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# **Tackling Health Inequalities in Primary Care: An Exploration of GPs' Experience at the Frontline**

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**Submitted in fulfilment of the requirements for the degree of Doctor of  
Philosophy**

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## Abstract

In Scotland, life expectancy and health outcomes are strongly tied to socioeconomic status. Specifically, socioeconomically deprived areas suffer disproportionately from high levels of premature multimorbidity and mortality. To tackle these inequalities in health, challenges in the most deprived areas must be addressed. One avenue that merits attention is the potential role of general medical practitioners (GPs) in helping to address health inequalities, particularly due to their long-term presence in deprived communities, their role in improving patient and population health, and their potential advocacy role on behalf of their patients. GPs can be seen as what Lipsky calls ‘street-level bureaucrats’ due to their considerable autonomy in the decisions they make surrounding individual patient needs, yet practising under the bureaucratic structure of the NHS. While previous research has examined the applicability of Lipsky’s framework to the role of GPs, there has been very little research exploring how GPs negotiate between the multiple identities in their work, how GPs ‘socially construct’ their patients, how GPs view their potential role as ‘advocate’, and what this means in terms of the contribution of GPs to addressing existing inequalities in health.

Using semi-structured interviews, this study explored the experience and views of 24 GPs working in some of Scotland’s most deprived practices to understand how they might combat this growing health divide via the mitigation (and potential prevention) of existing health inequalities. Participants were selected based on several criteria including practice deprivation level and their individual involvement in the Deep End project, which is an informal network comprising the 100 most deprived general practices in Scotland. The research focused on understanding GPs’ perceptions of their work including its broader implications, within their practice, the communities within which they practise, and the health system as a whole.

The concept of street-level bureaucracy proved to be useful in understanding GPs’ frontline work and how they negotiate dilemmas. However, this research demonstrated the need to look beyond Lipsky’s framework in order to understand how GPs reconcile their multiple identities, including advocate and manager. As a result, the term ‘street-level professional’ is offered to capture more fully the multiple identities which GPs inhabit and to explain how GPs’ elite status positions them to engage in political and policy advocacy. This study also provides evidence that GPs’ social constructions of patients are linked not only to how GPs conceptualise the causes of health inequalities, but also to how they view their role in tackling them. In line with this, the interviews established that many GPs felt they could make a difference through advocacy efforts at individual, community and policy/political levels. Furthermore, the study draws attention to the importance of practitioner-led groups—such as the Deep End project—in supporting GPs’ efforts and providing a platform for their advocacy.

Within this study, a range of GPs’ views have been explored based on the sample. While it is unclear how common these views are amongst GPs in general, the study revealed that there is considerable scope for ‘political GPs’ who choose to exercise discretion in their communities and beyond. Consequently, GPs working in deprived areas should be encouraged to use their professional status and political clout not only to strengthen local communities, but also to advocate for policy change that might potentially affect the degree of disadvantage of their patients, and levels of social and health inequalities more generally.

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## **Author's Declaration**

I declare that, except where explicit reference is made to the contribution of others, that this dissertation is the result of my own work and has not been submitted for any other degree at the University of Glasgow or any other institution.

Signature:



Printed Name: Breannon Babbel

## Abbreviations

BMA	British Medical Association
CHD	Coronary Heart Disease
CHP	Community Health Partnership
COPD	Coronary Obstructive Pulmonary Disease
CQI	Continuous Quality Improvement
CVD	Cardiovascular Heart Disease
DLA	Disability Living Allowance
DNA	Did Not Attend
ESA	Employment Support Allowance
GCPH	Glasgow Centre for Population Health
GGC	Greater Glasgow & Clyde
GP	General Practitioner
HEAT	Health, Efficiency, Access and Treatment
HIMS	Highlands and Islands Medical Services
IJB	Integrated Joint Board
JSA	Jobseekers Allowance
LDP	Local Delivery Plan
LHCC	Local Health Co-Operatives
LMC	Local Medical Committee
MDT	Multidisciplinary Team
NGMS	New General Medical Service
NSF	National Service Framework
PIP	Personal Independence Payment
PMS	Personal Medical Service
QOF	Quality and Outcomes Framework
RCGP	Royal College of General Practitioners
SDH	Social Determinants of Health
SGHD	Scottish Government Health Department
SHIP	Social & Health Integration Partnership
SIMD	Scottish Index of Multiple Deprivation
SLB	Street-Level Bureaucrats
SLO	Street-Level Organisation
SNP	Scottish National Party
WHO	World Health Organisation

# CHAPTER 1 Introduction

## 1.1 Introduction to the research

*It has often been said that modern medicine has exchanged early mortality for chronic morbidity.*

-Julian Tudor Hart, 1988, p.113

Scotland has come to a crossroads where modern medicine's 'exchange' of early mortality for chronic morbidity is at risk of becoming erroneous for certain members of the population. This is because in Scotland, life expectancy and health outcomes are largely associated with socioeconomic status, with premature multimorbidity on the rise in very deprived areas (Barnett et al., 2012; Scottish Government, 2013). For example, males living in the most deprived areas of Scotland can expect to live, on average, about 13 years less than their counterparts in the least deprived areas; for females, the difference drops slightly to almost 9 years<sup>1</sup> (Scottish Government, 2013). This dramatic difference holds up when looking at disaggregated mortality conditions such as premature mortality due to cardiovascular heart disease, which is four times more common in the most deprived areas than in the least deprived areas, and cancer mortality for individuals aged 45-74, wherein individuals in the most deprived areas are twice as likely to die of cancer than those in the least deprived areas (Scottish Government, 2013). These figures depict the "gross social inequities" (Marmot et al., 2012, p.181) Scotland faces today as systematic health differences are largely avoidable.

Health inequalities describe systematic differences in health linked to unequal societal structures (Graham, 2004) and have a compounding effect for individuals at the bottom of the socioeconomic gradient (Barnett et al., 2012; Goodwin et al., 2010; Jani et al., 2012; Macintyre, 2007; Marmot, 2010). Not only do these individuals face higher mortality rates, but also worse health outcomes exacerbated by a higher incidence of multimorbidity at younger ages than their affluent counterparts (Barnett et al., 2012). Furthermore, health—

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<sup>1</sup> Life expectancy rates calculated for the 2011-12 calendar year

while vital to quality of life—is also fundamental for “one’s ability to do what one has reason to do” (Sen, 2002, p.63). Consequently, the issue is a complex inter-relationship; individuals living in the most socioeconomic deprived areas not only have worse health than those higher on the socioeconomic ladder, they also have less opportunity to achieve good health as a result of their socioeconomic situation.

The basic premise of this thesis is to better understand the role, if any, of primary care in tackling Scotland’s pernicious health inequalities. While health care services are simply one determinant of health (and not necessarily the most effective at *preventing* health inequalities), primary care has been praised for its role in promoting equity (Rasanathan et al. 2011; Starfield, 2011; Zere et al., 2007). Aside from strengthening individuals via health knowledge and empowerment with regards to their health, primary care’s role in tackling health inequalities operates largely under the mechanism that improved access to healthcare mitigates (as opposed to prevents) health inequalities. It is also crucial that health inequalities are tackled from a population perspective (Starfield, 2004). Under Scotland’s NHS, everyone within the population is afforded access to a general practitioner (GP), thus positioning general practitioners as an ideal avenue for population-based strategies.

The position of GP is also conducive to addressing inequalities because of their role in the delivery of primary health care (Blane & Watt, 2012; Hull, 2010; Hutt & Gilmour, 2010; Marmot, 2010; O’Donnell et al., 2011; Starfield, Shi & Macinko, 2005) and their responsibility for population health (Goodwin et al., 2011). This is because within primary care, GPs are seen as particularly “well positioned to have a positive impact on health inequalities at a number of levels” (Hutt & Gilmour, 2010, p.5) as they are potentially “the natural advocates of the people” (et al., 1941, as quoted in Watt, 2012, p.14). As a result, this research has a particular focus on the experience of GPs and how they might combat this growing health divide via the mitigating of existing health inequalities and, potentially, the prevention of health inequalities.

The role GPs play in tackling health inequalities is, of course, subject to individual GPs’ levels of engagement both within their practice and the wider community. Reports from

organisations such as the King's Fund<sup>2</sup> identify the *potential* for both primary care and GPs to positively impact on health inequalities; however, minimal research has been conducted as to how GPs themselves view this role and whether or not they view themselves as 'advocates for the people.'

Just as the relationship between socioeconomic deprivation and individual health is well documented, research (particularly within the UK) has explored the impact social deprivation has on general practice (Popay et al., 2007). Out of this research it has been identified that GPs working in areas of multiple deprivation face a number of challenges including increased workloads and inadequate resources to manage their patient lists (Carlisle et al., 2002; Goodwin et al., 2011; Mercer et al., 2012a; Mercer et al., 2010; Teljeur et al., 2010). The increased workload of GPs working in areas of high multiple deprivation is evidenced through higher consultation rates, more out-of-hours calls, and longer consultation times (Carlisle et al., 2002; Mercer et al., 2010; Teljeur et al., 2010). Further to this, the problem of the experience of ill health in these areas is compounded by the problems of social deprivation, including: higher levels of unemployment, fewer financial and other material resources, and higher rates of addiction. Thus, GPs working in deprived areas face increasing challenges in meeting the complex needs of their patients. In particular, this research will examine the experience of GPs working in the most deprived practices of Scotland, a group known as the 'Deep End'. If changes are to be made to the growing health divide, challenges in the most deprived areas must be addressed.

The difficulties GPs working in very deprived practices face are similar to Lipsky's (1980; 2010) description of street level bureaucrats (SLBs). Defined as public service workers "who interact directly with citizens in the course of their jobs, and who have substantial discretion in the execution of their work" (Lipsky, 2010, p.3), SLB's actions establish the services 'delivered' by government. While GPs are not direct government employees, they still practice under the bureaucratic structure of the NHS and are subject to the 'bureaucratic goals' through performance measures and monetary incentives. The large and challenging patient lists that

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<sup>2</sup> Examples include Hutt & Gilmour's (2010) "Tackling inequalities in general practice" and Goodwin et al.'s (2011) "Improving the quality of care in general practice"

GPs in deprived areas face, combined with inadequate resources in the form of money, time, and personnel (Checkland, 2004; Lipsky, 2010) force GPs to “process workloads expeditiously” (Lipsky, 2010, p.18). Out of this, GPs in deprived areas may develop ‘coping mechanisms’ to manage their workload. Consequently, Lipsky’s street-level bureaucracy is a useful framework for evaluating their role in implementing health policy as front line workers at the ground level.

## 1.2 Ambiguity in terminology

While health inequalities have become a research priority, there remains a lack of consensus on definitions and terminology within academia and policy (Braveman, 2006). Although definitions may be problematic, Braveman & Gruskin (2003) point out the importance of determining “when different definitions represent substantially different paradigms” (p. 256). Thus, establishing a definition—and its underlying assumptions—serves as a means of guiding measurement and accountability (Braveman & Gruskin, 2003). This is particularly salient when addressing the impacts of policy on tackling inequality. However, defining is not a simple matter of specifying targets to reduce inequalities in health (Dahl, 2002). Rather, a number of factors must be taken into consideration, none of which are straightforward in political terms. Within policy and academic literature, inequities in health have been referred to in a number of ways (e.g., ‘health disparities’, ‘health inequalities’, ‘health gaps’, and ‘health variations’); however, it is important to first distinguish between ‘inequality’ and ‘inequity’.

Internationally, health *inequalities* are not always regarded as *inequities*. Inequalities in health are typically seen as differences that are largely inevitable or unavoidable, such as biological or genetic differences (Scambler, 2012; Whitehead, 1992; Zere et al., 2007). In contrast, inequities in health imply socially unjust or unfair systematic health disparities (Braveman, 2006) and specifically refer to group differences, such as by income, race, or geographic location (Whitehead, 1992; Scambler, 2012). In other words, health inequality is a description of what exists, while health equity is a normative notion of what should be (Ong et al., 2009). The word ‘avoidable’ is thus a key distinction in the differentiation between ‘inequality’ and

‘inequity’ in health. Equity seeks to minimize “avoidable inequalities in health” (Zere et al., 2007, p.3) and its associated determinants.

While this distinction is important, UK policy debates (and to a certain degree academic literature) rarely uses ‘health inequity’ (Graham, 2004). As it is widely understood in the UK, the term ‘health inequalities’ “links the health of individuals to the structures of social inequality which shape their lives” (Graham, 2004, p.117). Even so, inconsistencies remain, predominantly according to geographical locations (e.g. US or European context) (Bleich et al., 2012; Graham, 2009) and whether the term implies moral judgement (i.e. if it describes health differences as associated with an individual’s position in society) (Graham, 2004). This is because iterations of the term do not necessarily carry the same moral weight. For example, health inequalities in the US are referred to as ‘health disparities’, with a focus typically on health differences according to race or gender, but not necessarily due to an individual’s socioeconomic position. Within UK policy, terminology has varied largely according to the political party in charge. The Black Report, commissioned in 1977 under a Labour administration, used the term ‘health inequalities’ (Black, 1980). However, during the Thatcher-led Conservative administrations of the 1980s, health differences were referred to as ‘health variations’. The entrance of New Labour during the 1990s (during which time the Acheson Report was commissioned) brought back the use of ‘health inequalities’ in policy (Acheson, 1998). The shift in terminology between administrations is important to highlight as it represents shifts in policy priorities and is further explored in Chapter Two. ‘Health variations’, ‘health disparities’ and ‘health inequalities’ all acknowledge differences in health between population sub-groups; however, the first two terms fail to qualify the “nature of the difference or who or what may be affected” (Braveman, 2006, p. 169) and do not carry the same moral weight as the third term. Consequently, for sake of continuity and implication of moral weight, this research uses the ‘British convention’ of referring to health inequalities as avoidable (Whitehead, 2007).

Further important distinctions in health inequalities research exist to specify how equity is achieved and its end goal. This can be framed in the questions of ‘inequality among whom?’ and ‘inequality of what?’ (Anand, 2002). From this, achieving equity can be viewed in relation to three different goals: equity in health, equity in healthcare or health service delivery, and

equity in health financing (Ward, 2009; Zere et al., 2007). Equity in *health* was defined by Whitehead in the early 1990s as “a fair opportunity to attain their full health potential and ... that no one should be disadvantaged from achieving this potential, if it can be avoided” (Whitehead, 1992; Braveman, 2006). It is often measured in terms of mortality, morbidity and other measures of illness/wellbeing and is concerned with outcomes (Ward, 2009). Equity in *healthcare* consists of three components: equal access, equal treatment (also utilisation), and equal outcomes for people in equal need (Braveman, 2006; Goddard & Smith, 2005; Ward, 2009). This stems from the main goal of equity in healthcare: to match services with levels of need in a community (Ward, 2009). Finally, equity in *healthcare financing* maintains that payments for healthcare use correspond to ability to pay, i.e. those who can afford to pay more for healthcare do so (Wagstaff, van Doorslaer, & Paci, 1989), a goal which is not as relevant within Scotland’s universal health care system.

Further to this, equity can be framed in terms of ‘horizontal’ versus ‘vertical’ equity. Horizontal equity is generally deemed insufficient within health inequalities research as it implies equal treatment for equal health care need (Starfield, 2004). Vertical equity, on the other hand, recognises that individuals have different needs and should be treated *proportionate* to their healthcare need. For example, under horizontal equity individuals would receive equal portions of the health care ‘pie’; in contrast, individuals would receive a portion of the health care ‘pie’ proportionate to their needs under vertical equity. Within a universal health care system such as Scotland’s, primary care plays an essential equity role in the provision of health care services. Primary care services as they stand, however, typically follow a horizontal equity approach, as increased patient problems do not necessarily reflect greater access to resources in the most deprived areas of Scotland. Thus, the extent to which general practice might deliver health care proportionate to need is a supplementary focus of this research.

### **1.3 Structure of the thesis**

The overarching research questions this thesis aims to address are:

1. What can primary care do to contribute to tackling health inequalities?

2. Within this context, how can GPs—particularly working in areas of severe deprivation—tackle health inequalities?

To achieve this, it is necessary to lay the foundations of the study through the academic literature. Accordingly, the following three chapters discuss the academic literature relating to Scotland's health inequalities, primary care in Scotland, and the conceptualisation of GPs as Lipsky's SLBs. Specifically, Chapter Two describes the nature of health inequalities in Scotland, including an examination of how public health policy in Scotland has attempted to address health inequalities and the problematic position of primary care within this scope. Chapter Three begins by laying out the current structure of primary care and general practice in Scotland, including the specific challenges GPs face working in very deprived areas, known as the 'Deep End'. The Deep End group, a particular point of focus within this research, is an informal network of practices, broadly representing the interests and needs of GPs working in the 100 most deprived practices in Scotland. The chapter then builds on the health inequalities literature by exploring the potential role of primary care in improving population health and mitigating health inequalities. To round out the literature, Chapter Four describes the primary theoretical frame used within this thesis, Lipsky's street-level bureaucracy. This includes an overview of the framework, its applicability to GPs working in areas of high social deprivation and multimorbidity, and potential need to look beyond the framework in fully capturing GPs' work.

Chapter Five describes the methodological and conceptual foundations supporting this research and accompanying arguments for the chosen research methods. This includes a description of the research strategy and design, research collection, and methods of analysis.

Following discussion of the methodology, Chapters Six to Eight discuss the major findings within the research. Chapter Six explores the links between how GPs socially construct their patients and the conceptualisation of health inequalities, including how they see their role in tackling them. Building on this narrative, Chapter Seven utilises the SLB framework to uncover how GPs cope with and negotiate 'dilemmas' resulting from their demanding workloads. This includes uncovering a gap in terms of how GPs perceive themselves as 'going the extra mile' to mitigate the impacts other determinants of health have on their patient populations. Consequently, Chapter Eight attempts to fill this gap by examining GP advocacy

at various levels, ranging from individual patient consultations to involvement in policy and politics.

Finally, Chapter Nine discusses the study's contributions to the evidence base and theory, in addition to practical and policy implications for general practice and the Scottish Government. This chapter concludes by laying out the limitations of the study and highlighting areas for further research.

# CHAPTER 2 The persistent problem of Scotland's health inequalities

## 2.1 Introduction

*The health of the people is a matter of direct social concern*

-Salomon Neumann (cited in Rosen, 1947, p. 679)

Scotland has seen overall improvements in the health of its people over the past several decades; however, it remains touted often as the 'sick man of Europe' (McCartney et al., 2012) due to its low life expectancy compared to the rest of Western Europe (Eikemo et al., 2012; Popham & Boyle, 2011; Taulbut et al., 2014). Scotland is also faced with a growing health divide. This is particularly worrisome for individuals at the bottom of the socioeconomic gradient, where males and females live, on average, about 13 years and 9 years less, respectively, than their counterparts in the least deprived areas<sup>3</sup> (Scottish Government, 2013). Despite an increasing commitment from the Scottish Government to tackle these health inequalities, there has been little to no progress in closing this divide. Consequently, Scotland is faced with pernicious health inequalities, which stem from inequalities in living conditions and the societal structures that create them.

What follows is a review of social inequalities in health in Scotland. This includes an overview of the literature on the social determinants of health (SDH)—including health care as one aspect of the determinants—followed by a discussion of what causes health inequalities and how they might be tackled, as informed by the literature. This foundational overview of health inequalities is then applied to the Scottish context by examining how public health policy in Scotland has attempted to address health inequalities during the previous two decades. This chapter concludes, by exploring what primary care can do to address health inequalities, thus setting the context for the following chapter.

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<sup>3</sup> Life expectancy rates calculated for the 2011-12 calendar year

## 2.2 Health inequalities from an international context

Persistent health inequalities are widely recognised internationally. These avoidable systematic differences in health are not only evident between countries, as seen in the 36-year gap in life expectancy between Japan (life expectancy of 83 years) and Malawi (life expectancy of 47 years) (WHO, 2014), but also within countries (and in particular high income countries). For example, there is a 7.4 year life expectancy difference amongst the poorest one-fifth and wealthiest one-fifth of Canadian men (Raphael, 2012) and infants born to African-American women in the US have a mortality rate of 1.5 to 3 times higher than infants born to women of other races/ethnicities<sup>4</sup> (Centers for Disease Control and Prevention, 2011; WHO, 2014).

From an international comparative perspective, the research on the patterning of health inequalities has been categorised according to welfare state regimes to identify differences, in both general population health outcomes and socioeconomic inequalities in health (Bambra, 2007; Bambra, 2011; Bambra, 2013; Eikemo et al., 2008; Popham et al., 2013). Within Europe, specifically, there is general agreement on five regime types: Social Democratic (Nordic countries), Anglo-Saxon (UK and Ireland), Bismarckian (Germany, France, Austria, Belgium), Southern (Italy, Portugal, Spain, and Greece) and Eastern (Czech Republic, Estonia, Hungary, Poland, Slovakia, and Slovenia) (Eikemo et al., 2008; Popham et al., 2013). While the Social Democratic welfare regimes seem to have the strongest effect in terms of overall population health outcomes (e.g. life expectancy) (Bambra, 2013; Muntaner et al., 2011), the same does not entirely hold true for health inequalities. Instead, using cross-sectional European Social Survey data, Bismarckian welfare regimes showed the smallest income-related health inequalities in self-rated health. At the opposite end of the spectrum, Anglo-Saxon countries demonstrated the largest income-related inequalities in self-rated health (Eikemo et al., 2008). Further analysis of health inequalities in the Nordic states reveals a gender disparity wherein men have smaller inequalities in health than women (Popham et al., 2013). What this demonstrates is a complex public health ‘puzzle’ (Bambra, 2011; Popham et

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<sup>4</sup> While this infant mortality rate is low compared to international standards, it demonstrates the high relative risk and existence of inter country health inequalities.

al., 2013), such that income-related health inequalities vary with welfare state regime, but not in completely predicted directions.

Regardless of this ‘puzzle’, it is evident that social inequalities in health present a challenge worldwide (Marmot, 2010; WHO, 2008) and particularly within the UK. Although life expectancy has improved overall within the UK, these improvements have been unequal, with a faster increase at the top compared to those at the bottom of the socioeconomic ladder (Graham, 2009, p.12). In England and Wales this is evidenced, in the last decade and a half, by male mortality amongst individuals, in routine and manual occupations, rising from 2 times higher in 2001 to 2.3 times higher in 2008, compared with individuals in managerial and professional occupations (Scambler, 2012). The challenge in Scotland is even more problematic and stark, with the worst mortality rates and health inequalities in central and western Europe (McCartney, 2012). The scale of this health divide is a recent development, both the consequence of wider structural divisions and the accumulation of growing inequalities in health over the last several decades.

### **2.3 Scotland’s health divide**

Health inequalities are often defined as ‘health gaps’, a measure which compares the health of one group in relation to another (i.e. the health of those at the bottom of the socioeconomic scale to those at the top) (Graham, 2004; Wagstaff, Paci & Van Doorslaer, 1991). The health gap in Scotland is such that the life expectancy of men ‘at the bottom’ (i.e. most deprived decile) was 69.2 years in 2011-2012 compared with 82.1 years amongst ‘those at the top’ (i.e. the least deprived decile) (Scottish Government, 2013). This represents a difference in life expectancy of almost 13 years. The health gap between females in the most and least deprived deciles is not quite as large, but still considerable at 8.4 years (life expectancy in the most deprived decile at 76.4 years compared with 84.8 years in the least deprived decile).

The health gap not only remains, but also widens, when shifting the focus to ‘healthy life expectancy’, i.e. years spent in self-reported ‘good health’. Individuals living in the most affluent tenth live healthily almost 24 years longer for males and 23 years longer for females than their counterparts in the least deprived tenth (Scottish Government, 2013). As a result,

individuals in the 10% most deprived areas spend about twice as much time in poor health, whether male or female. This also means that by the time most people in the most affluent tenth see a decline in health and start to acquire serious conditions, most people in the most deprived tenth have died (Scottish Government, 2013).

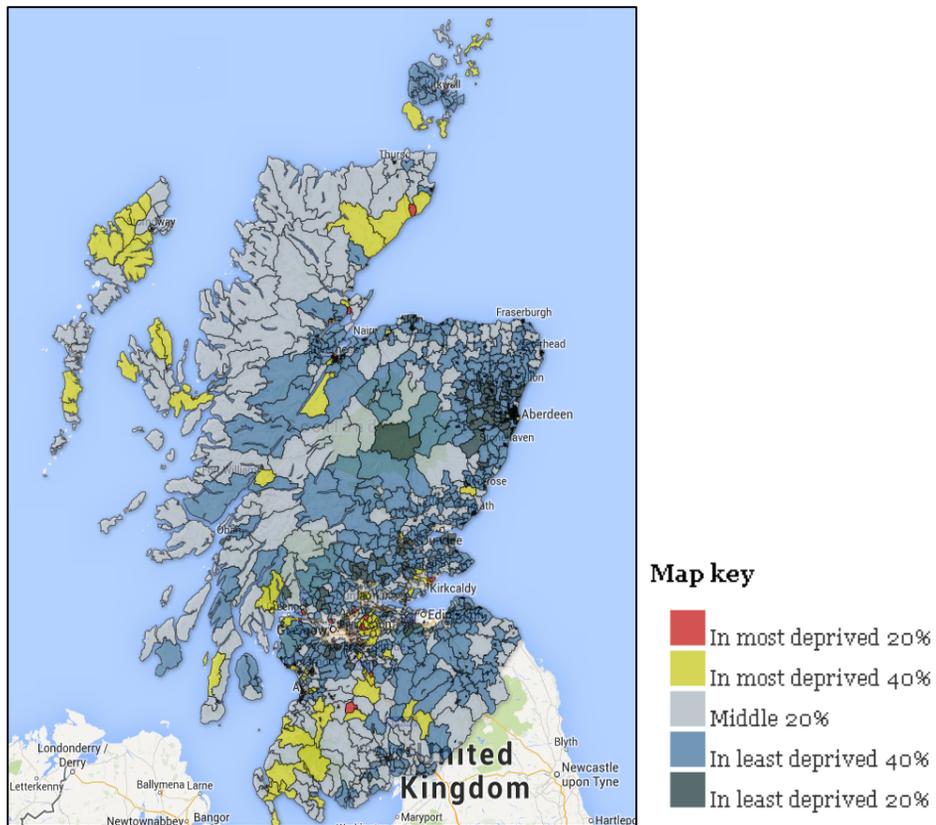
The use of ‘health gaps analysis’ (i.e. comparing the health of those at the bottom of the socioeconomic scale to those at the top), however, can obscure the fact that differences in health exist across the social spectrum. These differences are such that Mackay et al. (2005) found a 2.5-3 fold increase in ill health across the social spectrum, with a steady social gradient across each decile, when moving from least to most deprived areas. This ‘social gradient in health’ is defined as the proportionate relationship of socioeconomic class and health; in other words, the better one’s social situation, the longer life expectancy and better health one has (Bambra et al., 2010; Graham, 2004; Macintyre, 2007; Marmot, 2010; Scambler, 2012). Also known as the “stepwise socioeconomic gradient” (Braveman et al., 2011, p.385), this relationship has been observed in the UK and Scotland for over three decades and provides clues to understanding determinants of health beyond disease and individual poor health practices.

### **2.3.1 Spatial concentrations of inequalities**

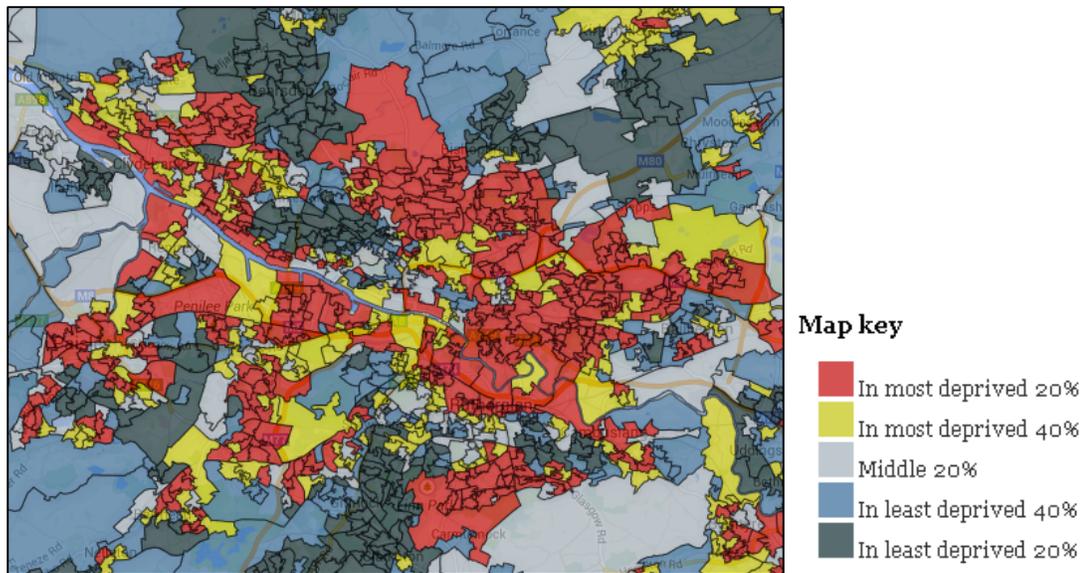
Understanding how the health gradient plays out spatially is particularly salient in Scotland, where concentrations of deprivation occur largely within urban centres. The Scottish Index of Multiple Deprivation (SIMD) is a deprivation measure which incorporates indicators of income, employment, health, education, housing, access and crime; with income and employment more heavily weighted (Scottish Government, 2012). Colour coding spatial concentrations of multiple deprivation (i.e. if there was no spatial concentration of deprivation there would be no colour) in mapping reveals the spatial concentration profile of the socioeconomic gradient (Figures 2.1 and 2.2).

While concentrations of people with above average levels of deprivation exist across Scotland, Figures 2.1 and 2.2 show that concentrations occur in and around major cities and in some small towns and remote rural areas. For example, Figure 2.1 shows only small specks of the most deprived 20% throughout Scotland in 2012, whereas a closer look at Glasgow (and

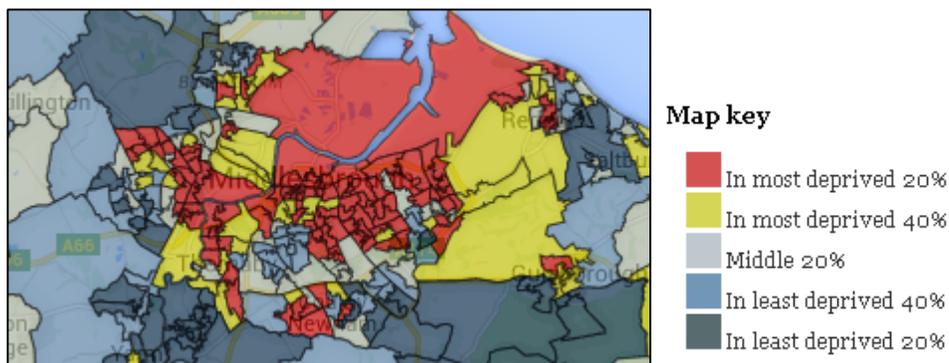
surrounding areas) reveals a high concentration of Scotland's most deprived 20% around the urban centre (Figure 2.2) (although not pictured, Dundee is another city with high area concentration of deprivation). It should be noted that mixed in with these concentrations of Scotland's most deprived 20% are also concentrations of Scotland's *least* deprived 20%. This means that the socioeconomic gradient as a whole spectrum (most to least deprived) exists within Glasgow. As a point of comparison for this spectrum, Figure 2.3 displays data mapping of the English Index of Multiple Deprivation for the Stockton-on-Tees and Middlesbrough areas, which are known for the highest health inequalities in England outside of London (APHO, 2014). While Figures 2.2 and 2.3 both have a high concentration of deprivation, the socio-spatial patterning in Figure 2.2 demonstrates Glasgow's unique challenge of deprivation mix, something that has considerable implications for Scotland's general practice, as revealed in the following chapter. While deprivation in Scotland has become "less concentrated over time" (Scottish Government Press Release, 2012), in Glasgow City (in addition to Edinburgh City and Aberdeen City), large geographical concentrations of the most deprived 20% still exist, which is evidenced in the health gradient.



**Figure 2.1 Health inequalities by data zone deprivation using 2012 SIMD in Scotland (source: Rae, 2013)**

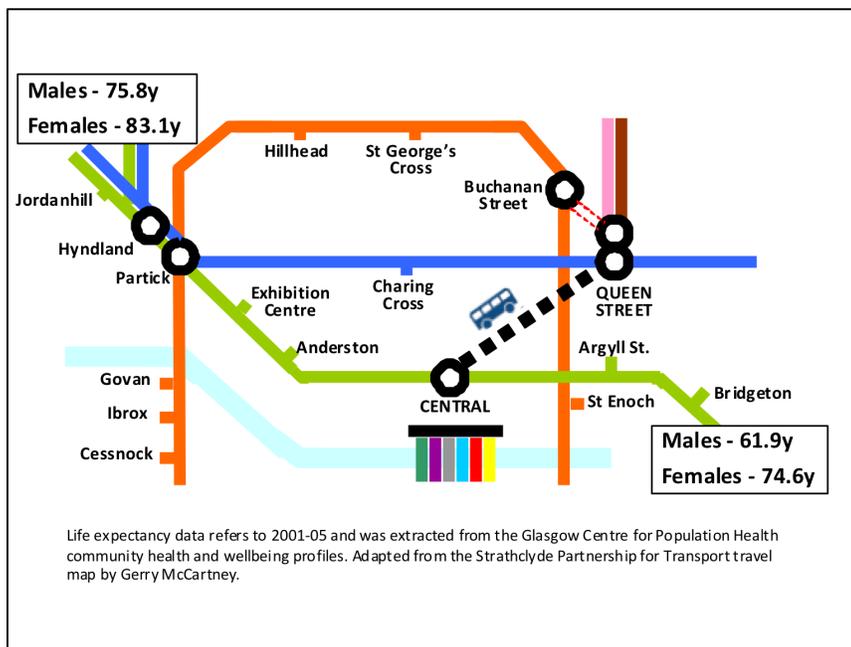


**Figure 2.2 Health inequalities by data zone deprivation using 2012 SIMD, showing Glasgow's high concentration of Scotland's most deprived 20% around the urban centre (source: Rae, 2013)**



**Figure 2.3 Health inequalities by data zone deprivation using 2011 EIMD in England (source: Rae, 2013)**

McCartney's (2012) Glasgow transport map (Figure 2.4) provides additional pictorial evidence of the health gradient when moving between varying levels of deprivation. For each railway stop there is a drop in life expectancy of 2.0 years for males and 1.2 years for females, when moving from the affluent area of Jordanhill to the more deprived area of Bridgeton (an approximate distance of 5.5 miles). This means that health becomes progressively worse across increasing levels of deprivation, within a small geographical area.



**Figure 2.4 Life expectancy differences between areas six railway stations apart in Glasgow (source: McCartney, 2012)<sup>5</sup>**

As previously noted, health in Scotland has improved overall in the last 50 years (Audit Scotland, 2012); however, health inequalities are increasing. For example, while there have been overall improvements in premature death since 1997 (a 28.1% decrease in European age-standardised death rate amongst those aged under 75 years, between 1997 and 2011), this improvement was much slower in the most deprived areas in Scotland between 1997 and 2006. The result was a widening of inequalities, such that premature mortality for individuals in the 10% most deprived areas was 3.5 times higher than those in the 10% least deprived areas in 2011 (Scottish Government, 2013). McCartney (2012) points out geographical inequalities in mortality actually *declined* from 1920 to 1970 in Scotland, before dramatically rising in the 40 years that followed. This, he argues, signifies that health inequalities are not inevitable. Instead, health inequalities should be viewed as avoidable (Graham, 2004; WHO, 2008), as they are systematic and socially produced (Whitehead & Dahlgren, 2007; Norbury et al., 2011) – systematic because rather than a random distribution there are consistent patterns across the socioeconomic spectrum, and socially produced since there is no law of nature

<sup>5</sup> Permission to reproduce this figure has been granted by Gerry McCartney

wherein low-income groups should have worse health than those above them. This suggests there are wider social and environmental determinants contributing to the poor health of individuals from more socioeconomically deprived backgrounds.

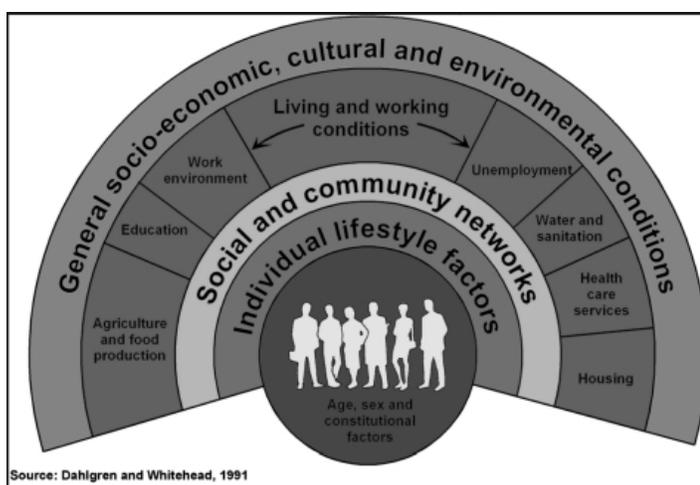
## **2.4 The SDH and health inequalities**

Health and human disease are “mediated and modified” (Rosen, 1947, p.674) by the sociocultural environment rather than simply the consequence of ‘pure nature’. From a contemporary standpoint, linking social and economic factors to health goes back to the age of industrialisation. It was during this time that social problems, produced by industrialisation (e.g. poverty), were linked to health. German physicians Rudolf Virchow and Salomon Neumann were among these 19<sup>th</sup> century pioneers to link health to social problems and in doing so conceptualising ‘medicine as a social science’ (Rosen, 1947; Scambler, 2012, Starfield, 2011). Virchow’s (1879, cited in Miller, 2000) famous pronouncement that “medicine is a social science, and politics nothing else but medicine on a large scale” (p.30) emphasised the importance of social, political and economic factors as underlying causes of, for example, typhus fever epidemics. Similarly, Neuman stated that the majority of disease and premature death were “not [due] to natural causes, but rather to artificially produced social conditions” (Neumann cited in Rosen, 1947, p. 679). Consequently, they argued that action to promote health and combat disease should be social as well as medical (Rosen, 1947). However, the idea that social conditions influence health would not be formalised, and widely acknowledged, until later, in the second half of the 20<sup>th</sup> century.

### **2.4.1 The Rainbow Model**

In the early 90s, Dahlgren and Whitehead (1991) designed a social ecological theory of health, known as the ‘rainbow model’, depicting the relationship between individuals and their environment (see Figure 2.5). Mapped at multiple levels, these social and environmental determinants are all known to have an influence on health. At the bottom of the model are individual factors which influence health, including behavioural (e.g. smoking, eating and exercise habits) and genetic factors. Above this layer are the social interactions individuals have within their family and community networks. The third layer represents wider influences

on health, including the material and social conditions people live in (e.g. housing, work environment) and the services that they are in receipt of (e.g. education and health care services). The structural environment is the “overarching mediator of population health” (Whitehead et al., 2001, p.313) and includes the socioeconomic environment at large. While this is a general model of the influences on health, it depicts individual factors as embedded within the higher layers (Whitehead et al., 2001). Although this model remains prominent, over 20 years after its conception, it fails to fully depict the complexity in which structures, systems, and services overlap and integrate. Additionally, its initial framework only referred to the main determinants of health rather than health *inequalities*.



**Figure 2.5 The main determinants of health (Dahlgren and Whitehead, 1991)**

With the exception of ‘individual lifestyle factors’, the layers on Dahlgren and Whitehead’s model are now more commonly referred to as the ‘social determinants of health’ (SDH).

These social and environmental influences are made up of circumstances into which individuals are born, grow up, work, live and age, in addition to the systems put in place to deal with illness. Importantly, these determinants go beyond individual characteristics (e.g. socioeconomic status, employment status, and social support network) to include the way in which the workplace, communities and society are organised (Diderichsen, Evans and Whitehead, 2001). Additionally, these determinants operate, and tend to accumulate, across the life course (as detailed later in this chapter) to impact on health and produce health inequalities. This means that compared to children from affluent backgrounds, children faced with disadvantage early in life (e.g. poor nutrition/housing/education) often face poorer health

outcomes later in life as they enter adulthood. Consequently, the World Health Organisation's (WHO) Commission on Social Determinants of Health recommends improvements in living conditions (e.g. working towards healthy work and housing environments, fair employment, social protection) to tackle health inequalities through the SDH (WHO, 2008).

#### **2.4.2 The role of health care as a determinant of health inequalities**

Health care—compared with other determinants such as education, income, and housing—has historically been considered marginal in improving population health (Bambra et al., 2010; Mckeown, 1978) and in tackling inequalities thereof. According to McKeown (1978), modern medicine's contribution to improved life expectancies has been minimal. They argue that this is evidenced in the early 20<sup>th</sup> century as deaths attributed to infectious diseases had been declining long before medical interventions such as antibiotics and immunisations were available (the extent to which this remains relevant in the 21<sup>st</sup> century, however, is up for debate).

In their systematic review of the health effects of interventions on specific SDH that occurred between 2000 and 2007 in developed countries, Bambra et al. (2010) found 'inconclusive' evidence that increasing access to "culturally relevant healthcare" (p.288) decreases (or even has an impact on) health inequalities. Similarly, research on England's NHS in terms of targeting resources via 'spearhead interventions' (i.e. interventions directed towards areas specifically prioritised, based on ranking in the bottom fifth of national health indicators) showed they had an insignificant impact on reducing health inequalities (Costa-Font et al., 2010) (although the effectiveness of targeting as an approach to tackling health inequalities will be discussed later on). However, Barr et al. (2014) found the NHS England's health inequalities resource allocation policy of proportionate NHS funding (i.e. funding in deprived areas increased at a greater rate than in more affluent areas) was associated with a decrease in absolute (but not relative) health inequalities related to healthcare. Consequently, the role of the NHS in addressing "socio-economic gaps in health outcomes" (Asthana et al., 2013, p.179) can be questioned, since the contribution of structural inequalities to the unequal distribution of health reflects inequalities in income and power structures (Asthana et al, 2013; Graham, 2004; McCartney et al., 2013).

Nonetheless, health care does play a key role in health inequalities due, in part, to its link with the other determinants; it is not only a determinant of health in itself, but is both influenced by and influences the other SDH (WHO, 2008). This is because individual characteristics (e.g. gender, ethnicity, education, occupation, income) are closely interlinked with an individual's "access to, experiences of, and benefits from health care" (WHO, 2008, p. 12). Furthermore, health services can reduce the severity and delay progression of disease (Starfield, 2004). Since the health system plays a vital role in "mediating the differential consequences of illness in people's lives" (WHO, 2007, p.6) health care can mitigate health inequalities via population health coverage which focuses on socially disadvantaged and marginalised populations (Gilson et al., 2007).

More specifically, universal health care can alleviate health inequalities through addressing access issues (i.e. allocation of services, ability to pay and quality of services), by implementing population health interventions, and "ameliorating the health damage caused by disadvantage" (Macintyre, 2007, p.5). Health systems which provide universal coverage tackle health inequalities by removing financial and other barriers to access and addressing previously unmet needs. Population health interventions, on the other hand, work to prevent health inequalities through primary (e.g. immunisation and health education) and secondary (e.g. health screening) prevention levels (Starfield, 2003).

Regardless of the UK's universal health provision—via the NHS—since 1948, the rise in health inequalities over the past 50 years (Audit Scotland, 2012; McCartney, 2012) indicates an insufficient focus on the most deprived areas. Consequently, the efficacy of health care in addressing health inequalities is also dependent on whether or not the availability of services matches need. If this is disproportionate, the result may actually be a widening of inequality. Unfortunately, this 'mismatch' of resource and need is already evident, as first reported by Julian Tudor Hart (1971), who coined the term the 'inverse care law' wherein "the availability of good medical care tends to vary inversely with the need for it in the population served" (p.7696). While his first article initially described the effects of market forces on health care (due to the threat of the private sector), the inverse care law today more broadly represents the combined result of the market, mismatch of resources and differential use of health care (Watt,

2002) and is frequently used to describe the stark contrast between GP resources in rich, healthy areas with those of deprived, ill areas.

In a similar line of argument, those who stand to profit most from health services are often less likely to participate in them (Baker & Middleton, 2003; Dryden et al., 2012; von Wagner et al., 2009). This is evident in several studies showing deprivation levels to be negatively associated with health screening participation rates. Utilising a retrospective analysis of cervical screening amongst English women between 1991 and 2001, Baker and Middleton (2003) found cervical screening rates to be higher amongst women in affluent areas compared with areas of deprivation (although this ratio has decreased over time, which was associated with an increased number of practice nurses). Differential uptake of cancer screening, associated with socioeconomic status, has also been shown in colorectal screening, with uptake amongst the most deprived quintile in a London study 50% less than the most affluent quintile (von Wagner et al., 2009). Similarly, Dryden et al. (2012) found that men from deprived areas were least likely to attend health checks. While this inequity in routine health screenings is not the inverse care law per se, it certainly is a manifestation of wider structural issues. Given the inequalities in access to GP services, this “suggests that the NHS has a potentially important role to play in helping to reduce health inequalities in the UK” (Smith & Bambra, 2012, p. 109). Health services provided by the NHS must therefore “avoid exacerbating inequalities” (McCartney, 2012, p.12) by being at its “best where needs are greatest” (Deep End Report 20, 2013). One of the ways in which it can do this is by focusing efforts on primary care, which is one of the overarching themes of this research and a topic explored in depth in the following chapter.

## **2.5 Theoretical explanations for health inequalities**

Understanding theories of health inequalities (i.e. how they are produced) is critical in the sense that in order to address a problem, it is necessary to accurately identify the cause (McCartney et al., 2013). Health inequalities imply a difference in health status, which can result from a variety of determinants ranging from genetics to socioeconomic status. The Black Report (1980) took these determinants into consideration when suggesting four

theoretical explanations for the relationship between health and inequality: artefact, natural/social selection, materialist explanations, and cultural/behavioural explanations.

The first two explanations reject a causal connection between “conditions of existence of the various social classes and their levels of health” (Blane, 1985, p.423). Thus, an artefactual explanation suggests the link between social class and health is simply a spurious experimental result while the social selection explanation implies a Darwinistic view that healthier individuals naturally rise up the socioeconomic ladder. As subcategories within the selection theory, intelligence (i.e. more intelligent individuals have better health outcomes) and meritocracy (i.e. a ‘more able’ individual born into a lower socioeconomic group will rise up the socioeconomic ladder) have later been added as suggested explanations for inequalities in health, but subsequently refuted due to flaws in understanding of the causal pathways (McCartney et al., 2013). The third, materialist explanation, maintains that class differences in health are the result of social structures and conditions found in daily life that inherently produce health inequalities (Link & Phelan, 1995). The cultural/behavioural explanation, in contrast, rests on the idea that health behaviours are socially patterned due to cultural differences and lifestyle preferences and are *not* inherently the result of structural inequalities, as the materialist explanation suggests. However, while health behaviour may be socially patterned (e.g. lower socioeconomic groups in Scotland are more likely to smoke than higher income groups), this does not sufficiently explain health inequalities. This is evidenced in the Whitehall study of civil servants wherein controlling for smoking, cholesterol and blood pressure did not explain the difference in coronary heart disease (CHD) mortality between grades (Rose & Marmot, 1981; West, 1998). Further research by McCartney et al. (2012) comparing the Whitehall occupational cohort to two additional cohorts from the late 1960s and early 1970s (a west of Scotland occupational cohort and a west of Scotland general population cohort) shows that socioeconomic differences ‘almost entirely’ explain higher male mortality in the Scottish cohorts in terms of all-cause, respiratory, and lung cancer.

Since the publication of the Black Report (also known as the “Report of the Working Group on Inequalities in Health”) in 1980, other explanations have been offered which are allied to the materialist explanation of health inequalities, including the ‘lifecourse perspective’ (Graham, 2000; Marmot, 2010; WHO, 2007). The lifecourse explanation posits that

disadvantage accumulates across an individual's lifespan. Thus, chronic exposure to poverty and other disadvantages such as lack of education and poor housing in early childhood and young adulthood will accumulate, resulting in worse health later on in that individual's life (Marmot, 2010). This perspective highlights the SDH and how they operate throughout an individual's life (i.e. early childhood to adulthood) by directly influencing health and providing a basis for illness later on (WHO, 2007).

The other theoretical explanation to highlight was most recently framed in the book, *The Spirit Level: Why Equality is Better for Everyone* (Wilkinson and Pickett, 2010). This explanation suggests that both health *and* social inequalities are strongly associated with income equality. Material conditions alone do not adequately explain health inequalities, but rather social and economic circumstances produce a psychosocial effect (Marmot & Wilkinson, 2005; Wilkinson & Pickett, 2010) wherein social inequality results in feelings of inferiority, which produce chronic stress responses and consequently lead to physical and mental health problems (Bambra, 2011). In other words, inequality's malignant effects include: an erosion of trust, increases in anxiety and illness, and promotion of excessive consumption (Wilkinson & Pickett, 2010). Consequently, countries with large income gaps are associated with increased health and social problems (e.g. mental illness, increased violence, higher rates of infant mortality, decreased life expectancy, and obesity). Income distribution was first considered as a health determinant in the early 1980s (Drabo, 2011; Starfield & Birn, 2007) and the link between socioeconomic status and health is now widely accepted across disciplines (Zheng & George, 2012). What the materialist/structural, lifecourse, and Spirit Level explanations have in common is the idea that health inequalities are avoidable and thus subject to change, resulting from wider inequalities in power and income structures (McCartney et al., 2013).

## **2.6 Approaches to tackling health inequalities**

While policy actions related to tackling health inequalities vary, depending on which social determinant is being addressed (e.g. housing improvements that eliminate damp with the intention of improving health; improvements in early childhood education with the intention of preventing poor adult health later on), *how* action tackles health inequalities depends on the overall aim of the intervention, regardless of the determinant being addressed. The *how* can be

further examined on the basis of two criteria, 1) whether the action is intended to mitigate or prevent health inequalities and 2) if it targets a specific population or is universally applied. With regards to the first criterion, preventing health inequalities entirely may be the ultimate goal, but mitigation is just as important to address the current state of health inequalities. However, researchers note ideally *both* efforts are needed to effectively reduce health inequalities (Graham, 2009; Macintyre, 2007; Marmot, 2010). The second criterion refers to targeting versus universalism of interventions. On one end of the spectrum targeting dictates that means-testing (or some other measure) determines eligibility for services (Mkandawire, 2005). Universalism lies at the other end of the spectrum and requires that the population has access to “the same range of (good quality) services according to needs and preferences, regardless of income level, social status, or residency” (WHO, 2008, p.12). Proportionate universalism can be seen as the compromise between targeting and universalism and is described as universal action with a “scale and intensity that is proportionate to the level of disadvantage” (Marmot, 2010, p.16). A proportionate universalist approach is in line with vertical equity (mentioned in the previous chapter), wherein individuals receive health care proportionate to their need (Starfield, 2004).

Table 2.1 maps out the differences between targeting, proportionate universalism, and universalism, including both a description and pictorial representation of ‘action’ (represented by an arrow, which could be in the form of services or resources) on the social gradient in premature mortality and what the theoretical (or intended) impact on the gradient would be. For example, targeting only the most disadvantaged to decrease mortality rates would only put a ‘kink’ in the gradient rather than reduce its steepness. Similarly, a universalism approach would not affect the steepness of the gradient either. In theory, “equalising health chances across socioeconomic groups” (Graham, 2004, p.125) would be the result of action proportionate to need, delivered across the gradient in order to reduce the steepness. Applying the concept of proportionate universalism in practice, however, may not be entirely straightforward (Mackenzie et al., 2015). One challenge is that it mandates some form of individual needs assessment (a concept explored in depth in the following chapter) to effectively deliver resources proportionately.

Table 2.1 Tackling health inequalities in relation to the mortality gradient (adapted from: Graham, 2004; Graham, 2009)

<b>Intervention Type</b>	<b>Targeting</b>	<b>Proportionate Universalism</b>	<b>Universalism</b>
<b>Description</b>	Action only delivered to those who need it most	Action delivered proportionately according to need, across the gradient	Uniform action delivered across the gradient
<b>Action</b> ↓			
<b>Theoretical/ Intended Impact on the Gradient</b>			

The choice between the three approaches ultimately depends on what the desired goals are, including who the target recipients of the intervention are, and the approach the intervention takes. Graham (2004) and Whitehead (2007) take both of these into account in their subsequent typologies of policies (Graham) and actions (Whitehead). These typologies can be examined from the perspective of the two criteria mentioned above— i.e. 1) whether they mitigate or prevent health inequalities and 2) if they target a specific population or are universally applied.

### **2.6.1 Graham's typology of policies**

The difference between Graham's (2004) typology of policies can be summarised as the difference between “remedying health disadvantages, narrowing health gaps and reducing health gradients” (p.118). At one end, one approach operates under the assumption that health inequalities “result from social disadvantage” (Graham, 2004, p.118). This approach can be seen as a form of targeting, focusing on absolute health improvement amongst the most disadvantaged. However, unless absolute improvements in the most disadvantaged occur faster than those above them, health inequalities will remain. Consequently, the second approach involves narrowing health gaps, i.e. focusing on the health of poor groups in *relation* to other groups. This approach highlights “the fact that population averages mask wide differences in health between social groups” (Graham, 2004, p.121). Consequently, both an absolute health improvement is needed in lower groups (the only focus for the first approach) *and* a rate of improvement that surpasses higher socioeconomic groups. However, this approach is still a form of targeting as it only takes into consideration those at the bottom of the gradient in comparison to either the population average or to the top of the gradient, neglecting those in the middle. Graham's third approach takes into consideration the entire health gradient and is concerned not just with health differences between the worst off and better-off groups, but how socioeconomic position affects health across the population gradient. As Graham (2004) puts it, this approach includes “remedying disadvantages and narrowing health gaps within the broader goal of equalising health chances across socioeconomic groups” (p.125). Focusing on the entire gradient acknowledges the role

excessive wealth (in addition to lack of wealth) contributes to overall inequalities in health (Mackenzie et al., 2012).

### 2.6.2 Whitehead's typology of actions

While Graham's approaches look at how the goal of tackling health inequalities is achieved, Whitehead (2007) looks at policy and intervention actions by organising them into four broad types: strengthening individuals, strengthening communities, improving living and working conditions, and promoting healthy macro-policies. These closely follow Dahlgren and Whitehead's rainbow model of health determinants, recognising how policy and interventions can target health inequalities throughout the different layers.

1. *Strengthening individuals* — These interventions focus on those from disadvantaged backgrounds and are akin to Graham's first approach of improving the health of the worst off (targeting). This type of intervention seeks to address perceived shortfalls in individuals such as self-esteem, competence, knowledge or belief in order to improve their health, including 'empowering' individuals to better access and make use of services and facilities that could improve their health.
2. *Strengthening communities* — These interventions work through building social cohesion and support either within disadvantaged communities or between different groups. This type is still a form of targeting and, along with the first type, tends to "treat the symptoms rather than the underlying cause of the problem" (Whitehead, 2007, p.474).
3. *Improving working and living conditions* — These interventions focus on environment (e.g. work or home) and access to essential goods. Whitehead (2007) identifies these as "classic public health measures" (p. 475) and include improving access to housing, sanitation, health and social care. While they benefit population health in general, they usually are focused on those worst off.
4. *Promoting healthy macro-policies* — These types of interventions aim to address the overarching causes of health inequalities, those that are structural and affect cultural and environmental conditions (e.g. income inequality and unemployment). Whitehead (2007) notes these span multiple sectors and work across populations as a whole. As

Rose (1992) argues, “the primary determinants of disease are economic and social, and therefore, its remedies must be economic and social” (as quoted in Watt, 1998, p.460).

From a policy perspective, there has been general confusion surrounding Graham’s typologies and strategies to effectively tackle health inequalities and action has commonly focused on improving the health of the poorest or reducing the gap between the most socioeconomically deprived and the population average (Graham, 2007; Krieger, 2008; Mackenzie, 2012).

Consequently, it is necessary to both summarise and evaluate the policy approaches Scotland has taken to address inequalities in health.

## **2.7 Addressing health inequalities through policy in Scotland**

Within Scotland, policy strategies tackling health inequalities have varied over the last few decades in terms of the focus on social determinants or individual behaviour. Crucially, there has been a schism between the rhetoric in government commissioned reports and the translation into public health policy in terms of both theoretical approaches to tackling health inequalities and understanding the causes of health inequalities. How the government conceptualises health inequalities is particularly important, as this ultimately dictates policy responses (Graham & Kelly, 2004; Smith & Hellowell, 2012). Political climate and research agendas have certainly influenced both, and while not the focus of this research, are important to acknowledge. Consequently, this section outlines both government commissioned reports related to tackling health inequalities and subsequent policy action (outwith general practice, which is summarised in the subsequent chapter), starting with a UK-wide overview before narrowing the focus to Scotland post-devolution.

Commissioned by an outgoing Labour government in 1977, the Black Report (1980) failed to garner policy traction due to the conservative administration in power at the time of its publication (Bambra et al., 2011). While the Black Report acknowledged the existence of health inequalities in the UK, including their cumulative effects, and the disproval of artefact and selection theoretical explanations for health inequalities, over a decade and a half would pass without substantial political attention; however, researchers kept the health inequalities issue ‘alive’ during this political stalemate (Bambra et al., 2011). The 1997 election of a

Labour government was therefore pivotal in finally providing a policy platform for addressing health inequalities in the UK (Bambra et al., 2011; Mackenzie, 2008; McCartney et al., 2013; Smith et al., 2009). This shift in political power also initiated a new government issued report, the Acheson Enquiry (1998). It followed in the footsteps of the Black Report in terms of understanding the causes of health inequalities, but also highlighted the existence of societal inequalities and, more importantly, conceptualised health inequalities as health gradients, in addition to health gaps (as the previous Black Report had done) (Bambra et al., 2011).

### **2.7.1 Public health policy in post-devolution Scotland**

A year later, in a newly devolved Scotland, the 1999 White Paper “Towards a Healthier Scotland” (Secretary of State for Scotland, 1999) established a public health policy framework recognising that health inequalities are not just the product of lifestyle but also life circumstances and that reducing them should underpin all health improvement action. In particular, it set targets for lifestyles/behavioural health topics, but failed to do so for life circumstances (Macintyre, 2007). The following year, the government document *Our National Health* (Scottish Executive, 2000) reiterated “poverty, poor housing, homelessness and the lack of education and economic opportunity” (p.14) as root causes of poor health and health inequalities. However, the conceptualisation of health inequalities focused on “the health gap between rich and poor” (Scottish Executive, 2000, p. 7). Around this time the government health initiative, Starting Well, was launched. Aiming to use health visitors as public health practitioners in health improvement, Starting Well was targeted at children living in the most deprived communities of Glasgow (Mackenzie, 2008). Collectively, this initiative and previous government documents demonstrated a post-devolution commitment to tackling health inequalities, acknowledging theoretically informed causes of health inequalities (i.e. social determinants of health) and the importance of early years in tackling health inequalities (a theme acknowledged in both the Black Report and Acheson Enquiry) (Mackenzie, 2008; Smith & Hellowell; 2012). This also demonstrated a commitment to improving the health of the most deprived groups as a means of tackling health inequalities (Smith & Hellowell, 2012).

It was not until 2003, when the Scottish Executive published the “Report of measuring inequalities in health Working Group”, that the government established specific indicators,

rather than targets, by which progress on tackling health inequalities could be measured. However, the government's previous commitment to narrowing 'health gaps' was diluted through the indicators, as they only focused on the most deprived areas of Scotland (Smith et al., 2009). In 2006, a new performance management framework was introduced, known as HEAT (Health, Efficiency, Access, and Treatment) targets. This new framework further diluted any measurement of 'health gaps' by removing their previous performance assessment, instead reinforcing "a conceptualisation of health inequalities as a problem of 'health disadvantage'" (Smith et al., 2009, p. 9). Taken collectively, this establishes a case of divergence between rhetoric and action (Smith et al., 2009; Smith & Hellowell, 2012). While the government conceptualised health inequalities as health gaps (Graham's second approach to tackling health inequalities), in reality their actions were more indicative of Graham's first approach (i.e. focusing on health improvement amongst the disadvantaged) as a way to remedy health inequalities (Smith & Hellowell, 2012). Exclusively targeting the most disadvantaged ultimately fails to address health inequalities across the gradient. In 2015, during the course of this research, the Scottish Government once again replaced the HEAT targets with a new performance measurement system called Local Delivery Plan (LDP) Standards. According to Health Improvement Scotland (2015) the LDP Standards focus on key organisational strategies and priorities to achieve a 2020 vision of "sustainable, world-leading and high quality health and care services across Scotland" (p.5). While the potential impact on health inequalities remains unclear, the report rhetoric of "empowering people to have an informed voice that maximises their impact in managing their own care" (Health Improvement Scotland, 2015, p. 32) suggests a misaligned focus on the individual, rather than a renewed commitment to measuring (and effectively tackling) health inequalities.

A notable exception to targeted public health policies during the mid-2000s was the nationwide smoking ban in all enclosed public places within Scotland (Smoking, Health and Social Care (Scotland) Act, 2005). Instated in March 2006, the smoking ban has dramatically reduced exposure to second-hand smoke (Akhtar et al., 2010;) in addition to reducing smoking rates (Levin et al., 2014), representing a positive improvement in overall population health. However, the ban's impact on health inequalities has not been as positive. Research proceeding Scotland's smoking ban shows a persistence of both socioeconomic inequalities in second-hand smoke exposure (Akhtar et al., 2010) and disproportionately high rates of

smoking amongst individuals living in the most deprived areas (Scottish Government, 2012b; Levin et al., 2014). While smoking explained almost all of health inequality in the Midspan cohorts (Gruer et al., 2009), health behaviours are not a sufficient cause of health inequalities (McCartney et al., 2013). Consequently, disregarding inequalities, as Levin et al. (2014) assert, “may lead us to the incorrect conclusion that the population as a whole is improving” (p.2).

This divergence between government rhetoric and policy action was not limited to the theoretical approaches to tackling health inequalities. During the period of 2004-07, public health strategies in Scotland (and also in England and Wales) also took a less socially determinant focus, regarding health inequalities, and increasingly concentrated more on lifestyle and health behaviours (Smith et al., 2009; Smith & Hellowell, 2012), as demonstrated in targeted medical interventions, focusing on tobacco and alcohol policy. In addition to the smoking ban (and previous tobacco legislation requiring health warnings on cigarette packaging in 2003 and updated in 2007 to include picture warnings), similar ‘legal addiction’ (Cairney & Studlar, 2014) legislation has been passed, but not yet implemented, for alcohol use: the *Alcohol (Minimum Pricing) (Scotland) Act 2012*. Minimum unit pricing is a price-based intervention targeted at reducing alcohol consumption and purchasing (i.e. it sets a uniform, minimum price per unit of alcohol below which alcohol cannot be sold). Using the Sheffield Alcohol Policy Model<sup>6</sup>, Holmes et al. (2014) advise that ‘harmful’ (heavy) drinkers from low-income groups would be most affected by the policy and see the greatest reduction in consumption (which coincides with the large weight of potential health gains). While this statistical modelling suggests the potential for a positive impact on tackling health inequalities, it remains policy focused on health behaviour nonetheless. Collectively, this recognises that while government reports during the mid-2000’s acknowledged ‘upstream’ root causes of health inequalities, public health policy emphasised ‘downstream’ lifestyle determinants (Bambra et al., 2011, p.401).

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<sup>6</sup> Since the legislation has yet to be enacted, potential effects on health inequalities can only be predicted through statistical modelling.

In 2007, the Scottish National Party (SNP) replaced the Labour government in Scotland, and (rhetorically) made a commitment to act as a ‘public health steward’ via a number of policy statements (Smith & Hellowell, 2012). This acknowledged the role of central government support in tackling health inequalities (a position importantly promoted by the WHO, 2008), reflecting concern for structural causes of inequalities in health. Additionally, the government commissioned report *Equally Well* (Scottish Government, 2008) and the follow-up review in 2010, shifted focus (at least on paper) back to social and economic determinants to tackle health inequalities (Smith & Hellowell, 2012). However, the divergence between rhetoric and policy action continued to persist, as public health strategies remained focused on individual lifestyle choices, with increased responsibility placed on local Health Boards for addressing health inequalities (Smith & Hellowell, 2012).

Public health policy in England has led a similarly divergent path wherein the New Labour government’s minister for health, Alan Johnstone, commissioned the so-called ‘Marmot Review’, *Fair Society Healthy Lives* (2010) reiterated key theoretical understandings of health inequalities (wider structural determinants) and, in terms of policy recommendations, notably called for ‘proportionate universalism’ to address the health inequalities gradient. Like its predecessors—the Black Report and the Acheson Enquiry—the Marmot Review had similar theoretical principles guiding the policy recommendations (Bambra et al., 2011). However, this has had little effect on policy action (and subsequent government reports), as the election of a Conservative government in 2010 brought even more emphasis on personal responsibility and individual lifestyle (Asthana et al., 2013) and an increasing focus on privatised health care (Smith & Hellowell, 2012). Following a similar trajectory as the Black Report (i.e. failure to directly result in policy action), the Marmot Review’s lack of impact on policy demonstrates the importance of a political environment conducive to putting research into action and ultimately tackling health inequalities (Bambra et al., 2011).

Ultimately, there has been clear divergence in government rhetoric and public health policy regarding the causes of health inequalities and the theoretical approaches for tackling them. This is evident in how government reports (generally) conceptualise health inequalities as ‘health gaps’ and identify the importance of wider SDH inequalities, yet public health strategies largely focus on targeting the most disadvantaged groups and interventions directed

at individual lifestyle behaviours. In terms of primary care, this contradictory position presents a challenge wherein rhetoric calls for tackling health inequalities outwith the scope of primary care (i.e. focusing on wider structural determinants) while policy strategies focus on changing individual lifestyle and behaviour, factors very much within the remit of primary care.

## **2.8 The problematic position of primary care in tackling health inequalities**

There is widespread agreement amongst researchers (both within and outwith public health) that health inequalities cannot effectively be tackled without addressing the wider social and economic factors that influence health and, importantly, the unequal distribution of income, power, services and resources (Asthana et al., 2013; Graham, 2004; Whitehead & Popay, 2010; WHO, 2008). As a result, researchers have criticised 1) the increased prioritisation<sup>7</sup> of the health service in public health strategies to reduce health inequalities in Scotland and the UK and 2) the increased policy focus on changing individual lifestyle and behaviour (Asthana et al., 2013; Katikireddi et al., 2013; Smith et al., 2009; Smith & Hellowell, 2012; Whitehead & Popay, 2010).

In terms of health service prioritisation, Asthana et al. (2013) maintain that the ‘medicalisation’<sup>8</sup> of health inequalities has narrowed the focus on the role that the health service plays in promoting health equity. They suggest that this restricted focus is the result of health inequalities being a ‘messy’ policy issue, which is less costly to address via NHS funding allocations rather than other social determinants of health inequalities. The end result of this ‘narrow focus’ is the failure of NHS resource targeting to “promote greater health equity” (Asthana et al., 2013, p.169) and the persistence of health inequalities. However, it could be argued that the reason the NHS has failed to address health inequalities is because it has not attempted to address the inverse care law by ensuring primary care services are

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<sup>7</sup> This ‘prioritisation’ equates to a focus on activities of NHS-employed staff in health improvement activities, but not necessarily general practice specifically, as the next chapter explores.

<sup>8</sup> To support their claim, Asthana et al. (2013) reference Conrad and Schneider’s (1992) description of ‘medicalisation’ in terms of “definition and description of a problem in medical terms, the adoption of a medical framework to understand it, use of medical interventions to treat it” (p.168).

distributed according to socioeconomic need, a topic further explored in the following chapters.

The other critique—a focus on changing individual lifestyle and behaviour—is linked to public health policy’s failure to address ‘upstream’ factors (e.g. education, housing, income) in tackling health inequalities. This has frequently been referred to as a ‘lifestyle drift’ (initially by Whitehead & Popay, 2010; later by Katikireddi et al., 2013 and others) (i.e. a policy focus on lifestyle choices). This is not to say that health behaviours shouldn’t be addressed in tackling health inequalities (Katikireddi et al., 2013). Rather, a primary focus on this neglects structural conditions that constrain individual ‘choices’ (Whitehead & Popay, 2010) and fails to recognise underlying reasons why unhealthy behaviours prevail in certain societies (Katikireddi et al., 2013).

### **2.8.1 Problems in discourse**

Part of the issue is that both researchers and policymakers often conflate ‘social factors’ which influence individual and population health and ‘social processes’ which cause the unequal distribution of social factors (Katikireddi et al., 2013). For example, delivering increased health and social services to individuals living in socioeconomically deprived areas may have an impact on individual (and potentially population) health, but they do not address why individuals in these areas may need increased health and social services in the first place. A focus on the latter would constitute addressing the social processes that cause social inequalities, i.e. the unequal distribution of power, wealth, and resources. This is in line with Raphael’s (2011) discourse analysis of the SDH, wherein research and policy discourses may consider the SDH but “ignore their public policy antecedents” (p.230), i.e. fail to address wider structural issues.

While previous research has used ‘upstream’ and downstream’ terminologies to construct health determinants and approaches to tackling health inequalities (Bambra et al., 2011; Katikireddi et al., 2013; Whitehead & Popay, 2010), these broad-based terms do not adequately represent the spectrum of potential constructions that occur between the two. As an alternative, Canadian researcher Raphael (2011) has used a Foucaultian approach to categorise the discourses used to characterise and construct SDH. The use of Foucault’s ‘discourse’

refers to “systems of thoughts composed of ideas, attitudes, course of actions, beliefs, and practices that systematically construct the subjects and the worlds of which they speak” (Lessa, 2006, p.285). Tracing discourse is particularly significant since research and professional practice—including activity and funding priorities—are largely dictated by the dominant discourses (Raphael, 2011).

Raphael’s (2011) seven discourses are summarised in Table 2.2 with the inclusion of an additional separator by Brassoloto et al. (2013). This latter work builds on Raphael’s initial discourse categorisation by simplifying his seven discourses into a three-stage categorisation including ‘Functional’, ‘Analytical’, and ‘Structural’ (Brassoloto et al., 2013). Collectively, their research looks at the extent to which individual risk factors or structural inequalities contextualise health inequalities. Within Raphael’s discourse levels 1 and 2, health determinants are used to identify individual risk factors for those in need of health and social services. This approach is classified as ‘Functional’ since approaches largely focus on targeted services and programmes for vulnerable groups. Discourse level 3 focuses on life circumstances conducive to good health (e.g. housing conditions), with discourse level 4 noting these are patterned by group membership, including class, disability status, race, and gender. An ‘Analytical’ approach moves beyond a focus on individual risk factors to improve living conditions that impact on health. Discourse level 5 acknowledges the importance of public policy decisions in determining health while levels 6 and 7 focus on the impact of social structures, political environments, and power distributions on the SDH. Consequently, levels 5-7 have a ‘Structural’ approach wherein public policy advocacy and public education strategies are targeted at addressing the social determinants of inequalities in health, with level 7 taking the focus higher to the unequal distribution of power.

**Table 2.2 Overview of Raphael's seven SDH discourses and Brassoloto et al.'s discourse approach framework (adapted from: Raphael, 2011; Brassoloto et al., 2013; Mackenzie et al., 2015)**

<b>Approach</b>	<b>Discourse Levels</b>	<b>Discourse Implications</b>
<b>Functional</b>	Level 1- Focus on identifying individuals from vulnerable groups and using health and social services to improve health.	Health determinants are used to identify individual risk factors for those in need of health and social services; focus on targeted services programmes for vulnerable groups, lifestyle and behaviour change
	Level 2- Focus on modifiable medical and behavioural risk factors and using lifestyle programmes to target behaviour change.	
<b>Analytical</b>	Level 3- Focus on how living conditions affect and shape health.	Life circumstances affect health and may systematically differ by group membership; focus on to improving living conditions that impact on health
	Level 4- Focus on how living conditions systematically differ according to group membership (e.g. race, gender, class, disability) and identifying antidiscrimination efforts.	
<b>Structural</b>	Level 5- Focus on the distribution of SDH as a consequence of public policy and identifying how policies contribute to social and health inequalities.	Public policy, social structures, political environments, and power distributions affect health; public policy advocacy and public education strategies are targeted at addressing the social determinants of inequalities in health
	Level 6- Focus on the distribution of SDH as a consequence of economic and political structures.	
	Level 7- Focus on the distribution of SDH as a consequence of unequal power distributions and how inequalities are determined partly by those who benefit from them.	

Raphael's seven discourses on the SDH have been applied within health inequalities research looking at senior public health leaders in Canada (Brassoloto et al., 2013) and a combination of NHS Scotland and Scottish government staff with policy or management roles, in addition to practitioners (Mackenzie et al., 2015). These studies found that participant discourse tended to focus on discourse levels 1-5, with particular emphasis on the lower levels of material and behavioural explanations for health inequalities. Notably, this represents a focus on material

disadvantage without attributing responsibility to policy, political activity, or structural inequalities (Mackenzie et al., 2015). Problems in discourse, therefore, suggest that a health service focus in tackling health inequalities may obscure the importance of the SDH and their unequal distribution. Another potential issue is that tackling health inequalities from a health service perspective has predominantly taken a targeting approach rather than addressing the health inequalities gradient. As a result, Katikireddi et al. (2013) highlight the importance of addressing the broader determinants of health inequalities from a population perspective.

### **2.8.2 Rethinking primary care's role in tackling health inequalities**

While research has been critical of placing too much emphasis on the role of the health service in tackling health inequalities, the strategic position of primary care in dealing with non-health factors must be acknowledged. In their patient encounters, GPs witness the many social problems individuals living in very deprived areas face (Popay et al., 2007). Consequently, there is a need for strong links between primary care and external social services and resources (such as housing, employment and financial services).

Additionally, primary care affords an opportunity to deliver population health approaches due to its widespread contact with the population and GP's responsibility for population health (Goodwin et al., 2011). Primary care's position within the wider health care system provides the most comprehensive access to a population's health, an attribute which enables population-wide interventions. Within the UK, GPs are largely depended on to undertake public health interventions such as population-based screening and immunisation programmes (RCGP, 2009). From a population perspective, this positions primary care to positively impact upon health inequalities because of its universal nature.

The fact that the most deprived groups in Scotland suffer from worse health than their wealthy counterparts indicates that equal access (horizontal equity) is not enough to reduce health inequalities. This entails Graham's (2004) focus on the gradient and "how health is distributed across society" (Graham, 2004, p.126). In terms of 'reducing' the gradient, primary care is also well placed for a proportionate universalist approach through its capacity to identify need. GPs are also placed in a discretionary role regarding need—and the subsequent distribution of health care resources—therefore it is critical to understand what the scope is for practicing

proportionate universalism in primary care, a topic which is explored in the subsequent chapter.

## 2.9 Conclusions

Persistent social inequalities in health present a major challenge in Scotland today. Not only are they largely the result of inequalities in living conditions and the societal structures that create them (i.e. inequalities in power, wealth and resources), they are also avoidable. Consequently, action is necessary to not only mitigate the current state of inequality but also prevent them from occurring.

While health care is one of many SDH, it is potentially important due to its links with the other determinants and the potential for alleviating health inequalities via universal access to services and population-wide health interventions. However, given the existence of universal health care since 1948 *and* the persistence of Scotland's inequalities in health, it is especially crucial that health services match need or inequalities will continue to widen. This dictates an approach that considers the entire socioeconomic gradient in health and equalises "health chances across socioeconomic groups" (Graham, 2004, p.125). While a 'proportionate universalist' approach might seem appropriate, operationalising it presents a different issue, as little is known about how this approach works in practice.

The Scottish government has widely acknowledged the persistence of health inequalities in Scotland during the last two decades, alongside an increasing commitment to tackling them. The fact that inequalities in health remain a major issue, however, is likely the result of a disconnect between rhetoric and action in public health policy in terms of both theoretical approaches to tackling health inequalities and understanding the causes of health inequalities. The overall result has been public health policy emphasising 'downstream' lifestyle determinants and primarily targeting the most disadvantaged groups. Recent government-issued reports acknowledge the structural causes of health inequalities and the vital role of central government support in tackling them, but are yet to be reflected in policy strategies (as exemplified in the case of Minimum Unit Pricing).

Researchers both within and outwith public health acknowledge the importance of addressing wider social and economic factors to effectively tackle health inequalities and have been increasingly critical of prioritising the role of the health service and focusing on lifestyle factors in public health strategies. However, this critique fails to recognise the potentially fundamental role of primary care in tackling health inequalities due to its: 1) position in dealing with non-health factors, 2) position within the wider health care system and 3) potential for adopting proportionate universalism. Consequently, the next chapter takes an in-depth look at primary care and its potential for addressing health inequalities including a comprehensive overview of primary care policy in Scotland.

## **CHAPTER 3 What is the potential for addressing health inequalities via primary care?**

### **3.1 Introduction**

The previous chapter discussed Scotland's pervasive social health inequalities, which are largely the result of inequalities in power, wealth and resources. These are manifested by dramatic differences in life expectancy between individuals living in the most deprived areas of Scotland compared to those living in affluent areas. While the Scottish government has acknowledged these social inequalities in health, policy and action have yet to succeed in making a significant reduction. As a result, this chapter undertakes an in-depth exploration of the potential role of primary care in addressing health inequalities in Scotland. It starts by setting out the foundations of primary care, including a discussion of Starfield's widely acknowledged key tenets of primary care and an overview of the primary care team, focusing particularly on the role of GP. This is followed by a historical exploration of primary care in Scotland, including key reforms in the GP contract, through to the structure and payment mechanisms that exist in general practice today.

Chapter Two discussed the impact of socioeconomic factors on individual health, and this chapter takes this argument further by examining the impact social deprivation has on general practice. Deprivation presents a particular challenge to urban practices (and elsewhere) in Scotland due to the challenging patient caseloads, represented by high levels of premature multimorbidity. In response to these challenges, a number of GPs working in the 100 most deprived practices of Scotland have convened in a group known as the Deep End. Practices located in the 'Deep End' deal with 'blanket'<sup>9</sup> deprivation (i.e. anywhere from 44-88% of their patients live within the most deprived 15% according to the SIMD) as opposed to 'pocket' deprivation (i.e. a smaller percentage of patients living within the most deprived 15%) (Watt, 2012). This chapter suggests the Deep End group be conceptualised as a 'critical case' in

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<sup>9</sup> 'Blanket' and 'pocket' approach were previously used to describe practice recruitment methodology in the primary care health improvement programme, Keep Well (Wang et al., 2010).

examining the potential role of general practice (including GP advocacy on behalf of their patients) in tackling health inequalities. To conclude, this chapter explores the potential role of primary care in both improving population health and addressing health equity.

## **3.2 Foundations of primary care**

The origins of primary care lie in responding to the needs of sick individuals at stages of ill health that can be dealt with in the community and do not require hospitalisation. This role is found worldwide and carried out by a variety of practitioners. Yet primary care as a formalised term has been linked back to a 1920 UK government white paper, known as the Dawson Report, which recommended a specific organisation of the health system under a single authority in Great Britain (Dawson, 1920; Starfield, 1998; Starfield et al., 2005). More than 20 years prior to the establishment of the NHS, the report distinguished three main levels of care: primary health centres, secondary health centres and teaching hospitals (Dawson, 1920; Starfield, 1998). Primary health centres were “intended to become the hub of regionalized services” (Starfield et al., 2005, p.457) in Great Britain. Additionally, Dawson designated primary health centres to be a combination of curative and preventive medicine delivered by GPs and developed around the local needs wherein the centre was established (Dawson, 1920). While Dawson’s concept of primary health centres has been elaborated on, primary care remains the recommended ‘hub’ of a health system (WHO, 2008).

### **3.2.1 ‘Primary care’ versus ‘primary health care’**

Primary health care gained international importance in the WHO’s 1978 Alma-Ata Declaration, defining it as “essential health care” which is “universally accessible.” The list of primary health care services deemed ‘essential’ include: health education, environmental sanitation, maternity care, family planning, childhood immunizations, treatment of common childhood illnesses, and the prevention and treatment of malaria, tuberculosis, HIV/AIDS (Disease Control Priorities Project, 2007; Starfield, 1998). Furthermore, primary health care includes health policy (system level and service provision level) involving “services delivered to individuals (primary care services) and population-level ‘public health-type’ functions” (Muldoon, Hogg & Levitt, 2006, p.410).

Although often used interchangeably (Muldoon, Hogg & Levitt, 2006), this thesis distinguishes *primary care* from *primary health care*. Primary health care is a much broader concept and denotes an overall “approach to health policy and service provision” (Muldoon, Hogg & Levitt, 2006, p.411). Not only is public health closely aligned with primary health care, it has also had considerable influence on its development; for example, many of the ‘essential’ health services listed above were defined as ‘basic health services’ in 1953 by the WHO Expert Committee on Public Health (WHO, 1995). These ‘basic health services’ were later absorbed into the definition of primary health care and acknowledged as “the strategy for achieving health for all” (WHO, 1995, p.2).

Primary care, in contrast, is more specific, focusing on clinical practice and the behaviour of health service professionals, including interactions with individual patients (Muldoon, Hogg & Levitt, 2006; Starfield, 2011). As Starfield (2004) notes, primary care is “conventional primary medical care striving to achieve the goals of primary health care<sup>10</sup>” (Starfield, 1998, p.11)<sup>11</sup>. Thus, primary care can be conceptualised as residing underneath the umbrella of primary health care and, accordingly, primary care functions are more explicit than those of general primary health care. Lying “between self-care and hospital/specialist care” (Smith et al., 2013, p.9), primary care functions include: diagnosis, prevention and screening, triage and referral to secondary services, care coordination (particularly for patients with multimorbidities), treatment for episodic illness, and palliative care provision (Smith et al., 2013).

### 3.2.2 Key tenets of primary care

Given its place at the centre of a health system, primary care has four main attributes that are integral to an overall primary health care strategy. Starfield (1994) succinctly identifies these as contact, continuity, comprehensiveness, and coordination; defined as follows:

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<sup>10</sup>The overarching goal of ‘primary health care’ is health for all, incorporating strategies such as community participation, self-reliance, and multi-sectoral linkages.

<sup>11</sup>‘Primary care’ is also defined as “the provision of integrated, accessible healthcare services by clinicians who are accountable for addressing a large majority of personal healthcare needs, developing a sustained partnership with patients, and practicing in the context of family and community” (Shi, 2012).

1. First contact – Primary care is a point of first-contact within a health system, i.e. this is where patients often go first for medical attention and ideally should present no barriers to access.
2. Continuity – Primary care provides continuity within the system as patients are able to develop an on-going relationship with their GP, building productive relationships and activity via serial encounters. This allows care to be placed in context (i.e. taking into consideration the patient’s history, family situation, and socioeconomic circumstances), making better use of short consultation times and allowing patients to participate in decision-making as it relates to their health.
3. Comprehensiveness – Since it is often the first point of care for all patients—regardless of gender, race, or socioeconomic status—primary care deals unconditionally with a diversity of health needs and challenges.
  - a. Along with this point is the holistic idea of ‘person-centredness’<sup>12</sup>, which is not always included in Starfield’s original 4 C’s but is equally important (Starfield, 1994). As William Osler points out “it is much more important to know what sort of patient has a disease than what sort of disease a patient has” (WHO, 2008, p.42). Considering that health is the result of multiple determinants—i.e. social and environmental determinants such as socioeconomic status, housing, work environment and education level have an influence on health, as discussed in Chapter Two—putting people first becomes especially critical in primary care. This involves understanding individual concerns and experiences to facilitate holistic medicine, which incorporates a patient’s physical, emotional, and social situation in their care treatment.
4. Coordinated care – Dependent on the support of a multitude of services and resources, primary care acts as a hub from which care can be coordinated and navigated, reducing fragmentation and complexity for the patient. Since primary care is often considered the “hub of regionalized services” (Starfield, Shi & Macinko, 2005, p.457), it is seen to provide a gate-keeping function to specialised services.

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<sup>12</sup>Shortly before her death in 2011, when asked if ‘patient-centredness’ should be included as a 5<sup>th</sup> ‘C’, Starfield replied, “if you provide care that is accessible, comprehensive, coordinated, and with good continuity, then it will be patient-centered” (Stange, 2011, p.293).

In addition to Starfield's 4 Cs, 'coverage' can be added since widespread coverage improves population health (provided there is universal access), especially when tied to quality of services via audit and research activities (Starfield, 2004).

### **3.2.3 The primary care team in Scotland**

Primary care services in Scotland constitute "services provided by health professionals in either clinics and practices, or sometimes in a patient's home" (Robson, 2011, p.4) and can be accessed directly via self-referral. Approximately 90% of patient contact in Scotland is conducted in primary care as 1) it is typically the first point of NHS contact for patients and 2) primary care professionals act as 'gatekeepers' to secondary and tertiary services (Robson, 2011, p.4). Used loosely within the NHS, the term 'primary care' generally refers to GPs (also known as general physicians or family physicians) and their teams (Lewis & Dixon, 2005). To accommodate the wide range of health problems, these teams include a number of professionals beyond the GP including: nurse practitioners, nurses, health assistants and administrative staff (e.g. receptionists and practice managers). Beyond the typical GP practice staff, additional professionals affiliated with primary care include: health visitors, physiotherapists, dieticians, pharmacists, dentists and podiatrists. While receptionists and practice nurses are employed within general practice, health visitors and district nurses (though frequently attached to practices) are employed by the NHS.

While each player is vital to the overall functioning of a primary care team, this research focuses on general practice and, more specifically, the role of the GP. Particularly within the UK, GPs represent the professional group with the most power and status within the primary care team. This power and status stems from their high level of education and remuneration in comparison to other members of the team (e.g. nurses and health assistants), in addition to their negotiating power as it relates to the GP contract (an item that will be discussed in further detail below). Within Scotland, most GPs contract with the NHS—and therefore are not direct salaried employees—to work in Scottish practices. As of September 2015, there are approximately 4,938 GPs working in Scotland, comprising 42% male and 58% female GPs (ISD Scotland, 2015).

### 3.2.4 The role of general practitioner

From a patient's perspective, the GP's role is two-fold: to serve as an "interpreter and guardian at the interface between illness and disease" and "as a witness to the patient's experience of illness and disease" (Heath, 1995, p.26). The first aspect relates to Starfield's concept of continuity, wherein GPs often see patients through many years of significant life events including major and minor forms of illness and disease (Heath, 1995). This places GPs in a unique situation to assist patients in making sense of what they are going through (Heath, 1995). Furthermore, a relationship of solidarity is potentially afforded between GP and patient as the former witnesses the latter's suffering.

Parallel to these roles are those of 'health system navigator' and 'gatekeeper'. This is because individuals typically interface first with primary care (another aspect of Starfield's 4 Cs), necessitating assistance and guidance from the GP for accessing secondary and specialist services (often via a referral)<sup>13</sup>. These specialist services may fall outwith the health care system (i.e. social care and housing), thus orienting the role of primary care and the GP within the wider system of health and its social determinants. Due to the complexity of both the health and social care systems, GPs are often needed to act as 'navigator' in helping patients chart health and broader systems.

An additional role, not often acknowledged in the literature—but a central focus of this research—is that of patient advocate. First recognised by Virchow over a century and a half ago and later on by Sigerist in the mid-20<sup>th</sup> century, the advocacy role, according to Heath (1995), "underpins all else" (p.42) because the GP has a "wider social and political responsibility to speak out on behalf of the most needy and least heard" (p.42). However, the extent to which individual GPs accept and actively take on this role is unclear and is a key issue to be explored in this research.

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<sup>13</sup> Access to unscheduled care (e.g. A&E and hospital services), however, is not typically controlled via a GP 'gatekeeper'.

### 3.3 Primary care practice in Scotland

#### 3.3.1 Historical foundations of primary care in the UK & Scotland

Historically, primary care in the UK (during the 19th century) was paid for according to what patients could afford, and the Poor Law designated that charitable and state-funded arrangements help the destitute. Risk pooling (as a payment mechanism) was first established with David Lloyd George's *National Health Insurance Act of 1911* (The National Archives, n.d.). However, this was limited to compulsory insurance for workers and did not provide coverage for their families (or those out of work). The subsequent *National Health Insurance Bill of 1928* included minor reforms, but did nothing to extend population coverage (finally achieved via universal coverage in *The National Health Service (NHS) Act of 1948*).

General practice, as a profession in Britain, emerged as the result of a “trade demarcation dispute” (Heath, 1995, p.26) during the 19<sup>th</sup> century, between surgeons and physicians (jointly), and apothecaries. Since then, the referral process (i.e. GPs acting as gatekeepers to secondary and specialist services) has been lauded as “one of the great successes of the British health care system” (Heath, 1995, p.26) and recognised for its general cost-effectiveness (according to the Commonwealth Fund's international ranking of health care systems) (Davis et al., 2014).

In terms of service provision, the first semblance of practitioner organisation occurred in 1912 when the Dewar Committee recommended the health service be run by the state as a way of addressing remote and rural access challenges in Scotland (Dewar Report, 1912). The Dewar Report suggested a more formalised structure to ensure the development and administrative coordination of public services provided an adequate financial base for general medical practices. This included the centralisation of services, local authorities were to “prepare a scheme of improved medical and nursing service for submission to the central authority” (p.36), and a guaranteed minimum income for “every medical practitioner recognised by the central authority” (p.37). Subsequently, the Highlands and Islands Medical Service (HIMS) was created the following year, putting into practice much of the Dewar Report's recommendations, including a basic income for doctors (Ournhsscotland.com, n.d.). State-provided health services for the rest of the UK would not come until later, with the creation of

the NHS in 1948. Spearheaded by the Minister of Health at the time, Aneurin Bevan, the NHS Act of 1948 entitled everyone to register with a GP, in general without duplication, and provided whole population coverage via the sum of thousands of clinic populations. This was a historical occasion in terms of health care access, as medical care would be free at the point of delivery, funded through general taxation. Additionally, independent contractor status was affirmed at the same time (i.e. GPs as contracted employees of the NHS versus salaried GPs employed directly by health boards), enshrining issues of engagement with GPs (Webster, 2002), which persist in contemporary general practice, and is resultantly a focus of exploration in this thesis.

At the start of the NHS, general practice was isolated and largely unorganised. In his 1950 report (commissioned to assess the overall quality of general practice in England), Collings described general practice as ‘bad’ and ‘deteriorating’ (Petchey, 1995; Webster, 2002). In particular, he described inner city practice as "at best ... very unsatisfactory and at worst a positive source of public danger" (Collings quoted in Petchey, 1995, p.311), identifying the need to explicitly outline the function of general practice amidst its ‘troubled’ state (RCGP, 2012a). Consequently, the year 1952 saw the creation of the Royal College of General Practitioners (RCGP). The intent was to provide an “academic body to support good standards of practice, education and research” (RCGP, 2012a, n.p.), thus supporting general practice as a profession.

### **3.3.2 General practice – 1960 into the 21<sup>st</sup> century**

By 1965 the need for change in general practice was clear; GPs threatened ‘mass resignation’ unless the NHS committed to a new GP contract (Lewis, 1998). Negotiations were dominated by income concerns, including a revision of the pay structure and “benefits of salary without moving to a salaried system” (Lewis, 1998, p.135). Two major outcomes of the 1966 GP contract were largely organisational—the increase in group practices (i.e. the decline of single-handed practices) and financial assistance (and incentivisation) to employ ancillary staff (Lewis, 1998). Perhaps another vital consequence of the 1966 contract was the persistence of professional autonomy for GPs, a key principle explored in the following chapter.

Since the 1966 GP contract failed to address the ‘content of general practice’, the following decade and a half was marked by inconsistency in practice leading to overarching concerns over cost and quality, as noted in the Government’s 1986 Green Paper, *Primary Care—an Agenda for Discussion* (Lewis, 1998). The follow up White Papers, *Promoting Better Health* (1987), and *Working for Patients* (1989) revolved around market-oriented services in the form of performance incentives to increase efficiency and patient choice (Ritchie, 2003). The result in the 1990 GP contract was a focus on capitation payments and a fundholding scheme wherein participating practices were given a budget to negotiate secondary care contracts and had the right to keep any savings. This scheme was meant to be an incentive for GPs to manage costs, but was ultimately abandoned in 1997 due to the unintended creation of a ‘two-tier system’ in terms of patient access, for fundholding and non-fundholding practices (Le Grand et al., 1998). However, another point of the 1990 contract remained—the use of financial incentives to perform various population health improvement activities—indicating the government’s attempt to exert managerial control over GPs (O’Dowd, 2013).

Post 1990 contract (and fundholding abolition), there was a shift towards improving partnerships between the Scottish Government and medical professionals, as outlined in the 1997 White Paper, *Designed to Care: Renewing the National Health Service in Scotland*. For primary care this meant the creation of Primary Care Trusts, operating under the direction of Health Boards, and their subsidiary Local Health Co-operatives (LHCCs). These LHCCs replaced the unsuccessful GP fundholding scheme and established networks of general practices. Another key change in 1997 was the inception of Personal Medical Service (PMS) Agreements, providing an alternative to General Medical Service arrangements (the standard contract) through local negotiations between the Health Board and practice (BMA.org, n.d.). These are known as ‘17C’ practices in Scotland and were initially piloted as a significant attempt to enable professional flexibility for practices to cater to local needs. PMS agreements continue to exist today, albeit with updates from the 2004 contract.

In attempts to further devolve power to local health services and ‘frontline staff’ as well as to establish greater links with local authorities and the voluntary sector, Community Health Partnerships (CHPs) were announced in 2003 as a replacement for LHCCs. NHS Boards were tasked with establishing CHPs roughly corresponding to council areas and were placed in

control of CHP funding according to specific provisions outlined in the *National Health Service Reform (Scotland) Act 2004*. In the original announcement Scotland's Health Minister at the time, Malcolm Chisolm, stated the intent of CHPs to foster partnerships between GP practices and hospitals in the provision of care "closer to home for those with chronic diseases such as diabetes, asthma and coronary heart disease" (Scottish Government Archives, 2003). Specific instruction as to the structure of CHPs or how they would function, however, was left to Board discretion, with the first CHPs operational in 2005.

### **3.3.3 Contemporary primary care practice in Scotland and the 2004 nGMS contract**

Presented in 2003 and introduced in full the following year, the UK-wide new General Medical Services (nGMS) contract was the culmination of 'prolonged' negotiations between GPs (represented by the British Medical Association's (BMA) General Practitioner's Committee) and the NHS Confederation (Audit Scotland, 2008). Building on the 1990 contract's financial incentives, the 2004 contract extended this approach to incentivise the mass delivery of interventions of proven effectiveness (including points on targeting and performance monitoring), with approximately 150 quality indicator targets (O'Donnell et al., 2011). As a result of the contract, there were several major changes including: the NHS contracting exclusively with practices (as opposed to individual GPs); the division of service provision into essential, additional, and enhanced services; the ability to opt out of out-of-hours work; and the introduction of the Quality and Outcomes Framework (QOF) (O'Donnell et al., 2011).

The resulting payment systems for general practice under the 2004 nGMS contract fall within three categories (adapted from Audit Scotland, 2008, p.8 and O'Donnell et al., 2011, p.36):

1. **Weighted capitation (i.e. the 'global sum')** – The global sum payment is given to all practices for the provision of 'essential services', i.e. those considered part of basic primary care services such as, first point of contact, home visits, referrals, and coordination. Immunisations, cervical screening, maternity services, and out-of-hours services are considered 'additional services' and are considered optional for practices; however, payment is reduced if practices 'opt-out' of these services. This constitutes

the largest portion of practice income and is supposed to reflect practice population needs (i.e. elderly patients and morbidity/mortality levels of the local area). However, McLean et al. (2015) recently challenged the extent to which this is adjusted for deprivation levels (and the corresponding multimorbidities).

2. **QOF payments** (i.e. ‘pay for performance’) – These performance measures are based on ~150 quality indicators including both organisational (e.g. staff-related training and patient satisfaction) and evidence-based clinical measures (e.g. 90% of patient population must reach a specified clinical target such as blood pressure at a particular level). Practices achieve ‘points’ based on these measures, which translate into variable payments according to the number of points achieved and weighted by population and disease prevalence. The intent of the QOF is to ‘incentivise’ high quality care within practices.
3. **‘Enhanced Services’ payments** – These optional services are considered separate from the ‘additional services’ under the global sum and are typically associated with more specialised care. They are categorised as ‘directed enhanced services’ such as flu and childhood immunisations, ‘national enhanced services’ chosen by the NHS board, or ‘local enhanced services’ targeted towards local needs such as alcohol and drug treatment and care for homeless people. Payment rates for the first two types are set nationally while NHS boards set the payment rates for local enhanced services.

Practices today operate under one of three contract types: the 2004 nGMS contract (known as a 17J contract), a 17C contract (i.e. PMS agreement) or a 2C contract, where the practice is directly employed by an NHS board. As of 2015, approximately 82% of practices operate under the nGMS contract, 13% have a 17C contract and health boards operate the remaining 5% of practices (2C contract) (ISD Scotland, 2015a). Additionally, 978 out of the 987<sup>14</sup> total practices in Scotland took part in QOF during the 2014/15 reporting year (ISD Scotland, 2015b). For 2014/15, the average number of QOF points achieved by nGMS practices was 645.4 out of a maximum 659 points. This resulted in an average QOF payment of £95,000 to nGMS practices (compared to £130,600 in 2013/14, a decrease which is primarily attributed to

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<sup>14</sup> The number of practices in 2015 decreased to 981 (ISD Scotland, 2015a)

the reduction in total points from 923 to 659) (ISD Scotland, 2015b). In terms of success, QOF has reached almost 100% engagement with practices in addition to developments and improvements in information gathering and team working; its impact on inequality, however, is considered later in this chapter.

### **3.3.4 Current structure of primary care in Scotland**

NHS Scotland<sup>15</sup> remains the primary state body for providing comprehensive health care services, ‘free at the point of use’, in Scotland. The ‘delivery of frontline healthcare services’ (e.g. primary care) and the responsibility for improving and protecting population health in Scotland, however, falls under 14 regional NHS Boards (NHS Scotland, 2014). The NHS Greater Glasgow and Clyde health board was established in 2006 as the union of NHS Greater Glasgow and NHS Argyll and Clyde and contains six CHPs including: Glasgow City CHP, East Dunbartonshire, West Dunbartonshire, Inverclyde, Renfrewshire, and East Renfrewshire. Figure 3.1 (Robson, 2011) is a comprehensive overview of the current organisation of the NHS in Scotland.

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<sup>15</sup> *The National Health Service (Scotland) Act 1978* provided the legal framework for NHS Scotland while health policy was devolved to Scottish Parliament in 1998 (Robson, 2011).



**Figure 3.1 Current organisation of the NHS in Scotland (adapted from Robson, 2011, p.6)**

In order to maintain the local planning and delivery of primary care and community-based resources, CHPs are intended to improve relationships between health and social care services (Robson, 2011). Since the majority of GP practices within Scotland are either on a nGMS or 17C contract, GPs remain independent contractors to CHPs and the corresponding NHS Board. While individual practices employ their own administrative and practice nursing staff, part of the team may include staff directly employed by the NHS, such as health visitors (Robson, 2011). Furthermore, it is important to note that the population registered to a GP practice may not all fall within the corresponding CHP (Tomlinson et al., 2008).

Beyond the structure outlined in Figure 3.1, there has been an increased focus on GPs and their teams to take the lead in the delivery of patient-centred care. Referred to as ‘integrated care’, this translates to “patient-centred, primary care led, delivered by multi-professional teams, where each profession retains their professional autonomy but works across professional and organisational boundaries to deliver the best possible health outcomes” (RCGP, 2012b, p.3). Suggested models for care integration place GPs at the centre to assist in the coordination and planning of patients’ care across health and social services (RCGP, 2012b). The integrated care agenda aims to improve continuity across services, with the ultimate goals of better health outcomes and quality of care and a reduction of health inequalities. In Scotland, this has been formalised in policy through the 2014 *Public Bodies (Joint Working) Act*. Individual Health Boards and Local Authorities have the discretion to determine how this is operationalised in practice, but effectively CHPs are replaced with Health and Social Care Partnerships. Within Glasgow, the integration scheme is being carried out via collaboration between Glasgow City Council and NHS Greater Glasgow and Clyde Health Board, resulting in the creation of a third body called the Integrated Joint Board (IJB) (2015). However, the overall impact IJBs have on GPs and the patients they serve has yet to be seen, given their recent acceptance of authority in April 2016.

### **3.4 The 'Deep End' of general practice**

#### **3.4.1 The challenge of working in areas of multiple deprivation**

Just as the relationship between socioeconomic deprivation and individual health is well documented, research has explored the impact social deprivation has on general practice (Popay et al., 2007). This includes research identifying how GPs working in areas of multiple deprivation face a number of challenges including increased workloads and inadequate resources to manage their patient lists (Carlisle et al., 2002; Goodwin et al., 2011; Mercer et al., 2012a; Mercer et al., 2012b; Norbury et al., 2010; Teljeur et al., 2010).

The increased workload of GPs working in areas of high multiple deprivation is evidenced through higher consultation rates, more out-of-hours calls, and shorter consultation times (for complex patients) (Carlisle et al., 2002; Mercer & Watt, 2007; Norbury et al., 2010; Teljeur et

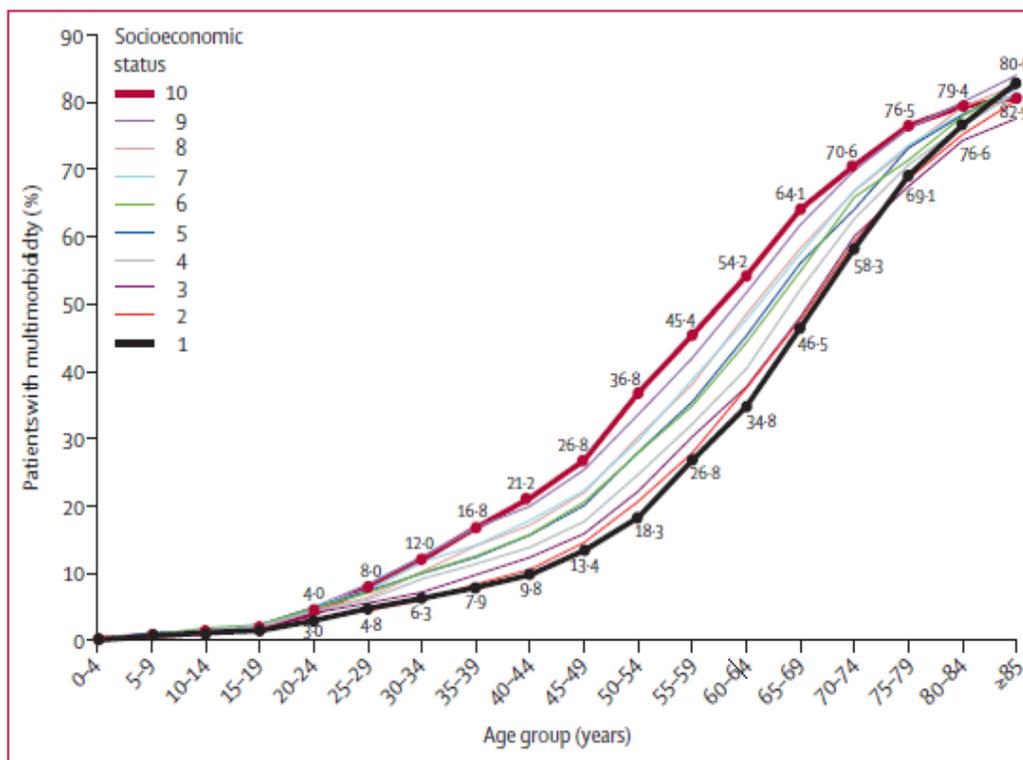
al., 2010). For example, the distribution of GPs in Ireland is viewed as relatively equitable on a per capita basis; however, practices in the most deprived areas have higher workloads and are seen as being ‘overstretched’ (Teljeur et al., 2010). Similarly, a study of two GP practices in Nottinghamshire found deprived areas to have 44% more out of hours contacts, 18% more surgery consultations and 28% more same-day consultations (Carlisle et al., 2002, p.43). GPs working within Scotland’s most deprived areas are no exception, with the findings of a RCGP Scotland Health Inequalities report citing lack of consultation time and lack of opportunity to provide anticipatory care, amongst other items, as issues that these GPs face (RCGP, 2010).

### **3.4.2 The complexity of primary care in deprived areas**

The challenge of working in Scotland’s most deprived areas is one of complexity. The problems of the experience of ill health in these areas is compounded by the problems of social deprivation including, for example, higher levels of unemployment, fewer financial and other material resources, and higher rates of addiction. Not only do individuals in these areas face poorer health outcomes than those in affluent areas, but also worse outcomes across the SDH such as income, employment, education, and housing. This complex interaction of the SDH means simply treating a patient’s illness may not be enough to improve health outcomes, especially given the influence socioeconomic, material, and political factors have in the contribution to poor health.

While the ageing population and rise in long-term illness and multimorbidities present a major challenge to primary care as a whole within the UK, this problem is exacerbated in the most deprived areas where multimorbidity begins at younger ages (Barnett et al., 2012; Mercer & Watt, 2007; Mercer et al., 2012a; Mercer et al., 2012b; Starfield, Gervas & Mangin, 2012). Defined as having two or more chronic disorders (Ravenscroft, 2010; van den Akker et al., 1996), multimorbidities in affluent areas are typically seen in ageing populations (Salisbury, 2012). However, the 2007 cross-sectional data, displayed in Figure 3.2, shows that young and middle-aged adults in the most deprived areas of Scotland had multimorbidity rates equivalent to individuals 10-15 years older in the most affluent areas (Barnett et al., 2012). Compounding the effects of deprivation, these individuals are also more likely to have mental illness, such as depression or anxiety, as one of their chronic disorders (Goodwin et al., 2011; Jani et al., 2012; O’Brien et al., 2011; O’Dowd, 2014). According to Barnett et al.’s (2012, p.39) cross-

sectional study, mental illness was almost twice as likely in the most deprived decile compared to the most affluent decile, with depression particularly common. This creates a more complex caseload in terms of both physical and mental disorders for GPs working in areas of multiple deprivation than their counterparts in affluent practices. Additionally, O'Brien et al.'s (2011) qualitative study of GPs and practice nurses working in areas of high socioeconomic deprivation describes the personal difficulties that both their patients, who suffer from multimorbidity, face and the struggle they face, as professionals, in supporting the patients. Ultimately, they identified the need to take a holistic approach to better help patients who have multimorbidities in deprived areas by taking the physical, psychosocial, and social problems into context. Of course, whether or not GPs have the time or other necessary resources to effectively take a holistic approach when working with their most complex patients is unclear and a key focus of this research.



**Figure 3.2 Prevalence of multimorbidity by age and socioeconomic status (scale of 1=most affluent and 10=most deprived) in Scotland, cross-sectional data from 2007 (Barnett et al., 2012)<sup>16</sup>**

Another challenge GPs working in areas of multiple deprivation face is coordination with secondary care and other services (both in and outwith the NHS). With the rise of specialists in health care, health systems such as Scotland's have become inflexible and fragmented, often focusing on a single disease (Aspin et al., 2010), e.g. a patient seeing separate specialists for diabetic care, hypertension, and asthma. This can largely be attributed to the research agenda in primary care wherein clinical evidence supporting interventions focused on multimorbidity—particularly in younger patients and/or in conjunction with the effects of deprivation—is limited (Smith et al., 2013). Thus, an 'individual disease approach' (Barnett et al., 2012) can be inefficient and duplicative, making it easy to ignore those with multimorbidities in the most deprived areas (Stange, 2009). Within a fragmented system, it becomes easy for individuals to fall through the cracks, especially if they are struggling with

<sup>16</sup> Permission to reproduce this figure has been granted by Richard Horton, editor of *The Lancet*

multiple illnesses, and lack the motivation, skills or resources to negotiate multiple points of care. Individuals with multimorbidities have been shown to receive less continuity of care, further marginalising those that also experience deprivation (Salisbury et al., 2012).

Additionally, addressing needs associated with multiple deprivation dictates that GPs have strong links with external social services and resources. In reality, poorly coordinated health and social care means that GPs may not have up-to-date knowledge on local services (Popay et al., 2007) or the time to adequately address these needs. Since time is the “real currency of general practice” (Hart quoted in Smith, 2002), GPs working in areas of multiple deprivation are forced to cope with increased need by shortening consultation times and working longer hours. Given the patient complexity these GPs work with, increased consultation time and improved coordination between health and social services is seen as vital to these areas.

### **3.4.3 ‘General Practitioners at the Deep End’**

While health inequalities have been widely recognised in Scotland since the end of the 20<sup>th</sup> century, action to mitigate and prevent them has been slow and inadequate (as indicated in the previous chapter). Indeed, amidst the increased prevalence of health problems in the most deprived practices (which are largely geographically concentrated), the distribution of GP workforce has remained relatively flat across the socioeconomic gradient (Deep End Report 1, 2009; Mackay, Sutton & Watt, 2005), i.e. GP resource does not adequately increase with the increased need in very deprived areas. Recognising these challenges, the group ‘General Practitioners at the Deep End’ formed in 2009 as an informal network of practices, led by a steering group, with academic, RCGP and Scottish Government Health Department (SGHD) support. The constituency of the Deep End group is the 100 most deprived general practices in Scotland, based on the proportion of their patients with addresses in the 15% most deprived Scottish datazones (Watt, 2011) (there is variable involvement from each individual practice). The initial meeting of the group involved 63 GPs from across these practices (in addition to the inclusion of GPs from remote and rural areas) and for the first time in the history of the NHS the meeting provided a means by which GPs could share experiences related to the challenges of primary care in areas of severe multiple deprivation (Deep End Report 1, 2009). Since then, with both academic support (from the University of Glasgow) and financial and in kind support (varying from the SGHD, RCGP, the Glasgow Centre for Population Health

(GCPH) and the Glasgow Local Medical Committee (LMC) Office), the Deep End group has produced 28 reports which have addressed various issues including, raising awareness around what is needed to address the inverse care law, proposals related to integrated care between primary care, secondary care and social services, and finally, patient advocacy for people living in severely deprived areas.

An overwhelming majority of the Deep End practices are located within the Greater Glasgow and Clyde NHS Board (86 of the 100 as of 2015 figures) (Table 3.1); the rest of the 100 most deprived practices are located throughout Scotland. The Ayrshire and Arran Health Board have the second highest number of most deprived practices at 5, followed by Lothian (4) and Tayside (4).<sup>17</sup> Given the socio-spatial patterning of deprivation within Glasgow (and high concentration of Scotland's most deprived 20% around its urban centre, as highlighted in Chapter Two), it is unsurprising that almost 90 of the 100 most deprived practices in Scotland are located there.<sup>18</sup>

**Table 3.1 Distribution of Deep End practices by NHS Board for 2015**

<b>NHS Board (Name)</b>	<b>Count</b>
NHS Ayrshire and Arran	5
NHS Greater Glasgow and Clyde	86
NHS Lanarkshire	1
NHS Lothian	4
NHS Tayside	4
<b>Total</b>	<b>100</b>

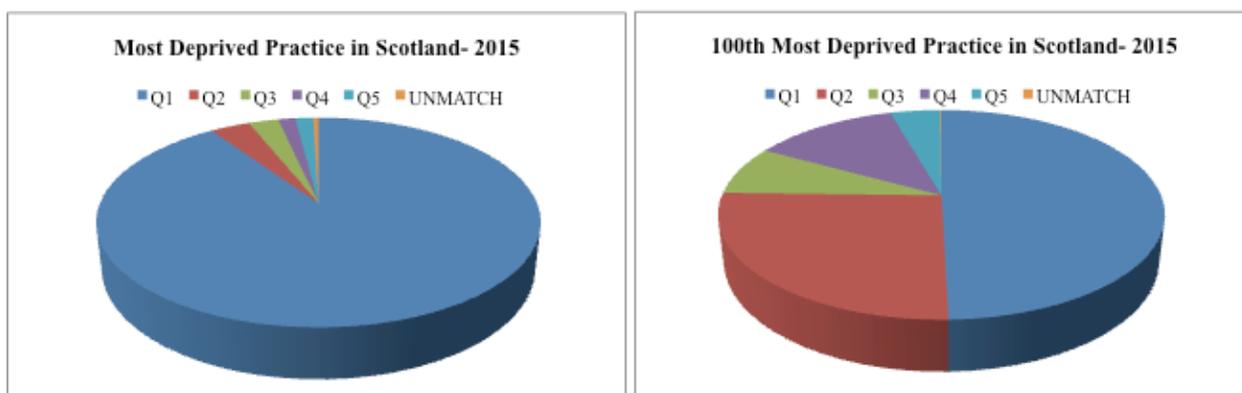
(Created 05.2016 using data from ISD Scotland, 2015c)

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<sup>17</sup> Figures are according to the ISD Scotland data for 2015. Rank and patient population is variable from year to year

<sup>18</sup> Detailed description of geographical location, populations they serve for GGC and Lothian in Methods

The average percentage of practice patients living in datazones defined as the 15% most deprived is approximately 60%<sup>19</sup> for Deep End practices (ISD Scotland, 2015c); however, the actual makeup of the practice population varies considerably amongst the practices. For example, the ‘most deprived’ practice in Scotland (located in the Greater Glasgow and Clyde region) has 87% of practice patients that fall under the most deprived 15%, whereas only 44% of the practice population in the 100<sup>th</sup> most deprived practice in Scotland (located in the Ayrshire and Arran region) fell into the most deprived 15%. The patient makeup of these respective practices is broken down in Figure 3.3. From this we see that Scotland’s most deprived practice serves primarily patients from the first quintile (most deprived) whereas the 100<sup>th</sup> most deprived practice serves a much more diverse patient population across all five quintiles.



**Figure 3.3 Patient makeup of most deprived and 100<sup>th</sup> most deprived practices in Scotland by quintile, where Q1 is most deprived and Q5 represents least deprived (Created 03.2015 using data from ISD, 2014)**

Furthermore, Deep End practices serve only roughly a third of people living in the 15% most deprived datazones (Watt, 2015). Considering the other two thirds are dispersed throughout the rest of the general practices in Scotland, two types of deprivation-related challenge arise—managing individual patients living in deprivation and managing concentrated deprivation, as found in Deep End practices (Watt, 2015). This ‘concentrated deprivation’ is what constitutes the challenge of working in a Deep End practice.

<sup>19</sup>According to the 2009 SIMD Version 2

### 3.4.4 The 'Deep End' as critical case

The Deep End group can be seen as a critical case (i.e. “having strategic importance in relation to the general problem” (Flyvbjerg, 2006, p. 229) when examining the potential role of tackling health inequalities via primary care. In particular, Deep End GPs are an important group to study for several reasons including, but not limited to: the unprecedented nature of the group (i.e. the Deep End as an organisational entity), the necessity to address health care need at the bottom of the socioeconomic gradient, their organised health and socio-political advocacy for the most deprived areas in Scotland, and finally, the opportunity for experience and knowledge sharing exchange and innovation both between practices and with other parts of the health system.

The convening of GPs for deprived practices in an informal, yet organised manner is unprecedented in the history of the NHS. While existing organisations—such as the BMA and RCGP—tend to represent practitioners’ professional practice interests, the Deep End group presents an opportunity to represent the needs of the deprived populations they are working with. This has the potential to depict a needs-based approach wherein if health care is not at its best where needs are greatest, the net effect is a widening of health inequalities. Unlike practices that may have some ‘pockets’ of deprivation, Deep End practices deal with more widespread, highly concentrated deprivation. Thus, improving health at ‘the bottom’ can positively impact on tackling the health of the most disadvantaged.

While the Deep End group represents GPs working in areas of severe multiple deprivation, solutions to the challenges they are faced with ultimately have wider implications as many practices outwith the Deep End have a mix of patients across all deprivation quintiles. By lobbying on behalf of the ‘client’ interests, the Deep End group exemplifies Sigerist’s view of GPs as advocates (although not all members take on an advocacy role), and can also be seen as an extension of the ‘history of activism’ which Smith (2002) describes regarding other GP organisations such as the LMC and RCGP in his oral histories of Paisley GPs. Given their professional authority, Deep End GPs provide a unique perspective on what is really going on at the bottom of the gradient, but in general there is a shortage of evidence on the delivery of health care in deprived areas and on patients with multimorbidity. Consequently, the Deep End provides unique insight on the experience of working in areas of severe deprivation and

high multimorbidity yet little is known about how Deep End GPs view this advocacy role (beyond ‘gatekeepers’ and ‘navigators’).

### **3.5 The potential for improving population health via primary care**

Broadly defined as “the health outcomes of a group of individuals, including the distribution of such outcomes within the group” (Kindig & Stoddart, 2003, p.380), population health is the culmination of a wide array of determinants. Importantly, this extends beyond health outcomes and patterns of health determinants to include the “policies and interventions that link these two” (Kindig & Stoddart, 2003, p.380). Consequently, improving population health is not as simple as changing health behaviours, but requires the support of organisations and services (both within and outwith health care), communities, and wider structures and policies.

Public health in the 1970s saw increasing concern for the distribution—not just aggregate levels—of population health in a society (Munthe, 2008). This spurred actions directed towards empowering disadvantaged groups and individuals. Around the same time, the WHO’s Alma-Ata Declaration (1978) decreed that primary health care be ‘universally accessible’. The central idea behind empowering disadvantaged groups and universally accessible health care is to afford individuals the opportunity to achieve health (which does not dictate that everyone will achieve the same health outcomes). However, Graham and Kelly (2004) suggest primary care can only address certain determinants. This is because intermediary factors such as work environment and health care access may be easier to address than changing an individual’s social position (although public health may play an advocacy and lobbying role in this). Subsequently, access to health and care services only plays a minor—albeit potentially significant—role in determining population health (and health inequalities as noted in the previous chapter) (Alderwick, Ham & Buck, 2015). Understanding the potential for improving population health via primary care generally stems from the increasing public health focus in primary care.

#### **3.5.1 The public health role in primary care**

Historically, the main domain for primary care has been clinical medicine, focusing on disease self-management skills and improving patient health through the delivery of high quality

patient-centred care (Showstack et al., 2003). There has since been a shift towards public health interventions provided through primary care. Since the 1960s, various public health measures have been introduced via general practice, using financial incentives in primary care to improve clinical care and to achieve high levels of coverage for immunisation and cervical screening. There has also been a push to orient care around local populations (through collaboration between neighbouring practices) as a means of improving population health (Smith et al., 2013; Thorlby, 2013).

During the 1970s, Hart identified the need to encourage GPs to become involved in population health management, stating, “The profession has a minority of doctors who seek to conserve health in populations rather than restore it in sick individuals” (in Thorlby, 2013, p.6). At the time he identified these doctors as being in the ‘periphery’; however, the shift towards preventive medicine is such that primary care is moving away from its traditional “purely curative and reactive” (Thorlby, 2013, p.6) role. Starfield (1998) suggests this involves orientating primary care services for communities’ needs (and individuals therein) to align closer with the Alma-Ata version of primary health care. This includes focusing not just on individuals and family care, but also the wellbeing of local populations and the distribution of health within populations (Thorlby, 2013). To meet population health goals, Smith et al. (2013) suggest the merging of individual’s treatment of illness and injury with proactive public health work in communities. In practice this means public health activities (e.g. immunisation and smoking cessation programmes) delivered through primary care as a way of improving population health, although not necessarily a way of reducing health inequalities.

### **3.5.2 Population health interventions**

In its approach to population health, primary care has the potential to operate at different levels of the health system. Starfield (2003) highlights this difference by describing public health and primary care approaches to population health in terms of intervention types within health care and their target recipients (Starfield, 2003). Health interventions target one of three levels:

1. Primary – to prevent a problem from occurring e.g. health education and promotion (both within and beyond the NHS), immunisation

2. Secondary – intervention a stage before health problem is manifested e.g. health screening
3. Tertiary – remediation to reverse manifestations of health problem e.g. treatment of disease

The traditional scope of public health lies in primary prevention—including health promotion, protection, and risk reduction (including both in and outside of the NHS)—and secondary prevention services such as health screening and health education (Starfield, 2003). This is not to say that public health does not extend beyond the health sector; the roots of public health in the first wave and the influence of the SDH demonstrate the intersectoral nature within public health, wherein the scope extends into non-health sectors such as employment and housing. Primary care overlaps in the primary and secondary intervention areas as they promote health and administer screening. This shift of public health action within primary care is particularly effective within universal health care systems as primary care has access to whole populations.

A major difference between public health and primary care is the ‘target’ recipients and whether these are defined as individuals or groups (Starfield, 1996). As a first point of contact within a health system, primary care’s duty remains attending to an individual patient’s problems. However, primary care within Scotland (and other universal health care systems) does enable a certain degree of population planning. This allows GPs to take a more proactive approach to population health by not only providing care for individuals already attending appointments, but potentially looking after the health of individuals who are registered but not regularly attending GP appointments (Goodwin, et al. 2011; Thorlby, 2013). For example, GP surgeries send screening notification letters (e.g. cervical exams) to their registered lists, thereby targeting patients who might not have otherwise made an appointment.

### **3.5.3 Specific examples in Scotland**

Population interventions related to primary care within Scotland can be distinguished as, population health approaches to clinical care and incentivised population programmes. QOF is a representation of the former, and can be initially linked back to Hart’s pioneering work in Glyncoirwg, Wales: taking blood pressure measurements for all his patients as a means of monitoring and reducing disease mortality. At the time, Hart was somewhat of a pioneer in his

population approach (i.e. public health approach) to blood pressure ascertainment, and did so, through continuity of care, for close to 100% of his patients. Today, QOF is a means of providing practices with incentives for meeting targets related to disease, for their registered patient populations. Part of the intent behind QOF was to provide a certain clinical standard across the population by reducing clinical practice variations and (ideally) reducing health care inequalities (Hutt & Gilmour, 2010). Consequently, QOF contains specific clinical indicators for certain diseases or illnesses such as ‘the percentage of patients with hypertension in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less’. The corresponding achievement threshold varies by indicator, but usually is around 90% to achieve maximum points (i.e. 90% of hypertensive patients’ last blood pressure reading would be 150/90 mmHg or less would dictate full points for that indicator).

While QOF has been shown to improve recording of population health data (Ashworth et al., 2008; Doran et al., 2008), the potential negative impact on health inequalities has been highly debated (Ashworth et al., 2008; Doran et al., 2008; Starfield, 2008). One of the main reasons QOF might negatively impact on health inequalities is due to the high burden of disease and multimorbidity in deprived areas (Hutt & Gilmour, 2010), since QOF primarily focuses on diseases in isolation. Other concerns with QOF from a population health perspective include the potential ineffective management of population care by allowing practices the ability to ‘exempt’ patients from disease monitoring (Hutt & Gilmour, 2010) and the potential reduction in quality of care in non-incentivised areas (Steel et al., 2007). Furthermore, targets aimed at reaching 90% of a defined clinical population mean that potentially 10% of that population (which often includes those having difficulty with service engagement) will essentially be ignored, a consequence which further widens health inequalities. Finally, since the effectiveness of population management of disease via QOF rests on the participation of individual GP practices, it is important to understand GP's attitudes and views on the framework. This is further examined in the subsequent chapter.

As previously noted, the 2004 nGMS contract provided means for incentivised population care in the form of ‘additional services’ under the global sum (e.g. cervical screening) and ‘directed enhanced services’ such as flu and childhood immunisations (although ‘fee for service’ for cervical screening and immunisation existed prior to the 2004 contract). Both types of services

are considered optional for practices, though there is a payment penalty if practices opt-out of ‘additional services’. Additionally, public health initiatives, such as Keep Well, have been bolted onto practices. Funded by the Scottish Government, Keep Well was a prevention programme implemented by local NHS Boards between 2006 and 2014. The aim was to aid in reducing Scotland’s health inequalities through ‘anticipatory care’ in the form of targeted health checks. In particular, the link between cardiovascular disease (CVD) and socioeconomic status was of particular concern, thus the programme targeted adults aged 40-64 (45-64 initially) years living in areas of high deprivation, with increased CVD risk factors. However, a rigorous academic evaluation proved insufficient evidence to determine Keep Well’s impact on reducing health inequalities (NHS Health Scotland, 2014).

### **3.6 The potential for addressing health equity via primary care**

A main role of health care services—as highlighted in Chapter Two—is to reduce the severity and delay progression of disease (Starfield, 2004). While health care services are simply one determinant of health (and not necessarily the most effective at *preventing* health inequalities), primary care has been praised for its role in promoting equity<sup>20</sup> (Rasanathan et al. 2011; Starfield, 2011; Zere et al., 2007). Compared to secondary and tertiary care, primary care “is associated with a more equitable distribution of health in populations” (Starfield, Shi & Macinko, 2005, p.457). This is largely due to its point of first contact within the health system (Starfield, Shi & Macinko, 2005) in addition to its “preferential benefit to the socially disadvantaged” (Starfield, 2011, p.2) as they have the most to gain from universal coverage. Within primary care, GPs are seen as particularly “well positioned to have a positive impact on health inequalities at a number of levels” (Hutt & Gilmour, 2010, p.5) in several ways including: their patient-centred approach, their potential advocacy role, their ability to take a population health approach, their potential for addressing non-health issues, and their potential for utilising a ‘proportionate universal’ approach.

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<sup>20</sup> Equity, as Chapter One highlighted, seeks to minimise “avoidable inequalities in health” (Zere et al., 2007, p.3) and the associated determinants.

Addressing health inequalities through primary care, however, is not necessarily about improving the quality of care. This is in line with what Stange and Ferrer (2009) refer to as a ‘primary care paradox’ wherein GPs in general provide poorer quality of care related to specific diseases than specialists do, but still remain associated with overall higher values of health and greater equity at a lower cost. This can be attributed to the idea that ‘generalism’, defined by the RCGP as “demonstrating concern not only for the needs of the presenting patient, but also for the wider group of patients or population” (RCGP, 2012c, p.7) is more holistic and integrated within a broader conceptualisation of health. Subscribing to this ‘generalist’ approach promotes relationship-centred, whole person care (Hutt & Gilmour, 2010; Norbury et al., 2011; Stange & Ferrer, 2009) and has the potential to be more community-based while supporting patient advocacy.

As potentially “the natural advocates of the people” (Sigerist, 1941 as quoted in Watt et al., 2012, p.14), the position of GPs is conducive to contributing to addressing inequalities because of their role in the delivery of primary health care (Blane & Watt, 2012; Hull, 2010; Hutt & Gilmour, 2010; Marmot, 2010; O’Donnell et al., 2011; Starfield, Shi & Macinko, 2005). As Robin Downie (as quoted in Heath, 1995) states, “doctors have a duty to speak out on broad issues of health, as for example they might speak out against cigarette advertising or cast doubt on the feasibility of medical services in the event of a nuclear attack” (p.42). GPs working in deprived areas have a particular responsibility, according to Heath (1995), to serve as an advocate for those whose health is affected either by chronic disease or adverse life circumstances. The way GPs interpret or take on this advocacy role will vary, ranging from calling specialists directly on behalf of a patient to writing benefit letters, and is one of the areas this research aims to illuminate.

Continuity in primary care means that GPs are ideally situated to acquire an intimate knowledge of their patients’ lives (Heath, 1995). This is particularly salient in the context of GPs working in very deprived areas as they repeatedly witness the complex social issues (e.g. unemployment, homelessness, poor housing, and poverty) their patients face. Heath (1995) maintains this places GPs in a position to contribute to research regarding the links between health and social conditions including which social changes may potentially improve the patient’s health. In a similar thread, Bambra (2010) advocates for the involvement of GPs in

welfare services via “successful social inclusion and a health return to work” (p.4). Practicing patient-centred, holistic care demands that GPs, particularly those working in deprived areas, must acknowledge and address the complexity of patients’ lives. Consequently, this provides scope for GP encounters to extend beyond non-health issues.

Aside from strengthening individuals via knowledge and empowerment with regards to their health, primary care’s role in tackling health inequalities operates largely under the mechanism that improved access to healthcare mitigates (rather than prevents) health inequalities. For example, studies in the US (where there is not a universal health care system) show that a sufficient supply of primary care physicians reduces health inequalities associated with race and socioeconomic status (Starfield, Shi & Macinko, 2005). This equity role can be attributed to primary care’s position within the wider health care system, providing the most comprehensive access to a population’s health (Goodwin et al., 2011), an attribute which enables population-wide interventions. Within the UK, GPs are largely depended on to undertake public health interventions such as population-based screening and immunisation programmes (RCGP, 2009). Due to the universal nature of the NHS, GP lists largely reflect the ‘whole’ population, positively positioning primary care to address health inequalities.

From a UK context, universal primary care coverage has been in existence since 1948. While this has certainly impacted on overall population health, the fact that the most deprived groups in Scotland suffer from worse health than their wealthy counterparts indicates that universalism is not enough to reduce health inequalities. This entails Graham’s (2004) focus on the gradient (from Chapter Two) and “how health is distributed across society” (Graham, 2004, p.126) to address this inadequate focus on the most deprived areas. This implies that universal health coverage (including Scotland’s primary care, in its current state) on its own is insufficient; rather increased efforts *proportionate* to need are required in order to impact on the health gradient. As part of the NHS that has regular and continuing contact with the most deprived part of the population, primary care is an ideal avenue through which to strengthen efforts towards mitigating the existence of poor health and reducing health inequalities via ‘proportionate universalism’.

### 3.7 Who determines health care 'need'?

Proportionate universalism, as highlighted in the previous chapter, can be seen as the union between targeting and universalism. On one end of the spectrum targeting dictates that means-testing (or some other indicator) determines eligibility for services (Mkandawire, 2005). Universalism lies at the other end and requires that the population has access to “the same range of (good quality) services according to needs and preferences, regardless of income level, social status, or residency” (WHO, 2008, p.12). In contrast to the all or some mentality of these concepts, proportionate universalism is more complex as resources must be proportionately allocated to meet disadvantage and need. Accordingly, it becomes necessary to define ‘need’ in order to achieve an allocation of resources based on this requisite. After all, the goal of most health care systems is to provide “good health care based on need” (Harrison et al., 2013, p.567); therefore, if needs are not systematically defined and/or measured then needs-based allocation may actually widen health inequalities.

While there is limited academic discourse on what is meant by ‘need’ (Harrison et al., 2013), Bradshaw’s (1972) ‘taxonomy of need’ has become a convenient way of conceptualising health care need (Ward, 2009). Within his classification, Bradshaw distinguishes four types of need: normative, felt, expressed and comparative (Bradshaw, 1972, 1994; Harrison et al., 2013; Ward, 2009). ‘Normative needs’ are those defined by an ‘expert’, which in this case can be seen as a GP or other health care provider. A criticism of this type of need is that it can be an elitist, paternalistic approach that ignores individual autonomy to define own need (Harrison et al., 2013).

The second type takes into consideration what individuals feel they need (i.e. similar to want) and is defined as ‘felt need’. While important in democratic societies, this may not adequately measure need since it is based on individual perception (Harrison et al., 2013), which may also be culturally determined (Dixon-Woods et al., 2005). Additionally, if an individual is unaware that a health care service is available, they may not feel need that is actually present (Harrison et al., 2013).

‘Expressed need’ is the third type and is seen as service utilisation, i.e. ‘felt need’ is turned into action, and action is expressed through service demand. This type of need poses the

problem that not all needs result in demand (i.e. not all individuals with ‘felt need’ seek out services) (Harrison et al., 2013, Ward, 2009).

The final type of need is ‘comparative need’ and is determined by examining characteristics of individuals/groups who receive a service, then comparing them to individuals/groups with similar characteristics who do not receive the service. Those who do not receive the service are identified as having a ‘need’. Bradshaw (1994) explains ‘comparative need’ is essentially about equity; using this process at a population level assists in identifying inequalities in health service provision (Harrison et al., 2013). Furthermore, GPs within Scotland have the potential to identify ‘comparative need’ within their individual practice populations, demonstrating their role in promoting health equity.

Some health economists have been wary of the use of ‘need’—perceiving it to be an ‘emotive word’—and instead prefer words such as demands, wants, and preferences (Harrison et al., 2013; Mooney, 2003). Thus, public health needs assessments focus on outcomes in the prioritisation of resource allocation (Harrison et al., 2013). From this perspective, health needs are seen as the capacity to benefit from health care (Harrison et al., 2013). This method, albeit rather narrow and medically-minded, places an emphasis on outcomes. This strategy is potentially problematic as it fails to acknowledge the need of individuals who might not benefit or do not have the capacity to benefit (e.g. if no known treatment exists) (Harrison et al., 2013).

Given the finite nature of health care resources “capacity to benefit will always be larger than what can be provided” (Harrison et al., 2013, p.577). Consequently, health care needs are prioritised and rationed. Within Scotland, this rationing means that GPs act as gatekeepers to ensure efficiency within the health care system, a function that only works with trusted relationships between GPs and their patients. This commodification of health increases expressed need/demand, as explained by Hart (2006, p.7):

*So long as health care is distributed as a social gift, it can have limits set by a combination of public expectations and scientific knowledge, but as soon as it becomes regarded as a commodity, demand will rise to whatever the public can be worried into demanding.*

This demonstrates potential issues when meeting health care need in conjunction with demand. GPs are consequently placed in a discretionary role regarding need (and in practice, it is left to practitioners to assess what patient needs are and which to address). How they negotiate between patient needs and practice priorities is examined in the following chapter, and is a key focus of the research overall.

### **3.8 Conclusions**

Primary care in Scotland has become a ‘hub’ not just for regionalised medical services, but increasingly for social services in deprived areas as well; this is in line with the 1920 Dawson Report. Primary care is well suited to this centralised position largely due to its four key attributes—as identified by Starfield—of first contact, continuity, comprehensiveness, and coordination. Consequently, this supports the role of GPs as health system navigators, in addition to potential patient advocates, in understanding the impact of wider social determinants on an individual’s health.

While GPs have historically been contracted through the NHS to provide medical services, the current 2004 nGMS contract is evidence of the increased managerial control Health Boards have in relation to GPs through incentivised delivery of interventions and performance monitoring via targets. How this affects individual GP autonomy and discretion is important to understand and is consequently a main focus of the next chapter. Thus far, government initiatives, including the contract directed QOF and prevention programmes such as Keep Well, have had minimal (if any in the instance of QOF) impact on tackling health inequalities (Dixon et al., 2011; NHS Health Scotland, 2014).

Socioeconomically deprived areas bear the burden of Scotland’s persistent health inequalities, with GPs working in these areas struggling to meet demand with the resources available. This is because the patient caseload in very deprived areas is a complex mix of high multimorbidity (in terms of volume and intensity), often combined with the presence of mental health conditions and exacerbated by problems associated with social deprivation (Mercer & Watt, 2007). This means that individuals in deprived areas suffer greater illness at a younger age than those living in affluent areas, and often lack sufficient resources to participate more in

self-management of their individual health. As a result, GPs working in deprived areas face increasing time demands to adequately address the needs of a patient with a complex background and allow them to participate in decision-making about their own health. In response to this growing concern, a number of GPs, working in the 100 most deprived practices of Scotland, have convened to both shed light on the challenges deprived practices face and identify potential solutions to address them. Individual GP engagement with the Deep End group has not been comprehensive across all 100 deprived practices, with a large participation coming from the Glasgow region (where ~86 of the 100 most deprived practices are located). Thus, a key question for this research is to explore the extent to which the group has garnered government attention and its potential to positively influence policy in support of deprived areas.

Various reports from the King's Fund (including Hutt & Gilmour's (2010) "Tackling inequalities in general practice" and Goodwin et al.'s (2011) "Improving the quality of care in general practice") identify the potential for both primary care and GPs to positively impact on health inequalities. Additionally, the Deep End position on narrowing health inequalities is that GPs working in very deprived areas can contribute by increasing the volume, range, and quality of care they provide for patients. This, of course, is subject to individual GPs' level of engagement both within their practice and the wider community. Furthermore, minimal research has been conducted as to how GPs themselves view their potential role in tackling health inequalities, including whether or not they view themselves as 'advocates for the poor'. This is particularly topical in the context of how GPs prioritise need with available resources (i.e. providing more consultation time to patients presenting larger 'need'). Within a universal health coverage context such as Scotland, the idea of 'unmet need' would not be expected. However, Scotland's health indicators suggest a different story, of a large degree of unmet needs concentrating at the bottom of the socioeconomic gradient. This indicates the importance of understanding the views and opinions of GPs working in the most deprived areas and subsequently involving them in policy decisions as they relate to primary care in Scotland.

# CHAPTER 4 Conceptualising the role of General Practitioner

## 4.1 Introduction

The primary goals of this thesis are to 1) explore the role of primary care—and specifically GPs—in tackling health inequalities and 2) capture the experience of GPs working in the most deprived practices of Scotland. Thus, the purpose of this chapter is to understand how GPs reconcile individual practice and policy goals in relation to health inequalities and to determine whether Lipsky’s street-level bureaucracy is a useful conceptual framework for understanding how they do so.

In order to accomplish this, Section 4.2 first provides an overview of Lipsky’s framework. This overview pays particular attention to the role of discretion and autonomy in frontline work (i.e. face-to-face work with clients) before outlining three main dilemmas that Lipsky argues street-level bureaucrats (SLBs) face. This section then describes the coping mechanisms street-level workers develop in order to deal with their demanding work environment. Next, Section 4.3 explores the application of Lipsky’s framework in health care, and in particular how GPs might function as SLBs. This review explores how the framework has been utilised to understand how GPs negotiate between “external, bureaucratic pressures to adhere to clinical guidelines and the professional practice of everyday patient care based on experiential, individualised knowledge” (Spyridonidis & Calnan 2011, p.395).

Following this overview of street-level bureaucracy and its application in health care, Section 4.4 assesses the applicability of Lipsky’s framework by exploring its relevance to GPs working in areas of high social deprivation and multimorbidity. It does this by first providing an overview of the concept of professionalism as it relates to GPs. Then, building on Lipsky’s three dilemmas, it extends the SLB debate by discussing three additional dilemmas unique to GPs. Having opened up Lipsky’s framework, Section 4.5 subsequently explores whether there is a need to look beyond the SLB framework in order to properly conceptualise the work of GPs. This is followed by a focus on multiple identities by borrowing from the literature on

professionalism, an examination of the ‘social construction of patients’, and, finally, what the scope is for GPs to address health inequalities.

## 4.2 Street-level bureaucracy

In 1969, Lipsky coined the framework ‘street-level bureaucracy’ to understand better the experience of frontline workers and the dilemmas they face in delivering public services in the context of massive caseloads, inadequate resources, and ambiguous agency goals. In his examination of public service workers, Lipsky (1980; 2010)<sup>21</sup> defined SLBs as those “who interact directly with citizens in the course of their jobs, and who have substantial discretion in the execution of their work” (Lipsky, 2010, p.3). As workers at the frontline, SLBs’ actions establish the services ‘delivered’ by (or on behalf of) government and include public service employees such as social workers, teachers, police officers, and health care professionals. Some SLBs may be seen as ‘low-level’ workers, but this is not a stipulation and is in fact challenged when the framework is applied to GPs. Rather they are workers who interact directly with the individual needs of the people they serve. As a result of their direct contact with the public, they have “considerable impact on people’s lives” (Lipsky, 2010, p.3).

### 4.2.1 Discretion and autonomy

Discretion and autonomy are key characteristics featuring in Lipsky’s framework as SLBs have a considerable amount of discretion in the decisions they make regarding individuals and also have a certain level of autonomy from the organisational authority they work within. The nature of the decisions SLBs make is important in the sense that they are usually made in the moment and focused on the individual (Lipsky, 2010), as opposed to making a decision based on a comprehensive view of the population. Discretion, according to van Berkel (2014), has fundamental implications such that workers’ agency helps shape “how contextual influences determine the work they do and the decisions they make” (p.188). Thus it is important to understand both the nature and context of frontline work (i.e. the ‘space’ in which decisions

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<sup>21</sup> Lipsky’s, *Street-Level Bureaucracy: Dilemmas of the Individual in Public Services*, was first published in 1980 and re-released with a thirtieth anniversary expanded addition in 2010.

are made) as this provides insight into the implementation of public policy (Durose, 2011; van Berkel, 2014). Discretionary space provides SLBs the freedom to determine the sort, quantity, and quality of sanctions (Lipsky, 2010) and is particularly important in individual consultations as opposed to administrative processes. Furthermore, it allows frontline workers to provide “the choice and voice of clients” (van Berkel, 2010, p.451), although discretion is not always used to do ‘good’ on behalf of the client. Consequently, discretionary space is used to negotiate solutions and provide compromise between the organisational needs and that of the client.

This research is interested in how GPs use discretion in adherence/noncompliance to bureaucratic guidelines. Tummers and Bekker’s (2013) study of Dutch mental health care professionals provides insight into the underlying motivations of SLBs. They maintain that discretion increases SLBs’ willingness to implement a policy, but only if there is perceived meaningfulness for clients. Specifically, if a SLB perceives a policy to be beneficial for a client, the more likely they are to implement it. However, this operates under the assumption that SLBs want to make a difference in their clients’ lives when implementing a policy, which may not always be the case. In the example of Tummers & Bekker’s (2013) research, however, the more useful they perceived a reimbursement policy to be for patients, the more likely they were to follow it.

The levels of discretion SLBs experience within the same policy, however, will vary according to knowledge of the policy, how the policy was operationalised, and the individual personality of the worker (for example if they are a ‘rule-following’ or ‘rebellious’ worker) (Tummers & Bekkers, 2013). