social determinant of health, and that for many complex reasons access can be most problematic for those who need it the most (ie the inverse care law). More specifically, access to primary care is a social determinant of health, and in countries across the world where primary healthcare systems are strong and accessible, health outcomes and health equity are better.
* Addressing mental health is also crucial: it is one of the WHO’s identified contributors to NCD morbidity, and a driver of Scotland’s premature mortality. Prior to the pandemic that was four times higher in the poorest[[7]](#endnote-7), and traditionally driven by mental health and psychosocial factors, with trauma, alcohol, drugs and suicide accounting for the excess (and half of that due to alcohol and drugs alone)[[8]](#endnote-8) . The vast majority of mental health consultations take place in general practice, and increasingly GPs are also picking up work because of gaps in specialist mental health provision. This is not an area of success for Scotland: addressing mental health inequalities would need an expansion of GP services, and a weighting of specialist ones to account for socioeconomic deprivation. This has not happened, and worse, specialist mental health services are often designed in ways that serve the most vulnerable poorly (referral exclusions, the separation of mental health from drugs and alcohol services (when so many have co-morbidity), a massive shift to digital care, appointment notifications which are not user-friendly, discharging patients following Do Not Attends (DNAs) whatever the level of risk or illness etc). Please see question 6 for more detail.

1. **What actions would you prioritise to transform the structural inequalities that are the underlying cause of health inequalities?**

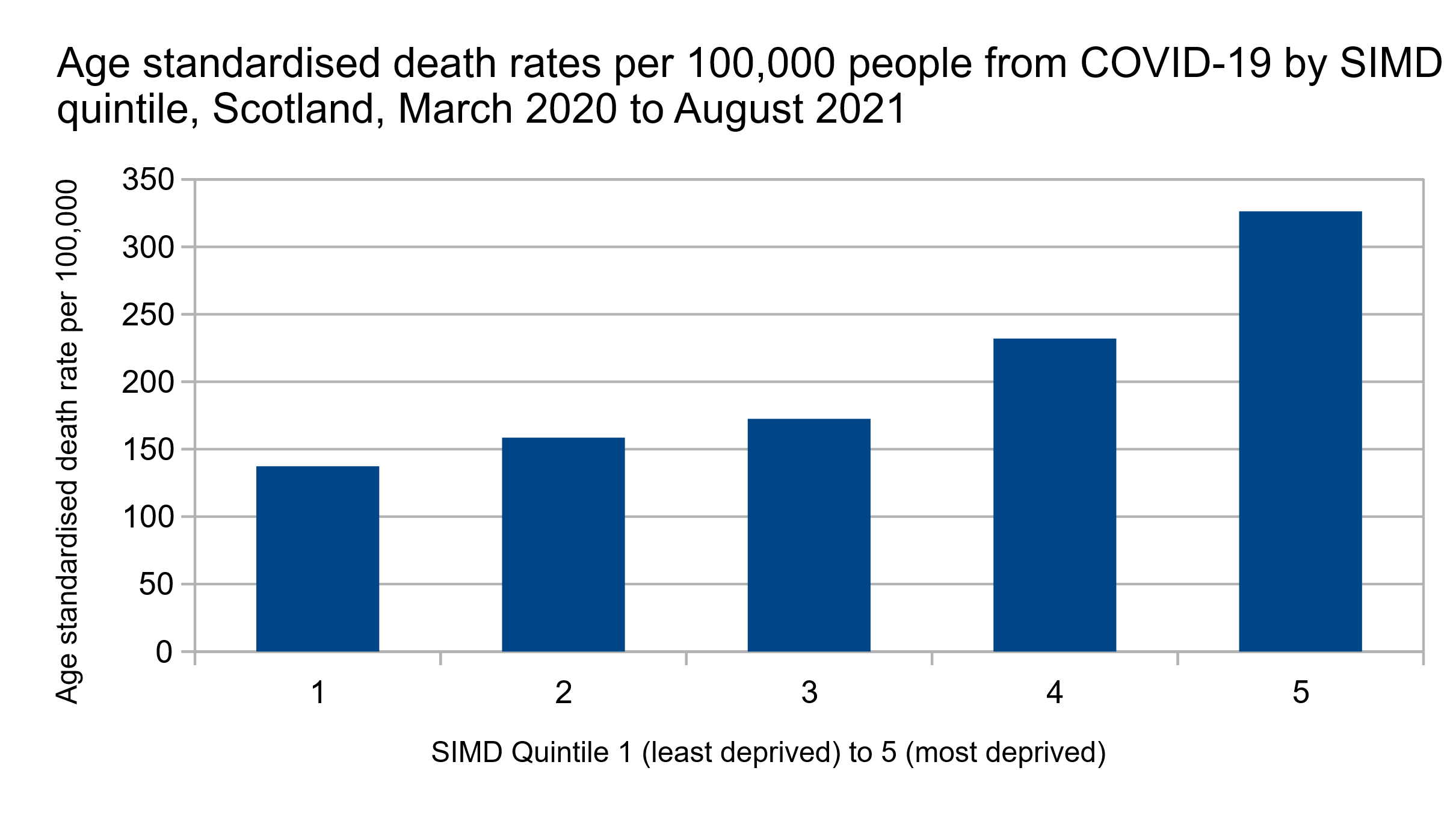
* We suggest the following are measures which address what we know to be determinants of health inequalities, the societal inequalities being the most powerful: income redistribution – always first, more equal educational opportunities, housing, better green spaces and other facilities in poor neighbourhoods, better public transport, work on stigma, food policies, land ownership reform, social security reform, employment opportunities, digital equality and so on. We know that maternal and children’s health (‘the first 1,000 days’) has a disproportionate effect on long-term outcomes and should be prioritised, that is also emphasised by Sir Harry Burns in the 2015 report. (Our view though would be closer to Professor Sally McIntyre’s[[9]](#endnote-9): *“we all know that good parents can help to ameliorate problems and provide more resilience, but health inequalities are not about parenting; they are about the socially structured issues that cause those inequalities, such as poverty, unemployment and living in terrible places*”). “Terrible places” are neighbourhoods and we have failed to address that core issue, of poor amenities as well as housing, and all the associated inequity. We need to also consider the specific drivers of rural poverty, which may differ from urban in terms of contributory effect (transport, connectivity, access to housing and land).
* Planet sustainability is the most critical and urgent health imperative of our time. The evidence is that climate change affects the poorest most, and that measures to address it disproportionately helps those people too - the Deep End report summarises some of the issues[[10]](#endnote-10). The Institute of Health Equity has also carried out important work in the realm of climate sustainability and health equity and their recommendations as outlined in their 2020 report for the UK Committee on Climate Change must be considered and acted upon[[11]](#endnote-11).

