

Minutes

Attendees (See separate sheet)

Meeting chaired by Malcolm Chisholm MSP

Speakers : Prof Graham Watt
Dr Katharine Smith

Welcome and Introductions
Minutes agreed as accurate record.

Speaker One: Prof Graham Watt

“GP’s at the Deep End”

Key Points

People who have no contact with the public taking into account single contacts develop Public Health Policies.

GP’s give care services at the heart of communities and our health service should be at its best where it is needed most. There is a challenge with universal coverage.

This care needs to be evidence based and an unconditional personalized continuity of care. Integrated care is required for the 15% of patients who account for 50% of general practice workload.

There are huge life expectancy differences between the least and most deprived. e.g men in a deprived area can expect a life expectancy of 67.8 years with only 56.9 of them spent in good health compared to a man who lives in less deprived area to an age of 80 with a healthy life expectancy of 75.7 with only 5 years spent in ill health.

There are more people in Scotland with multimorbidity below 65 years than above. People living in more deprived areas in Scotland develop multimorbidity 10 years before those living in the most affluent areas. Mental health problems are strongly associated with the number of physical conditions that people have, especially in deprived areas of Scotland.

The key points to note for GP encounters are the people they see are socially complex and have multiple morbidity. The Gp’s are short of time to spend with these patients and the patients develop reduced expectations of their health. Their health literacy is poor and the practitioner due to their workload usually is suffering from stress.

Policies such as Keep well and Equally well have been developed to improve Scotland’s health.

The RCGP wrote a report, “Time to care” on health inequalities, Deprivation and practice in Scotland. This report concluded that practitioners lack time in consultations to address the multiple, morbidity, social complexity and reduced expectations that are typical of patients living in severe socio economic deprivation.

The problem of concentration (BLANKET DEPRIVATION)

50% are registered with the 100 “most deprived” practice populations
(From 50-90% of patients in the most deprived 15% of postcodes)

The problem of dilution (POCKET DEPRIVATION)

50% are registered with 700 other practices in Scotland
(Less than 50% in the most deprived 15% of postcodes)

The problem of non-involvement (HIDDEN DEPRIVATION)

200 practices have no patients in the most deprived 15% of postcodes

INVERSE CARE LAW

“The availability of good medical care tends to vary inversely

With the need for it in the population served”.

The inverse care law is a policy of NHS Scotland, which restricts care in relation to need.

Not the difference between good and bad care, but between what General practices can do and could do with resources based on need.

INTRINSIC FEATURES OF GENERAL PRACTICE

Contact
Coverage
Continuity
Coordination
Flexibility
Relationships
Trust

To avoid fragmentation of services which cause dysfunctional consultations, discontinuity, poor coordination and gaps in coverage mutuality and trust need to be developed and sustained.

SIX ESSENTIAL COMPONENTS

1. Extra TIME for consultations
2. Best use of SERIAL ENCOUNTERS
3. General practices as the NATURAL HUBS
Of local health systems
4. Better CONNECTIONS across the front line
5. Better SUPPORT for the front line
6. LEADERSHIP at different levels

THE QUESTION

Can we imagine, develop, and support
A plurality of local health systems based on general practices,
Providing resources according to need (proportionate universalism),
Combining the strengths of area-based and list-based services,
Recognising leadership roles at both levels,
Committed to long term change
And to shared learning on the way (a learning organisation)?

Second Speaker: Dr Katharine Smith Global Public Health Unit, School of Social & Political Science, University of Edinburgh (Katherine.Smith@ed.ac.uk)

“ Do we have enough evidence on health Inequalities yet? “ Assessing the quality and utility of health inequalities research for policy

Dr Smith discussed the various political approaches to health inequalities from the 1950's to present day and discussed a news headline which stated that health divide between the north and south was its widest for 40 years.(the news clip was from 2011) She spoke of How did the Labour governments respond to health inequalities in the UK and what can we learn from this? Dr Smith detailed all the respective policies to improve health and wellbeing from 1997 until 2010. Dr Smith then compared the ideas about health inequalities and whether these were supported by research evidence and were those ideas present in Labour's policies?

Labours policies were informed by a social determinant of health and conceptualised health inequalities as health gaps resulting from health deprivation therefore a targeted approach was required.

Possible conclusions are not enough time has passed to know whether or not post 1997 approaches to tackling health inequalities were effective or the approach was appropriate but the dose was too low.

Or was the whole approach mistaken?

According to the Marmot Review (2010) the answer is 'yes and no':

- 'Health inequalities result from social inequalities. Action on health inequalities requires action across all the social determinants of health.'

BUT

- 'Focusing solely on the most disadvantaged will not reduce health inequalities sufficiently. To reduce the steepness of the social gradient in health, actions must be universal, but with a scale and intensity that is proportionate to the level of disadvantage. We call this proportionate universalism.'

