Réseau-1 Québec
Réseau de connaissances sur les soins primaires

CONFÉRENCE PLÉNIÈRE

Modératrices : Jeannie Haggerty, PhD, directrice du RRAPPL de l'Université McGill, et Maud Mazaniello-Chézol, membre étudiante du R1Q

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CONFÉRENCE PLÉNIÈRE

Quand tous les systèmes échouent : le fardeau de la gestion de la santé dans les communautés en situation de précarité socio-économique

- présentation en anglais

Marianne McCallum, MBChB, BSc, MRCGP, MSc, médecin généraliste et chercheuse universitaire, University of Glasgow

University of Glasgow

THE AWARDS 2020 | UNIVERSITY OF THE YEAR

When all the systems fail: the burden of managing health in socioeconomically deprived communities.

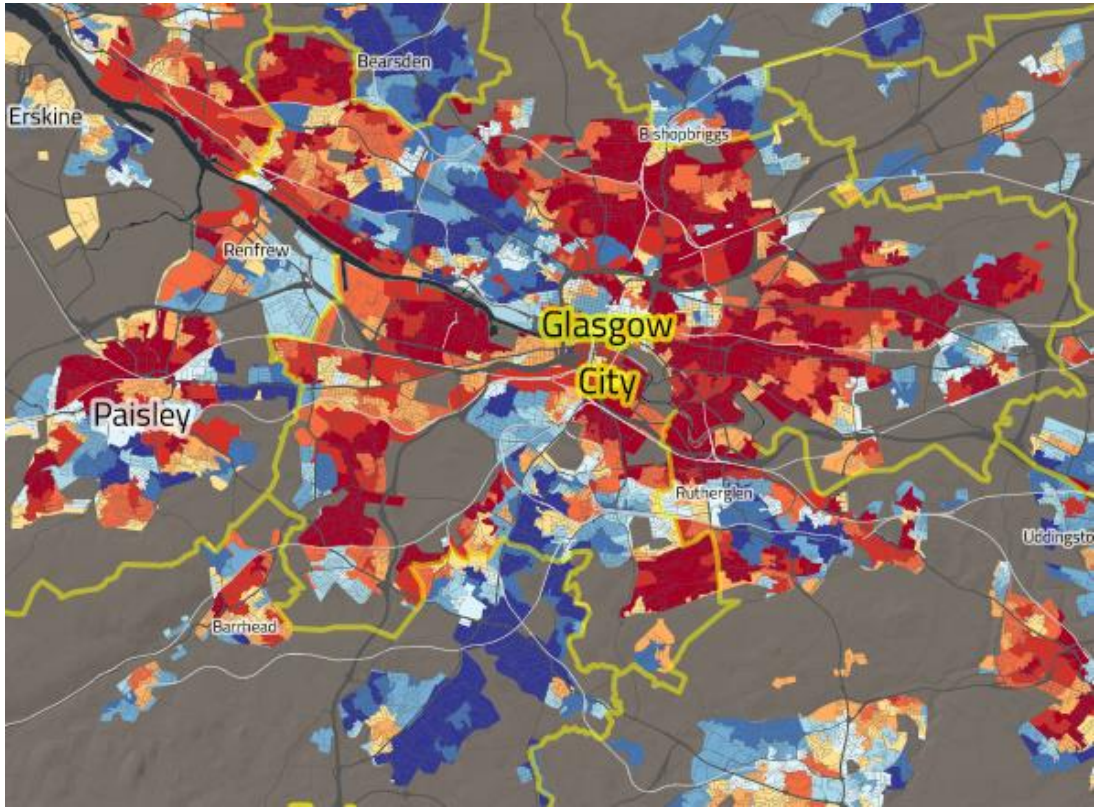
Dr Marianne McCallum
GP Clinical Academic Fellow, University of Glasgow

WORLD CHANGING GLASGOW

United Kingdom (UK) Health System

- The National Health Service (NHS)
  - Taxpayer funded
  - Universal health care, free at the point of need
- Medical Training
  - 5-year undergraduate degree followed by 2 years hospital foundation training
  - Specialist training: General Practice requires further 4-5 years training (mixed hospital/community)
- The role of Primary Care
  - “Foundation” of the NHS- over 90% all clinical encounters (<8% of budget)
  - Act as “gatekeepers” – secondary care dependent on GP referral

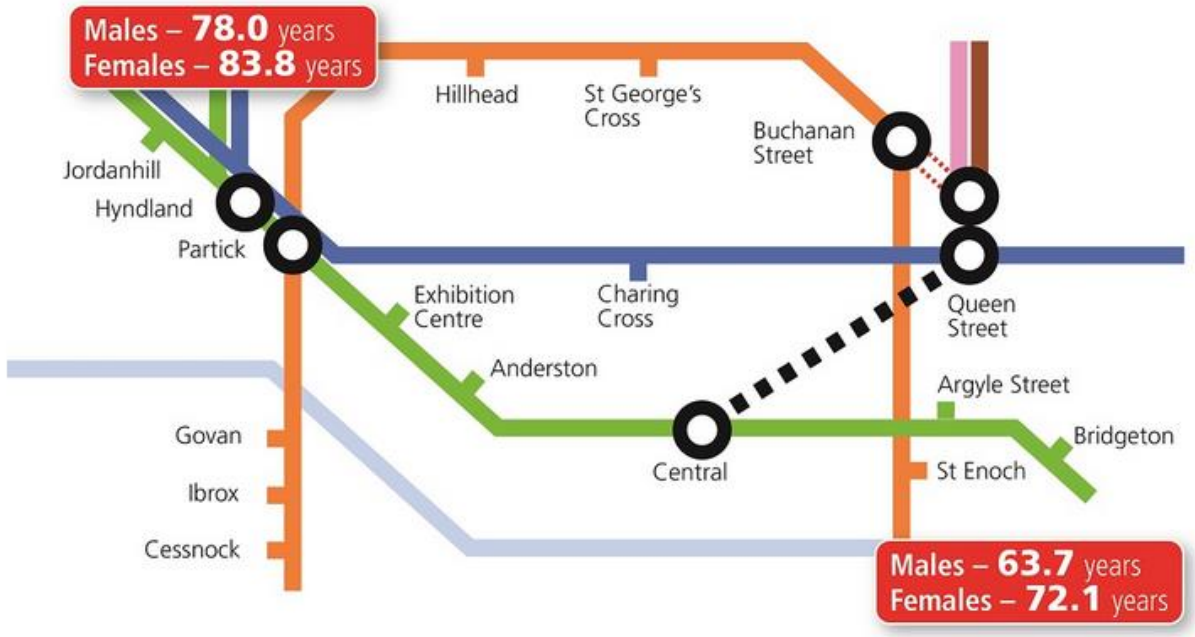
Health Inequalities are due to wider societal inequalities