In urban settings, where possible, 20-minute neighbourhoods[[12]](#endnote-12) would bring benefit and the potential to define the distribution of amenities, which make such a difference to the wellbeing of communities - currently the best are in the most affluent areas. Could we see exploration of the concept of 20-minute GP practices (or equivalent)? Many practices have outdated and inefficient boundaries, with lack of co-location of other services, making joined-up team working more difficult. That would have to be done carefully, when general practice is already working under severe pressures, avoiding any destabilisation. Such approaches would potentially help in developing health inequalities provision in general practice.

* There are structural NHS inequalities that need to be addressed as well - the most pressing is to expand resource (including premises) in the primary care setting, where health inequalities can be most effectively addressed. However, structural change is urgent in the secondary care setting, too, where provision is also subject to the inverse care law: for multiple and complex reasons outpatient services are less well accessed by the most socioeconomically deprived. General practice then picks up that care as best it can, but the patient loses valuable specialist management. The temptation will be to increase funding to outpatients and urgent care, whereas health inequalities (like most else in health) are more effectively managed in primary care, which simply has not had the expansion in resource and staff required for the work over many years.
* The Scottish dialogue round health inequalities has tended (for good reason) to focus on those facing socioeconomic deprivation. However, other inequities which need to be considered more, many of which are also worsened by poverty. A deprived Edinburgh practice has coded all those needing a translator for appointments, and that rate currently runs at 10% of its population; whilst a deprived practice in Glasgow has a practice list that includes 88 different spoken languages. Translated appointments take longer, and the worry always is missing nuances, particularly with telephone consultations. We do not know what the translation rates are in wealthier populations but suspect that more are likely to speak English. The elderly face inequalities with over-stretched social services, and the growing NHS reliance on digital approaches. We know that LBQT+ people face discrimination and have higher levels of mental health difficulties.

1. **What has been the impact of the pandemic both on health inequalities themselves and on action to address health inequalities in Scotland? Please note, the Committee is interested in hearing about both positive and negative impacts.**

Pandemics hit the poorest hardest, even where there is universal free health care. There is clear evidence that Covid affected the poor disproportionately, and we must remember that each of those deaths leaves a legacy of loss and grief in those families and communities, with consequences for mental health. We should not see Covid as too ‘different’ in terms of factors driving inequalities: in normal times the poor die earlier and following more years of ill health than the wealthy and the underlying factors are largely the same. Had we addressed some of those factors prior to the pandemic some of the outcomes might have been different.



There were some particular issues relating to Covid mortality – overcrowding, the impact on some minority ethnic populations, a bigger vaccine gap. GPs at the Deep End refers to the “triple whammy of Covid risk”, with deprived populations more likely to catch Covid, more likely to get sick or die from Covid[[13]](#endnote-13), and less likely be to be vaccinated against it[[14]](#endnote-14). Yet that Covid would disproportionately affect the poor was entirely predictable, with Public Health England stating early in the pandemic that *“these inequalities largely replicate existing inequalities in mortality rates in previous years”[[15]](#endnote-15)*. Professor Bambra and colleagues have highlighted in their excellent overview that there has been a ‘syndromic’ of Covid, chronic disease and the social determinants of health[[16]](#endnote-16), reflecting many of the drivers of health inequalities in non-pandemic times. The solutions are much the same too.

Positive impacts are difficult to discern in the most deprived communities: many young families especially struggled greatly with childcare (made worse by poor housing) and loss of income; others had to work in public facing jobs where they felt exposed, and those with the lowest paid jobs were least likely to work from home during lockdown, losing the protection that afforded[[17]](#endnote-17). There was a sense of camaraderie and support, both in communities and NHS services, but some of that has eroded with fatigue, worry and loss. There have been some positive organisational impacts (see below) in the NHS.

On a national level, the prominence of health inequalities appears to have risen higher up the political and public agenda. This is most likely as a consequence of the pandemic worsening health inequalities (as previously described) and as such should not be viewed positively. However, we recognise that greater recognition and focus on health inequalities has the potential to lead to desperately required action in this arena. However, this will only be possible with necessary resource dedicated and action being taken.

1. **Can you tell us about any local, regional or national initiatives throughout the pandemic, or prior to it, that have helped to alleviate health inequalities or address the needs of hard-to-reach groups? How can we sustain and embed such examples of good practice for the future?**

For many of these initiatives, there is the caveat that delivery or impact in hard to reach groups is blunted by their circumstances. Our aim should be to reduce variation in outcomes, and that will mean increasing variation in inputs, weighting and flexing for the most deprived populations. There is very little evidence of proportionate universalism in Scottish NHS structures, and even less in services delivered by Health Boards.

**Pre-pandemic**

National initiatives pre-pandemic likely to have helped alleviate health inequalities include:

* the ban on smoking in public places
* minimum price of a unit of alcohol legislation
* government initiatives to reduce poverty, especially in childhood; as well as other societal initiatives (education and so on)
* the rolling out of the nationally-defined Health Visitor programme
* drug misuse and Alcohol Brief Intervention enhanced services
* development of GP practices for homeless people
* expansion of the third sector
* initiatives to expand general practice.

There appear to be very few initiatives by Health Boards, other than their support of any of the above, in helping alleviate health inequalities, and their traditional relentless focus on secondary care will have instead contributed to them. There are some exceptions - services focussing on health inequalities - for instance the Lothian Sexual Health service led by Chalmers, where outreach clinics are sited in areas of deprivation and there is a specific focus on the marginalised, and on relationships with GP practices. That is managed by Edinburgh Health and Social Care Partnership. There are some minority ethnic health services which will also have brought benefit. However mainstream board-delivered services such as outpatient care rarely account for deprivation in their structures.

GP Cluster working is meant to focus on reducing health inequalities, particularly in its extrinsic role, but the evidence is that they have not yet developed the capacity to do that effectively. The development of Community Treatment and Assessment Centres (CTACs) whilst very welcome, also means that those services cannot be delivered by practice-employed staff. Particularly for common procedures such as phlebotomy, increasing the need to travel and the loss of familiar local settings as services move from practice-based facilities will increase inequalities, because patients are simply less likely to access care.

There are indications of fewer GPs per head of population in areas of deprivation[[18]](#endnote-18) and practice resource does not match mortality or workload estimates[[19]](#endnote-19):



There are many examples of innovative general practice, for example; Community Link Workers; Hepatitis C clinics in general practice; use of House of Care models for chronic disease management; specific measures to reach those patients who do not engage with care; the Govan SHIP model[[20]](#endnote-20); the Pioneer Scheme[[21]](#endnote-21); novel approaches to mental health including the use of practice-based psychology and mental health services; local engagement with third sector. [The GPs at the Deep End website](https://www.gla.ac.uk/researchinstitutes/healthwellbeing/research/generalpractice/deepend/) provides other examples, but what is crucial is to develop better systems to: capture innovation; understand what works best in terms of models of delivery; and roll out practice that works, but starting - always - with the most deprived, then extending along the principles of universal proportionalism.

Following that model, as the workforce capacity is so restricted (we cannot always effect change even if we have the resource) the rolling out of new programmes may never reach the wealthiest, who are least in need of them.

**During the pandemic**

**National initiatives**

* COVID vaccination programmes benefitted all in society, and in particular uptake in the deprived elderly population was excellent. However, the high vaccine take-up rate did not extend to younger deprived populations. Many Health and Social Care Partnerships (HSCPs) planned vaccination clinic sites taking account of deprivation but that programme was undermined by the extremely poor system of matching people to clinics at national level. This was damaging and vaccination arrangements must be determined locally in future to ensure the highest possible take-up of vaccines.
* Financial and other schemes for furlough and to support those shielding supported the socioeconomically deprived, but we know that the poorest in society were more likely to do face to face work, and some of those were living with people who were shielding and were unsupported. During the pandemic the rich have grown richer, and the poor have been made poorer.
* The move to digital messaging, information and provision will likely have reduced   
  inequalities for those with access to phones and IT. However, digital poverty is a very real concern and we know that older people (and the disabled) are less likely to access online information and services. This needs to be addressed going forward.
* The move to remote consulting, even for those who did have access to technology and reliable internet also relied on an ability to articulate needs, access to safe space to discuss personal or sensitive issues, and no communication issues (in terms of cognitive functioning, English-as-a-second language etc.)
* Social care services were withdrawn from many who traditionally benefitted from it, and we need to gain a better understanding of who needs social care and to what extent. We hope that this will be addressed in the development of a National Care Service.
* The specific recognition of the impact on health and social care staff wellbeing and the introduction of new wellbeing services for NHS and social care staff during the pandemic are very welcome and should be continued to be supported and developed. This should be done in such a way to ensure that they cater for the needs and circumstances of the many different professions that make up our health and social care workforce.
* Throughout the pandemic, we saw with surety, that there *is* such a thing as society; that children deteriorate when not at school, not only educationally, but in terms of their emotional wellbeing too; that many lost their social networks including those provided by a whole range of community-based services. This situation may have contributed to the high rates of mental ill health, and in those with drug dependence, fatal outcomes; that people in care homes with dementia deteriorate and die sooner than expected when they don’t see their loved ones; that face to face contact in healthcare settings brings added value for both technical and relational medicine. All of these effects will have a greater impact on the poor.

**Regional initiatives**

* HSCPs supported primary care providers with their input into the shielding programme: many liaised closely with general practice in that work, helping to identify and provide support to those patients who were most vulnerable. That should have helped mitigate growing inequalities. Community Pharmacists remained very accessible and were given support to deliver much more medication directly to people’s homes, particularly those who were shielding. Generally, patients were asked by practices to go directly to pharmacists for their prescriptions, rather than the GP first, and this yet again highlighted our outdated paper prescription system. Paper prescriptions not only add needlessly to practice workload (mainly that of reception and clinical admin staff) but add unnecessary and sometimes confusing steps to the patient journey and impact on efficiency and safety.
* Health Boards developed virtual services at pace (such as NHS Near Me) and, like within general practice, that will have helped some in poverty who find it difficult to attend face to face appointments, but disadvantaged others.
* There seems to have been very little, or no, Health Board delivered care during the pandemic, which focussed on reducing inequalities. Covid Assessment Centres were not sited in areas of deprivation and often access for those without cars was not addressed. We know that some very vulnerable patients with chaotic behaviours attend A&E when they need help and that needs to be accounted for within the ‘Redesign of Urgent Care’ initiatives which aim to divert patients elsewhere.
* Particularly early in the pandemic, some outpatient clinicians ‘delegated’ phlebotomy and other healthcare tasks to practices and asked patients to attend there. This would help those in deprived settings as they were more local but added to GP practice workload as this was generally neither agreed or resourced, depleting GP capacity for its own work. This must therefore be seen as exacerbating inequalities overall. For various reasons CTACS have been slow to develop secondary care phlebotomy services and the pandemic highlighted how poor many of those were in existing services. We suggest a survey of current facilities and plans to take those forward, viewing those with an inequalities’ lens: there is real potential for local delivery not dependent on general practice. Many of our most vulnerable find it difficult to repeatedly attend hospital, particularly when an appointment is just to have blood taken.
* We would like to see mandatory interface groups established in every health board area: inequality could be addressed at the interface between primary and secondary care, outpatient referrals being a key area.

**Local initiatives**

GP practice-based changes (including those reflecting national changes) which may have affected health inequalities include:

* Move to digital approaches which was especially useful for those with mobile phones, and gave new avenues of care and sharing information; but we know that inequalities were likely increased in those with less access or understanding.
* Anticipatory care planning discussions by GP practice teams with those identified as requiring shielding allowed discussion of health concerns as well as future care plans. They were hugely appreciated by patients.
* Changes in access – whilst practices remained open and providing care throughout the pandemic, we recognise that this was not always the perception. In addition, some highly vulnerable people were simply too frightened to access care, including transfer to hospital. This may have included some of those who died early in the pandemic, suddenly at home, and who had not been tested for Covid. Overall, the inevitable (albeit necessary) reduction in access especially at early stages of the pandemic, and including for routine chronic disease checks, will have caused harm. This should serve as a reminder that we need to protect general practice and other core primary care services in the future.
* During the pandemic, with the reduction in availability of other health and care services, many GPs extended their reach. For instance, many saw those with mental health problems or drug dependence when it was not strictly clinically necessary; a reception team which made elective phone calls to the most vulnerable during lockdown to offer practical support; district nurses, care home staff and other members of the team worked hard to look after their housebound patients and found new ways to communicate and maximise care. GPs working in the Lothian homeless practice even helped secure housing for their patients and visited them in hostels and B&Bs to provide care on site, including their methadone treatment[[22]](#endnote-22).
* Finally, all of the social distancing measures put in place to protect against Covid may have harmed the vulnerable most, by potentially reducing access to services or their perception of it; but it also protected them by offering local safe clinical care to populations with high levels of, and risks from, Covid.

1. **How can action to tackle health inequalities be prioritised during COVID-19 recovery?**

We need to consider that we are now facing Covid waves three and four in general practice, whilst still managing the earlier ones too[[23]](#endnote-23):

Diagram

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More general actions are covered in covered in answer to question 7, but considering these waves in more detail:

**First and second waves**

Covid precautions still need to be actively considered, and reflect the evidence base for best pandemic response, with GPs remaining involved in that planning. As public provision of testing ceases, the risks to patients in poor areas, and of the staff providing their health and social care, will add to the ‘intrinsic’ higher Covid risks in those populations. The direct Covid-related workload in deprived areas may also be higher. GP capacity remains restricted because of infection control measures and COVID-related workforce absences and there needs to be clear ongoing messaging about that. Long waiting lists for some secondary care services also mean that GPs are now carrying the workload of providing additional care for those patients, whose secondary care management has been postponed.

**Third wave**

Big drivers for health inequalities relate to Non-Communicable Diseases (NCDs) and mental health. GPs are also reporting an upsurge in late-presenting cancers. Michael Marmot has highlighted that multimorbidity occurs 10-15 years younger in the most deprived, and we know that there is a strong association between NCDs and workload. The Scottish data is well known[[24]](#endnote-24):

Histogram

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What this means in practice is a doubling of the multimorbidity prevalence in middle age in the most compared with the least deprived (shown by the red arrow), and we know that *“the impact of multimorbidity in younger (20-44 years) in the most deprived quintile was 80% greater than that in the least deprived quintile”[[25]](#endnote-25).*

We need to far better account for this in both medical, nursing (and community nursing) workloads. Longer practice nurse as well as GP appointments are required to help patients with difficult behaviour change as well as mental health issues relating to multimorbidity. We also need shared data with wider primary care resources focussed on those with the poorest outcomes (which will be the poor). This has worked well in some of the most disadvantaged populations in London. The rollout of Community Link Workers trained to help in this area to GP practices is also required.

**Fourth wave (mental health)**

Prior to the pandemic it was estimated that mental health accounted for around a third of GP consultations, but the widespread perception is of far higher rates, in line with the rise in mental ill health and distress during the pandemic.

Deaths due to drugs and alcohol have also risen during the pandemic, and GPs report increasing gaps in specialist provision, with some not having a sector psychiatrist at all, and work (including monitoring normally done by specialist services) handed back to them. There are extremely long waiting lists for mental health services, especially for Child and Adolescent Mental Health Service (CAMHS), but for adult services too, meaning that GPs essentially carry that workload. It is difficult to describe the breadth and depth of the current demand for mental health support from general practice, some GPs in deprived settings having to sometimes manage more than one suicidal patient in a single duty doctor session. Mental wellbeing is so key to self-care and enablement, that health more generally is undermined by the current rise in prevalence and severity of mental illness. GPs and mental health teams see people developing severe mental illness, who have never suffered in that way before. What account is being made of this at national level?

We require mental health clinicians working in every practice, starting with the most deprived; clear accounting for the outcome of general practice Action 15 monies; an analysis of the current mental health workload carried by practices and the available routes to other services. We also need funded Protected Learning Time (PLT) for practices to consider changing models of care (including how to manage those not seen by secondary care, Distress Brief Interventions (DBI), the Medication Assisted Treatment (MAT) standards and so on. There also needs to be very close scrutiny of the new mental health and wellbeing resources, to ensure that they are reaching GP practices, allowing them to care for those most in need.

Mental health and NCD management are offered as two suggested areas to prioritise, but there are many more. However, it is hoped these examples will provide some markers of the specificity, data and focus on implementation that we now need at practice level. What is crucial in all this is the GP workforce, who not only provide clinical care, but also manage partnerships, taking account of their practice population needs, a highly localised public health focus. One of the casualties of the pandemic has been the day-to-day building of relational care in face-to-face settings. The potential loss of continuity both requires, and is compounded by, a very significant shortage of GPs and other healthcare staff in practices, and short appointments as workloads rise. Continuity is especially important in deprived settings; we lose it at our peril. It provides *“better clinical outcomes for an array of conditions; reduced mortality; better uptake of preventative services; better adherence to medication; reduced avoidable hospital admissions; and better overall experience of care among patients who prefer continuity and are able to obtain it”,* and *r*elational continuity is preferred by those with poorer health status[[26]](#endnote-26).

1. **What should the Scottish Government and/or other decision-makers be focusing on in terms of tackling health inequalities? What actions should be treated as the most urgent priorities?**

Whilst we recognise that upstream and population-based structural approaches are key, the following focus on general practice is required. This is particularly important as we recognise that there are patients living with socio-economic deprivation in every area of Scotland.

* Continue to recognise the central role of general practice in mitigating health inequalities and providing evidence-based care to reduce the adverse gradients in a setting designed for that. RCGP Scotland, as well as GPs at the Deep End should be key participants in those discussions and planning. Going forward, we need to adjust care and resource to account for health inequalities, extending those principles to secondary care planning too.
* Stabilising the GP workforce must be a key priority for the Scottish Government to help tackle health inequalities. General practice is currently facing unprecedented challenges, particularly in terms of retention of a demoralised workforce and ensuring that general practice is an attractive career choice for the medics of the future. Without credible short, medium and long term workforce planning, which is based on Whole Time Equivalent, rather than headcount figures, this situation will not improve and will, in all likelihood, worsen. This situation must be urgently addressed and prioritised by the Scottish Government.
* Protected Learning Time is not currently available to all GP practices. Without this time during the working week, practice teams are rarely able to find the time to come together to discuss challenges, develop as a team and devise and implement solutions to support their patient population. We view PLT as a potential solution to the current retention crisis in general practice and this time could be used by teams to build essential knowledge and expertise around key areas, such as health inequalities. We would like to see a solution put in place to enable GPs and their teams to be able to regularly come together within their working week.
* We recognise that standard 10-minute GP appointments are insufficient in length to deal with the complexities of concerns brought by patients. However, due to the current workforce crisis in general practice and the level of demand on GP services, GPs and their teams are often unable to offer longer appointment times as standard. We urgently need action to boost the GP workforce to ensure that clinicians can move towards offering 15-minute appointments as standard. This is particularly important in the context of addressing health inequalities. In addition, recognition should be given to digital poverty and RCGP Scotland views the future of general practice consultations as reflecting the needs of patients, and especially the most deprived.

* Health inequalities training as part of all medical school education and GP training programmes, and introduction of Pioneer-type Fellowships. As described in the report of the Scottish Government Primary Care Health Inequalities SLWG[[27]](#endnote-27), consideration should be given to implementing a Scottish programme of multidisciplinary postgraduate training similar to the ‘Fairhealth’ programme in England[[28]](#endnote-28).
* We welcome the recent publication of the report by the Scottish Government’s Short Life Working Group for Mental Health in Primary Care[[29]](#endnote-29), which RCGP Scotland were pleased to be represented on. We also welcome the additional investment that has been committed by the Scottish Government to implement this model. As part of the mixed model announced, we need to ensure that the mix of mental health professionals working in GP practices includes a significant number of mental health clinicians, who can manage their own caseloads. This model of mental health in primary care has the potential to be transformative for patients as alongside providing expert care to patients presenting with mental health concerns, it will also reduce the workload of GPs. RCGP Scotland has a longstanding ask for every GP practice to have access to a dedicated mental health clinician.
* As part of the Scottish Government’s focus on reducing drug related harms, assessment should be carried out on the most effective models for integrating care with general practice, including alcohol (see a recent report highlighting the benefits of in-practice alcohol nurses[[30]](#endnote-30). Time and again, the focus and resource is on specialist services, which often fail to engage with the most vulnerable patients).
* A rapid appraisal should be undertaken (perhaps with input from Public Health Scotland) of how to measure and determine unaddressed health need.
* RCGP Scotland welcomes within the Scottish Government’s and COSLA’s ‘Health and Social Care: national workforce strategy[[31]](#endnote-31)’ a commitment to develop a new Remote and Rural Workforce Recruitment Strategy. This will have the stated aim of supporting employers, “to ensure that the Health and Social Care needs of people who live in remote and rural communities are met”. Reducing health inequalities must be a key consideration within this work.

In the short to medium term the following actions for those practices serving the most socially deprived populations (defined by decile) must be taken:

* A review of premises and the GP workforce must be undertaken. The indications are that Deep End practices are under-staffed in terms of doctor provision[[32]](#endnote-32), and there is clear evidence of that in England[[33]](#endnote-33). This is profoundly worrying when we know the benefits of generalist care (particularly with relational continuity) on population health. Addressing this imbalance must be a clear priority for the Scottish Government.
* Increased support for deprived practices to allow them to take on more medical students, Foundation Year doctors and General Practice Specialty Trainees, to address the current under-representation of such placements in deprived settings (the ‘Inverse Training Law[[34]](#endnote-34)’).
* An expansion of practice nurse teams is required to manage the NCD workload, this would help account for the increased time with patients required for those with low levels of literacy and health literacy.
* Additional training and resource to develop receptionists’ skills to meet the deeper Care Co-ordinator role. This is particularly important for those working in deprived settings as most frontline staff need to be highly skilled to not only determine the appropriate medical path, but the social prescribing one too.

1. **What role should the statutory sector, third sector and private sector have in tackling health inequalities in the future?**

**Third and Statutory Sector**

The third sector provides crucial support, particularly for the most marginalised. We know that health inequalities relate powerfully to wellbeing and personal agency and as such, third sector organisations have an important role to play.   
  
From a general practice perspective, their effectiveness is often hampered by organisational factors which reduce their accessibility and scope. We know that some people prefer services outwith general practice (sometimes for reasons of anonymity). The experience of general practice is that for those who have no private transport, who rely on the familiar and relationships to overcome anxiety about engaging with services and who may find it difficult to take the next step after the first, the following interventions help:

* Stable long-term services so that both users and GPs can become familiar with them, know who they best suit, and build long term organisational and human relationships. The current ‘churn’ of third sector organisations results in a significant workload for GPs as they must constantly learn about new services, and what they provide, but also then grasp the subtleties of which suits individual patients best. This is a skilled and underestimated part of deprived general practice.
* We know from health service research that continuity of clinical care provides better outcomes, and it is difficult to think that this would not apply in other sectors providing relational care. We must continue to innovate, but we should aim for what we have in the NHS: a structured, planned provision, with long term contracts and a clear public health steer in terms of provision. That needs to be accompanied by better recognition of the public health role of the third sector.
* Pilots which are successful, but then not continued, are particularly damaging in terms of morale, again for both users and the GP practice staff who have grown to know and value that service.
* We need a clear Public Health assessment in the planning of these organisations and where they work, with respect to health inequalities.
* The multiplicity of services, and particularly their turnover, makes it difficult for GP staff and their patients to keep track. The Link Worker programme is extremely helpful – but is in part needed because of the complexity of provision. We need to increasingly consider Community Link Workers (CLWs) as a professional group bringing patient benefits, rather than in terms of reducing GP workload as the primary gain. CLWs are in part needed because the social prescribing landscape is so complex and fragmented, though they also have a crucial role in enabling people to engage with other services. Work by Prof. Stewart Mercer has shown that engagement does happen, but only after several contacts, so we need to account for that when considering CLW service capacity. CLWs are funded from Primary Care Improvement Funds, this means that HSCPs with more deprived populations then have *less* resource to spend on other services. This needs to be addressed because currently it clearly follows the inverse care law.
* The majority of social prescribing and ‘signposting’ is not done by link workers, but rather by practice receptionists, GPs and nurses. Receptionists need to be recognised for this crucial work, as they determine the course by which patients subsequently engage with the NHS, and others, and getting that path right requires training and expertise. All this needs time, not just to know about third and voluntary sectors, but to have an understanding of them too. It is therefore crucial to have PLT for all members of the practice team.
* The statutory sector has to have strong relationships with practices and be locally available to those in poor neighbourhoods: geographical distance reduces their efficacy. Consideration should be given to assessing their success in engaging with the most in need, and how they address failures to do that (eg. ‘DNAs’).
* We need to consider neighbourhood factors. Poverty is geographically distributed, and neighbourhood is key through ensuring high quality local provision of services and amenities. Poor local amenities are detrimental to wellbeing.
* Many third and statutory sectors have moved to digital services, as have so many others. We need policies going forward to strengthen both literacy and digital access for all.
* Finally, we would like third and statutory services to move, where possible, to 20-minute neighbourhood planning, and that they prioritise the poorest neighbourhoods first.

**The Private Sector**

We are increasingly hearing from GPs that patients are asking for referrals to the private sector because of long, and growing secondary care waiting lists. This situation can only widen health inequalities. The uncertainty of knowing when patients might get their treatment is also driving this and having better appointment information might help in planning, particularly for the GP who is shouldering much of the additional healthcare burden. There is no ‘weighting’ of NHS referrals in terms of socioeconomic status, although we know that poverty is an important determinant of outcomes. How is that accounted for in terms of waiting times?

Whilst those seeking private treatment then moving into the NHS waiting lists do not get prioritised, that does not apply in general practice: increasingly GPs are seeking transfers of monitoring and other work from the private sector, sometimes following inadequate specialist assessment, and this is an area where we would like to see centralised policy.

Private medicine increases health inequalities.

**Dr Catriona Morton, Deputy Chair (Policy) RCGP Scotland**

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