Further support for the idea that the overall approach was flawed:

- Evidence and arguments outlined in *The Spirit Level* (Wilkinson and Pickett, 2009) also suggest there were flaws with the approach Labour took – the focus was on addressing deprivation and poverty, rather than inequality:

"We are intensely relaxed about people getting *filthy rich* (as long as they pay their taxes)" Peter Mandelson

What would we need in Policy terms?

Much more training for individuals working in policy contexts on how to assess evidence, to enable an assessment of whether:

- The methodology is appropriate
- Data provide evidence of causation or correlation
- Any baseline or control group comparisons are appropriate
- Participants who dropped out of trials are accounted for
- Data have been 'cleaned' (e.g. 'outliers' omitted or ignored)
- The period of data collection is appropriate
- (In overviews of research) duplicate publications relate to the same study
- There is any evidence of 'ghost' writing
- There is any evidence of conflicts of interest

Important initiatives in Scotland that might aid the use of public health research in policy MRC and CSO funded units:

- Current study on 'Telling Good Population Health from Bad Population Health' being led by the MRC Unit in Glasgow – see: <http://www.sphsu.mrc.ac.uk/research-programmes/pe/ksynth/temp1.html>
- The Scottish Collaboration for Public Health Research and Policy, led by Professor John Frank

Broader collaborations:

- The new Scottish School of Public Health Research
- The research 'impact' agenda

Can we use experimental approaches to study complex social interventions effectively or to judge what is good or bad?

- Complex systems are non-linear and may involve multiple feedback-loops.
- They cannot be explained by studying the constituent parts – indeed concentrating on particular parts of the puzzle may actually inhibit understandings, as "the interacting systems involved will always overwhelm predictions of independent effects of any single factor, reducing them to very limited and uncertain information" (Gee, 2008: 258–9).

And if we translate good research from bad research does this translate into clear policy recommendations?

And isn't the relationship between research and policy a bit more complex? Key findings from my Dr Smith's research.

1. It is ideas, rather than evidence, that move between research and policy;
2. Ideas change as they move and this translation process is influenced by a host of factors, often unrelated to the quality of evidence;
3. Policymaking bodies operate as institutional filters and there is a lack of vertical and horizontal connectivity;
4. There is a lack of institutional memory within policymaking organisations;
5. To understand the relationship between research and policy, it is crucial to explore why researchers do the work they do and how they package messages for policy

- (and other) audiences – researchers may feel uncomfortable about being too critical of existing policy approaches;
6. Funding plays a crucial role within research-policy relations (and policymakers are perceived to be connected to most funding sources);
 7. Ideas change as they move and there is a continuous 'guessing game' that influences this translation process.

Where next?

- Health inequalities in the UK “do not arise by chance, and they cannot be attributed simply to genetic makeup, ‘bad’, unhealthy behaviour, or difficulties in access to medical care, important as those factors may be. Social and economic differences in health status reflect, and are caused by, social and economic inequalities in society. The starting point for this Review is that health inequalities that are preventable by reasonable means are unfair. Putting them right is a matter of social justice. A debate about how to close the health gap has to be a debate about what sort of society people want.” (Marmot, 2010)
- “[M]ore advocacy is needed to make sure that elected governments have a democratic mandate to make necessary policy changes.” (Mackenbach, 2010)
- “It is not *inequalities* that kill, but *those who benefit from the inequalities* that kill.” Argues for much more attention to be given to power (class, gender, race, and national power) and “how power is produced and reproduced in political institutions” (Navarro, 2009)

Exploring the relationships between research, advocacy, lobbying and policy

- Can researchers retain their academic credibility whilst also acting as an advocate?
- Should researchers develop closer relationships with advocacy organisations?
- Should researchers seek to emulate (or link with) think tanks and consultancy organisations?
- What about the commercial sector?
- How do advocacy and lobbying differ?

Summary

- Whether you think we yet have enough evidence about health inequalities to take effective action to reduce them is likely to be informed by your interpretation of the existing evidence, your ideological/political position, your ethical stance and your disciplinary training.
- Most of the academics, and many of the policymakers, I interviewed said they felt that sufficient evidence does now exist but that there is a lack of political will / public support for the required policies. These interviewees often suggested that academics should do more to engage with the broader public and that they should be more politically active.
- However, a not insignificant minority of interviewees were much more cautious, believing that the evidence remains insufficient and that researchers need to do much more to guide policymakers in terms of the kinds of interventions that are most likely to be cost-effective.

But we do need to remember that researchers can only evaluate policies as they are implemented. In this sense, policy will (necessarily) always be ahead of research.

No AOCB

Next meeting date May 17th. Speaker Sir Harry Burns