- Map of Glasgow as example demonstrating spread of deprivation using national index:
  - Deprived = red (darker more deprived)
  - Affluent = blue (darker more affluent)
- Deprivation index combines indicators from employment, transport, income, education, housing, health, access and crime

Scottish Index Multiple Deprivation: https://simd.scot/#/simd2020/BTTTFTT/9/-4.0000/55.9000/

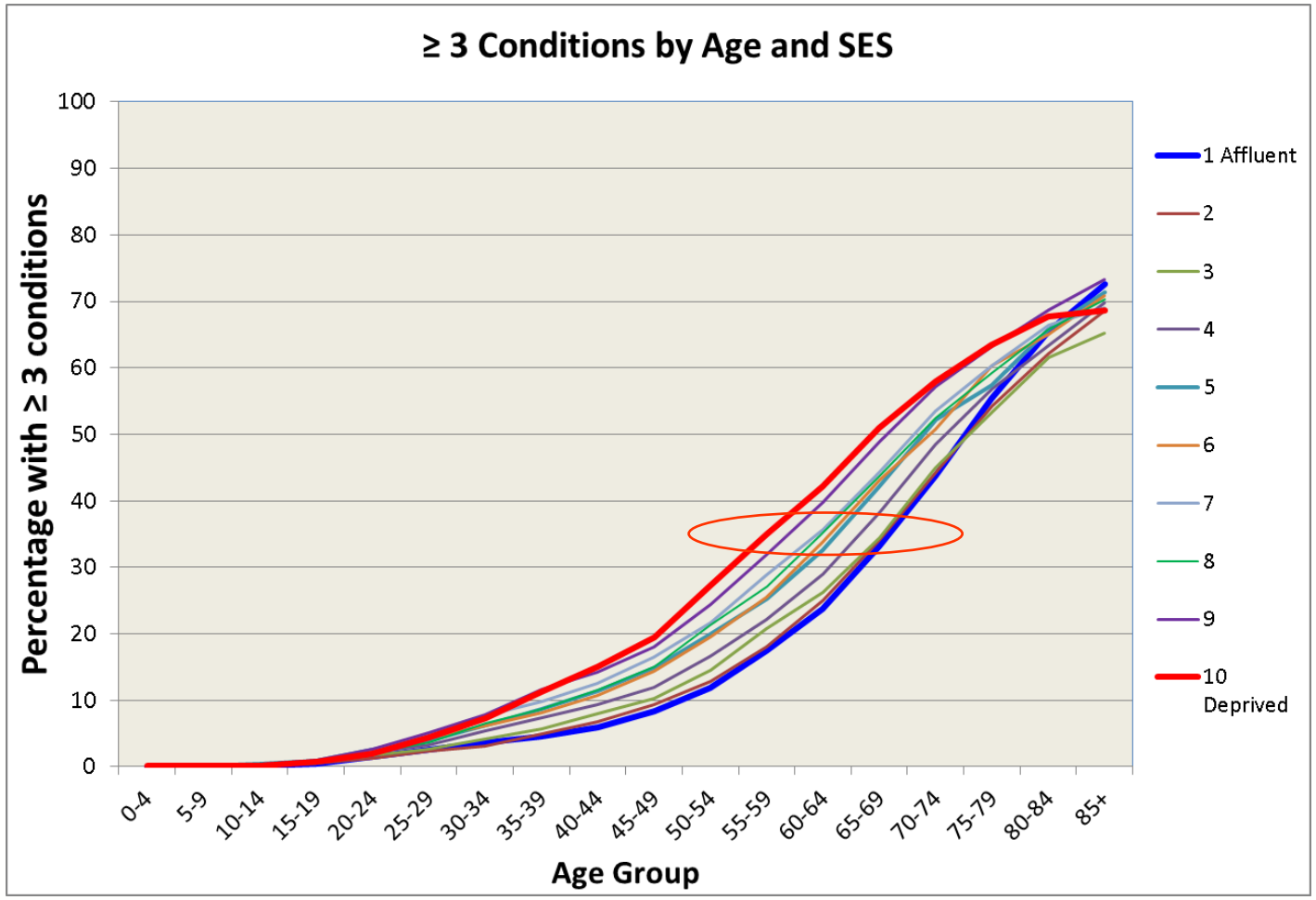
Mortality gap in Scotland up to 15 years, increasing in last 10 years



- Map of train line across Central Glasgow
- Life expectancy drops by 15 years for males (11 females) travelling from an affluent area (Jordanhill) to a deprived one (Bridgeton)

Public Health Scotland, Improving Health. http://www.healthscotland.scot/health-inequalities/measuring-health-inequalities

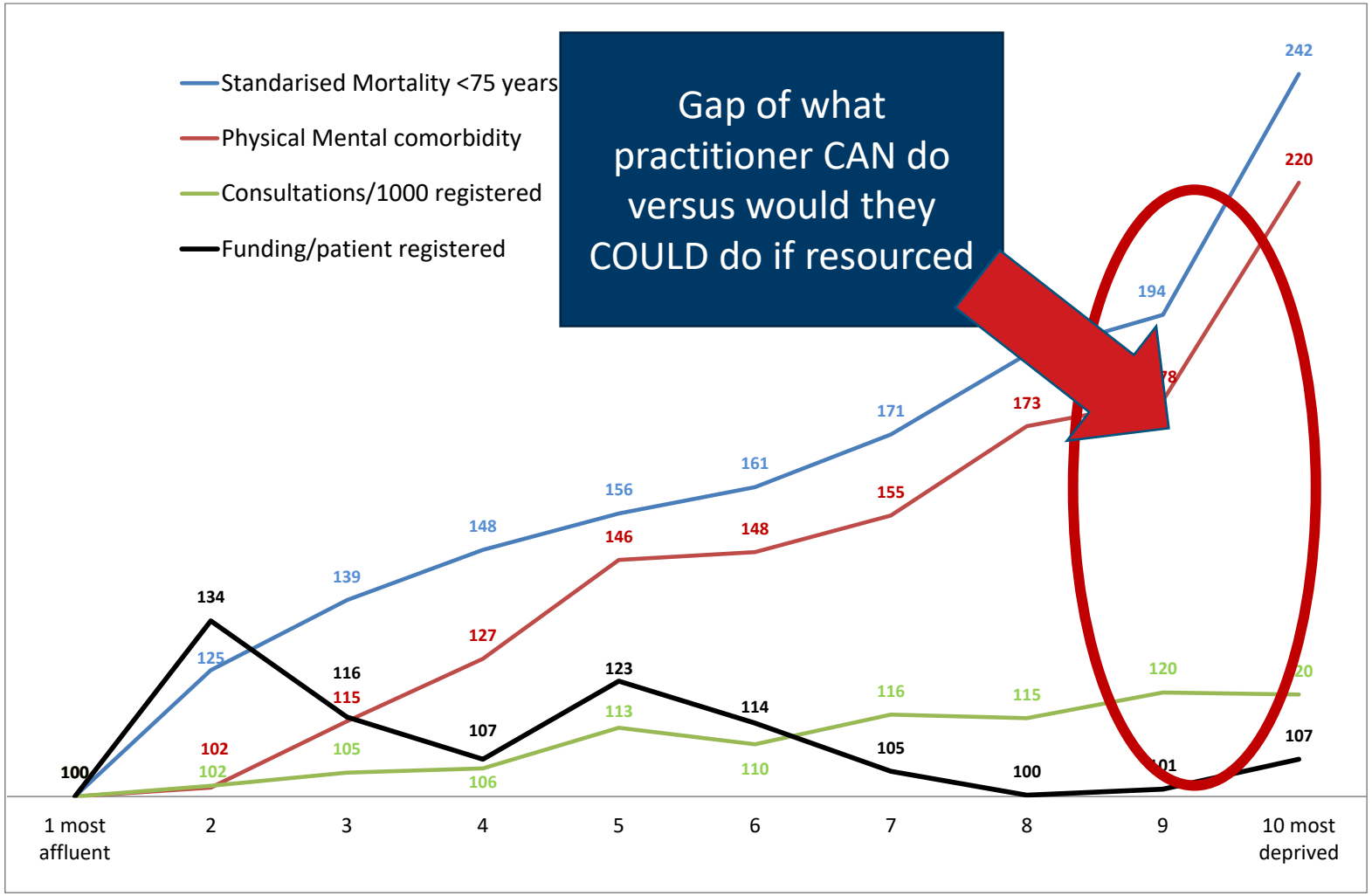
Multimorbidity more prevalent, and starts 10 to 15 years earlier in the most deprived decile compared to the most affluent



Barnett et al. (2012) Epidemiology of multi-morbidity and implications for health care, research, and medical education: a cross sectional study. The Lancet. Available at: http://www.ncbi.nlm.nih.gov/pubmed/22579043

Graph comparing GP funding and number of consultations with mortality and morbidity rates by deprivation quintile

- Despite mortality and morbidity increasing with deprivation funding and GP numbers are distributed equally across the population
- This leads to lack of time to address needs



McLean G, Guthrie B, Mercer SW, Watt GC. ***General practice funding underpins the persistence of the inverse care law: cross-sectional study in Scotland?*** BJGP 2015; 65(641): 799-805.

It is not just the increased rate of multimorbidity, but the additional social complexity that impacts practitioners: “multimorbidity plus”

“…it is known there is more multimorbidity. I think we talk about the multimorbidity, rather than the **multimorbidity plus.** **P**erhaps also a greater chance of having literacy difficulties **plus** …**plus**…It is **several layers”**

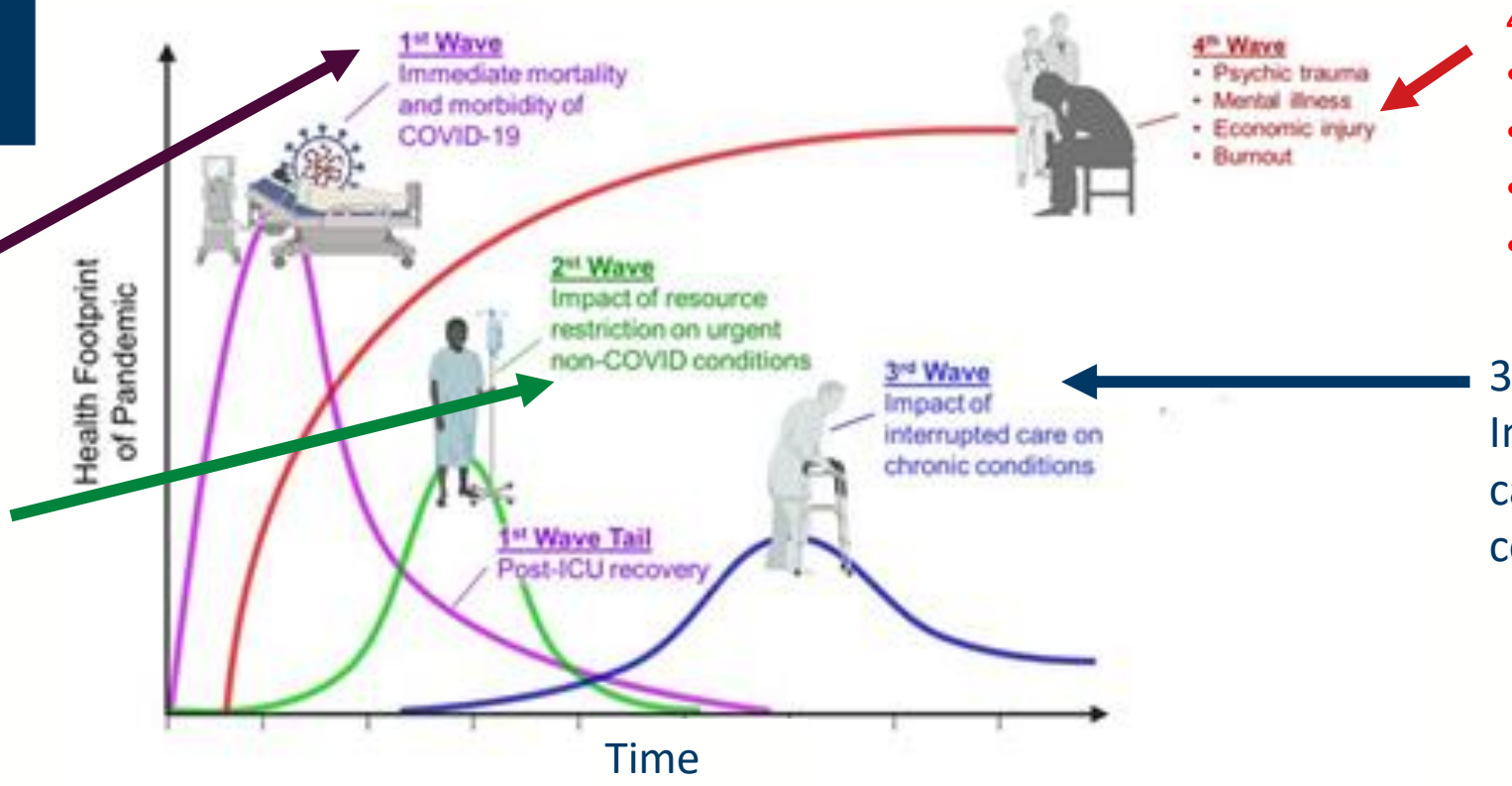
GP working in deprived area

McCallum, M. and S. MacDonald (2021). "Exploring GP work in areas of high socioeconomic deprivation: a secondary analysis." BJGP Open: BJGPO.2021.011

Covid 19

1st Wave:
Covid 19 immediate
Mortality/morbidity

2nd Wave
Impact of resource restriction non-COVID conditions

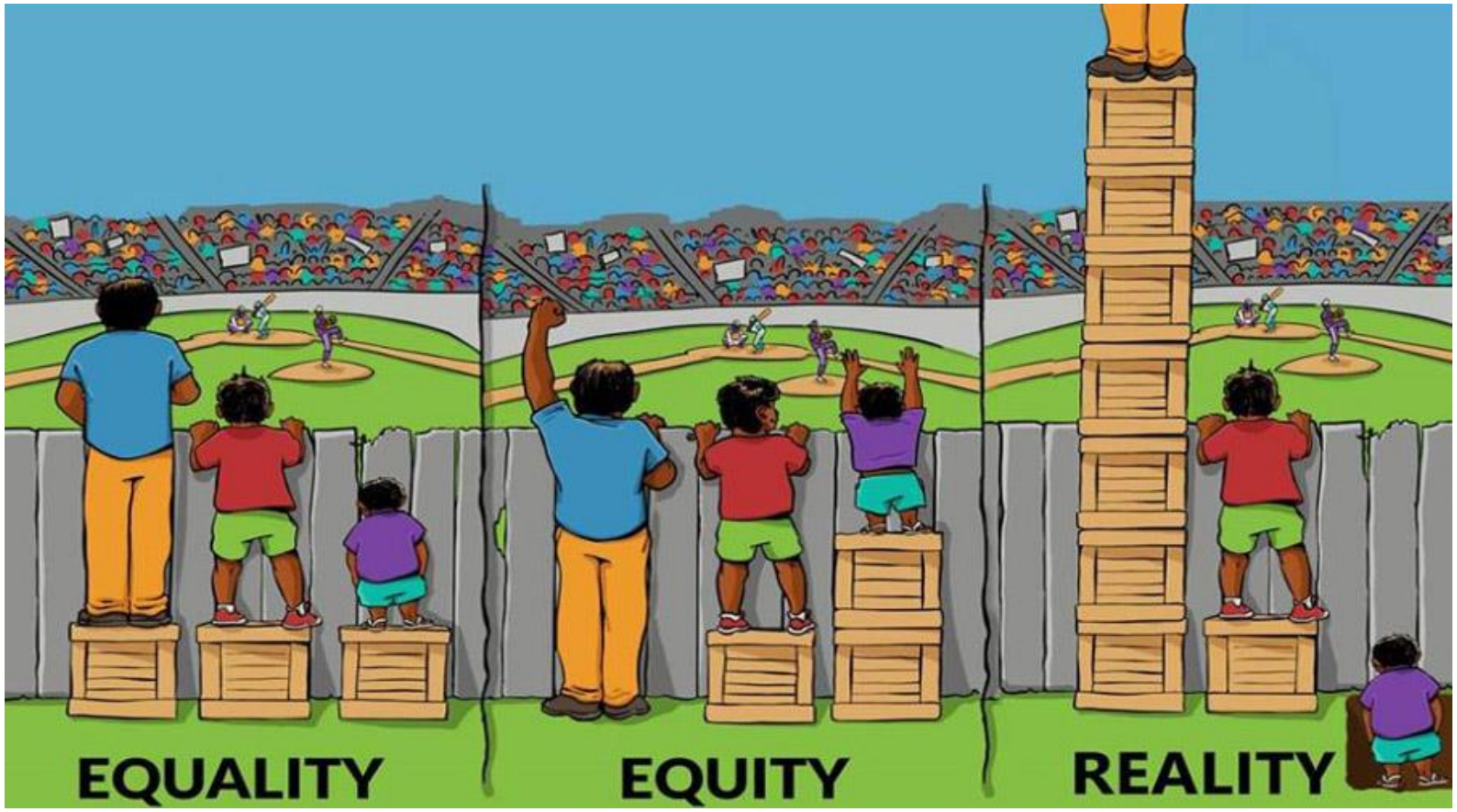


4th wave
- Psychic trauma
- Mental stress
- Economic
- Burn out

3rd Wave
Impact of interrupted care on chronic conditions

- Communities experiencing high socio-economic deprivation
  - Disproportionally impacted by Covid 19
  - Expect 3rd and 4th waves of the pandemic to disproportionally affect them further

Source: https://twitter.com/VectorSting/status/1244671755781898241?s=20



- Despite over 20 years investment by UK and Scottish government no change in health inequality outcomes, in some cases getting worse.
- UK politicians and media focus on individual's behaviour choices; but is this a choice?
- I believe we need to recognise the underlying unequal structures: aim for equity not just equality.

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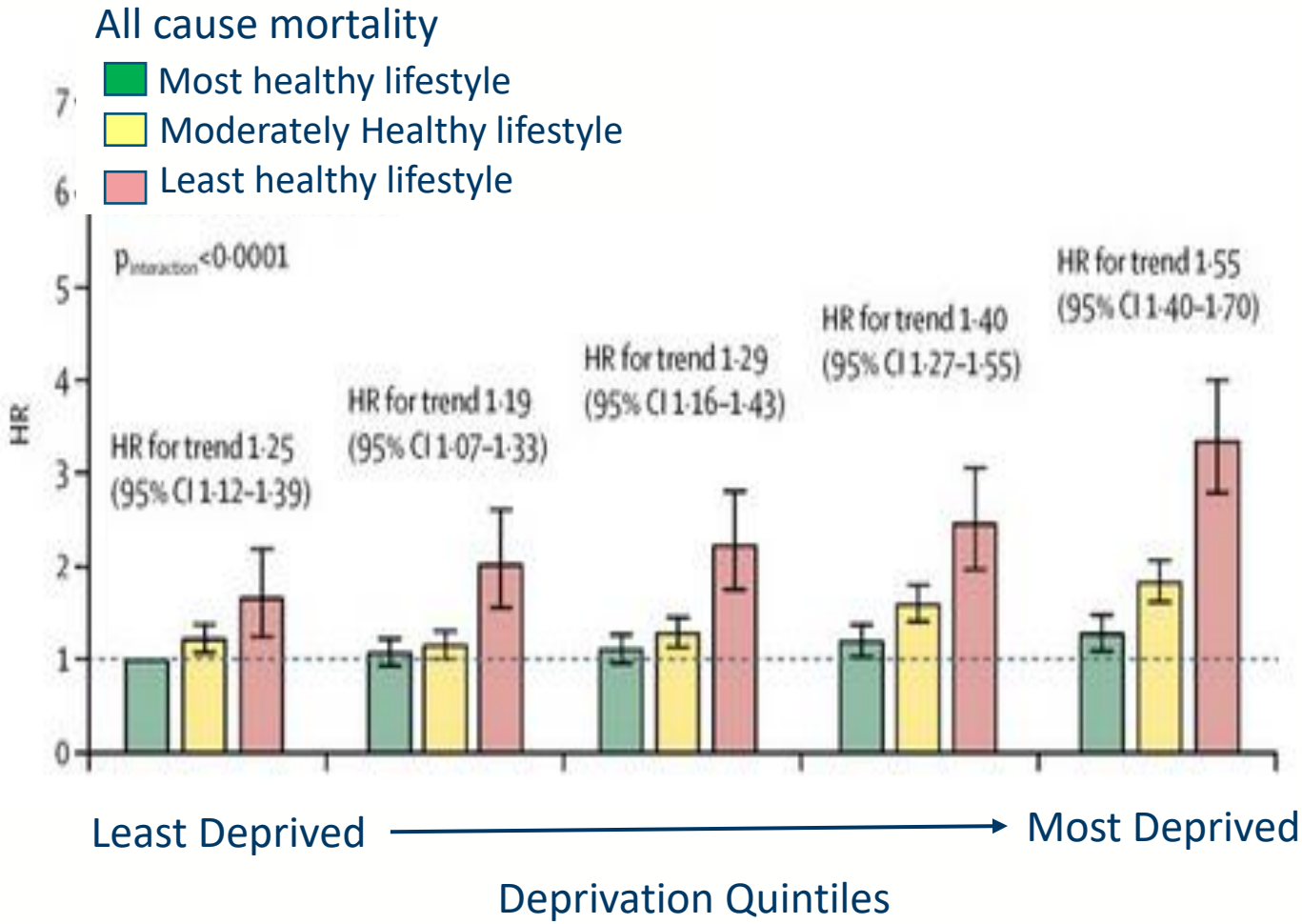
- Graph shows socioeconomic deprivation has an INDEPENDENT impact on mortality separate from lifestyle factors[1]
- Another study showed behavioral risk factors explains only 40.8% of the difference in multimorbidity by socio-economic deprivation[2]
- We have to go beyond focusing on unhealthy behaviours

Hazard Ratio for Association between lifestyle score, socio-economic deprivation quintile and Mortality[1]



1. Foster, H. M. E., et al. (2018). "The effect of socioeconomic deprivation on the association between an extended measurement of unhealthy lifestyle factors and health outcomes: a prospective analysis of the UK Biobank cohort." The Lancet Public Health **3**(12): e576-e585.
2. Katikireddi, S. V., et al. (2017). "The contribution of risk factors to socioeconomic inequalities in multimorbidity across the lifecourse: a longitudinal analysis of the Twenty-07 cohort." BMC Med **15**(1): 152.

Are these behaviours a choice? The Patient view

- According to a meta-ethnography (systematic review of qualitative literature), people living in areas experiencing high socio-economic deprivation :
  - View health inequalities as a consequence of wider societal inequality
  - Are aware that wider society often blamed inequalities on the community for making bad choices, experienced as significant stigma
  - Do not see unhealthy behaviours as a “choice” but as a *“**rational (even inevitable) response** to **difficult circumstances**, coping mechanisms or forms of escapism”*

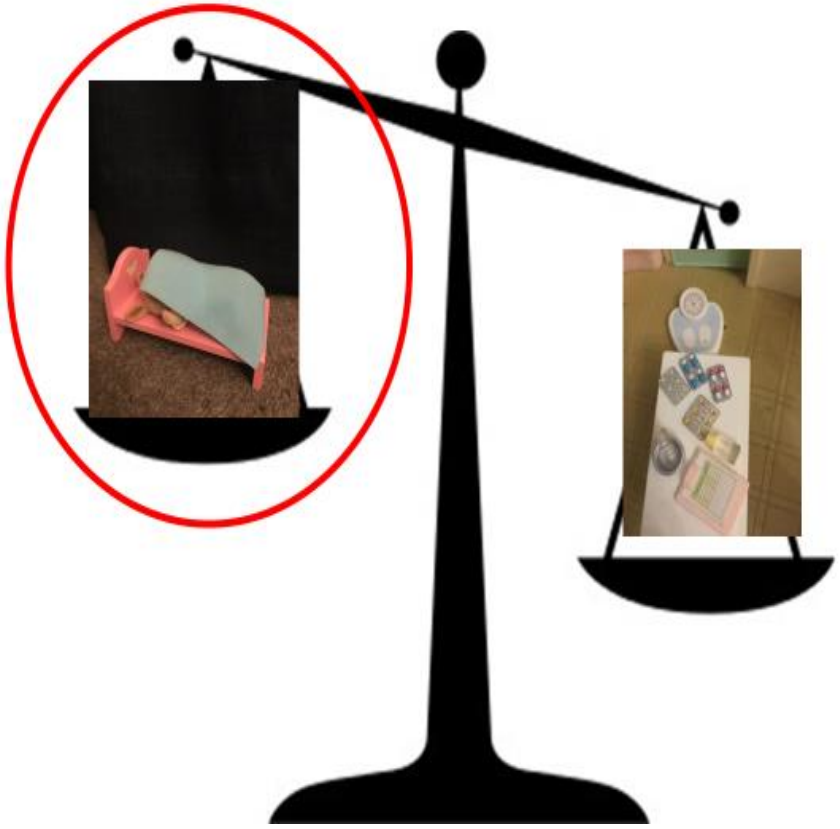
Smith, K. E. and R. Anderson (2018). "Understanding lay perspectives on socioeconomic health inequalities in Britain: a meta-ethnography." Sociology of Health & Illness **40**(1): 146-170.

My current work

Theoretical approach

Capacity

Ability to carry out that work

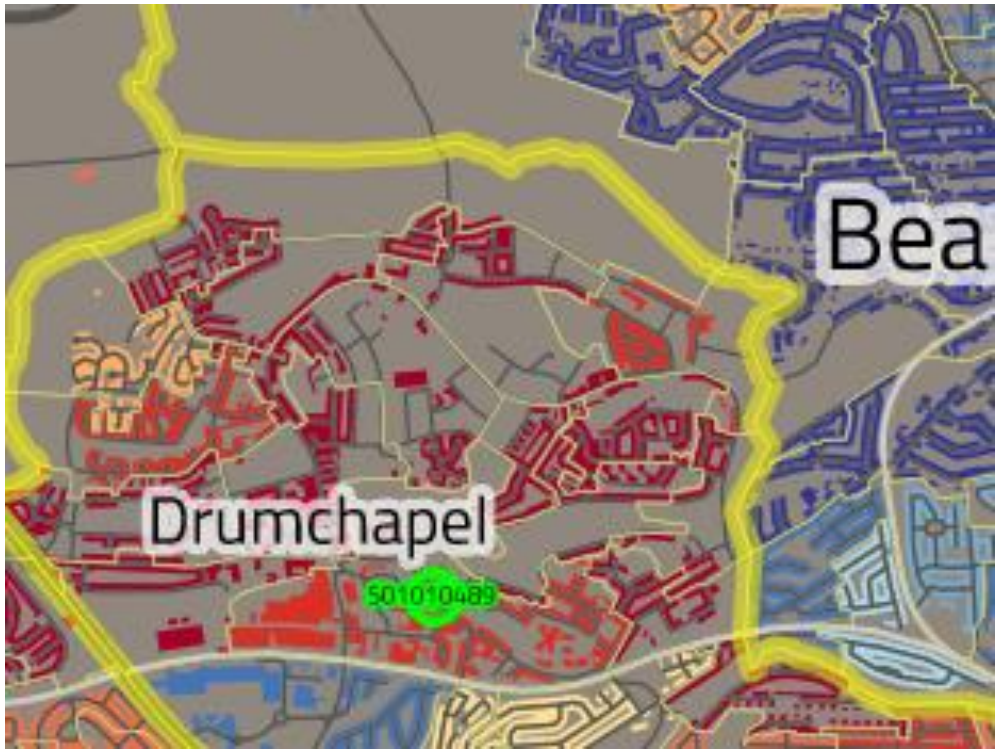


Burden of Treatment Theory

Treatment Burden

Work clinicians give patients

Ethnography in Drumchapel: community experiencing high rates of socioeconomic deprivation within Glasgow



Map showing Drumchapel:

- Entirely red (high deprivation)
- Surrounded by areas of high affluence (blue)

- Participant observation in four community groups (parent support, community garden, men mental health, cycling group)
- In-depth Interviews (30 people with multimorbidity)
- Method chosen to explore
  - Private story (what people actually do and why)
  - Versus Public story (what people believe they do and would do)

Interim findings: Shared community experience

- **When none of the systems work**
  - **There is a shared experience of living in a community where NONE of the systems work for you (social services, benefits, education, housing)**
  - **This is not just you but every one you know**
- Shared shame and stigma

Interim findings of this work

- When none
  - There is
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The shared community experience of stigma and none of the systems working for you fundamentally altered how people approached all official services – including health care

Interim findings: Holistic care matters

- Continuity of care, and strong relationship with primary care teams were highly valued and critical for patient enablement.
- Where this existed people viewed primary care teams differently from other statutory services: places that they were not judged and where people were “for them”
- Where relationship was poor (in primary or secondary care) it reinforced underlying beliefs that professionals did not care about “people like them”
  - In this context people responded in two ways: by shutting down and not engaging, or by getting angry and aggressive.
- People often experienced doctors focusing on diagnosed illness rather than what was important to them, it rarely occurred to them to challenge this.
- Current experience of telemedicine exacerbated a feeling of lack of agency, and significantly increased difficulty navigating the health system.

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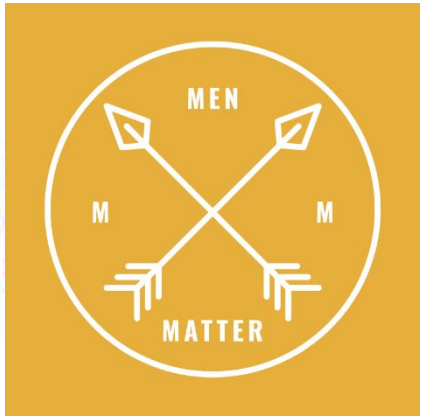
Community groups that were successful in engaging vulnerable people had several things in common

- **Authentic**
  - Recogni
    understa
- **"Safe Spac**
  - People v
    judged.
    experien
- **"power of t**
  - Seeing "
    particula
- **Tension be**
  - They did
    provided
  - They allowed people to progress at their own space, and time

IN CONTRAST, MOST HEALTH INTERVENTIONS ARE:

- **PRACTITIONER LED**
- **TIME LIMITED**
- **FIXED AND PRE-DETERMINED**
- **OFTEN IN HEALTH CARE SETTINGS**



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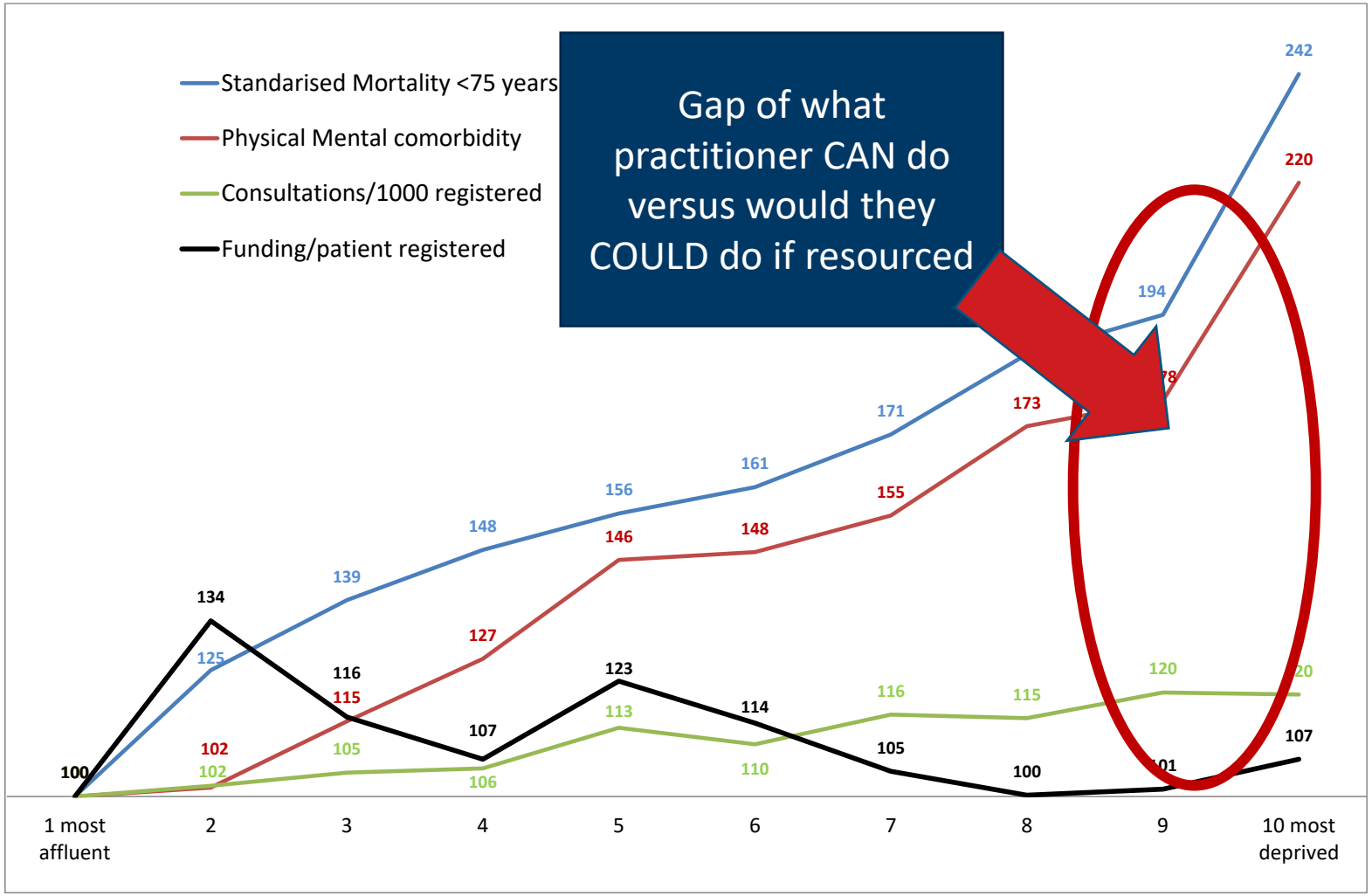
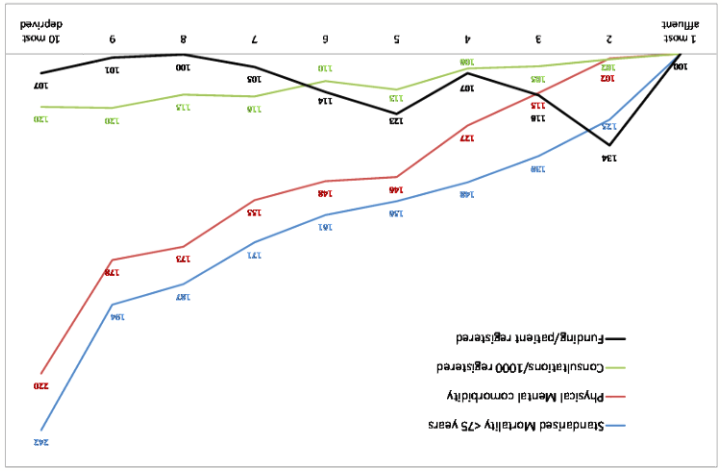
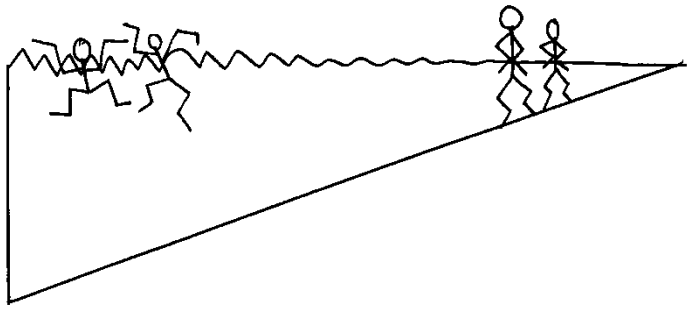
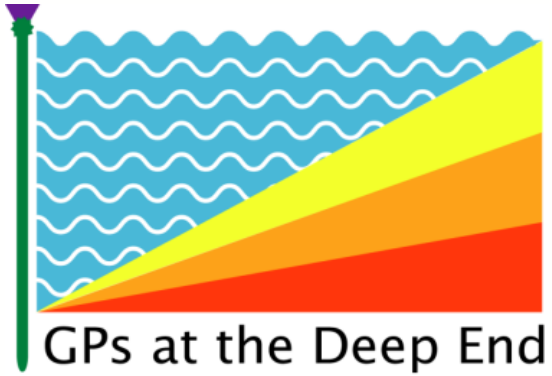


McLean G, Guthrie B, Mercer SW, Watt GC. ***General practice funding underpins the persistence of the inverse care law: cross-sectional study in Scotland?*** BJGP 2015; 65(641): 799-805.

General Practitioners at the Deep End







- GPs at the Deep End group is a practitioner led group started over 15 years ago at Glasgow University.
- The term “Deep End” came when one of the founders turned the graph showing unmet need upside and imagined it as a swimming pool.
- While all GPs were working hard those GPs working in the most deprived communities were struggling at the “Deep End” created by the mismatch between need and resource.
- There are now multiple Deep End groups nationally and internationally and in Scotland “Deep End” has become a phrase used by politicians and health care managers

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Initially the group gathered evidence regarding Deep End issues and experience using roundtable discussions with practitioners (over 50 reports available)

ISSUES AFFECTING DEEP END COMMUNITIES

- Unemployment
- Benefits sanctions
- Cuts to services
- Drugs and alcohol
- Child protection
- Migrant health
- Vulnerable adults
- Bereavement
- Higher cancer prevalence

KEY POINTS ABOUT DEEP END ENCOUNTERS

- Early multiple morbidity
- Social complexity
- Shortage of time
- Reduced expectations
- Lower enablement
- Health literacy
- Practitioner stress
- Weak interfaces

Mercer S, Watt G. (2007) ***The inverse care law: clinical primary care encounters in deprived and affluent areas of Scotland.*** Ann Fam Med, 5(6): 503–510.
Mercer SW, Jani BD, Maxwell M, Wong SYS and Watt GCM. (2012) ***Patient enablement requires physician empathy: a cross-sectional study of general practice consultations in areas of high and low socioeconomic deprivation in Scotland***. BMC Family Practice, 13, p. 6

Conclusions

- Ongoing structural societal inequality continues to result in persistent health inequalities with significant implications for practitioners, and patient outcomes
- The influence of social stigma on access and treatment decisions needs to be considered in health system delivery.
- The GPs at the Deep End experience is an example of practitioner-led solutions and that may be of value in other settings

Conclusions

- Future interventions should consider focusing on meso as well as individual level factors, and seek to enhance individual capacity.

- The tenants of Person Centred Care (compassionately eliciting ideas, concerns and expectations, continuity of care and shared decision making) appear to be particularly important in this context.

- Future multimorbidity interventions and services that target communities experiencing high levels of socio-economic deprivation should
  - seek to involve patients
  - find ways to make them authentic
  - empower, train and utilise peers wherever possible
  - understand the importance of safe space as a pre-requisite to engagement

Acknowledgements

- Professor Frances Mair, Professor Sara Macdonald, Professor Jim Lewsey
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- General Practice Primary Care, Institute of Health and Wellbeing, Glasgow University


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Thank you for listening
Any Questions?
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QUESTIONS ET DISCUSSION

Comment poser des questions :

1. Cliquez sur « Discussion » et posez votre question par écrit ou

2. Cliquez sur « Réactions » et ensuite sur « Lever la main » si vous souhaitez que l'on vous adresse la parole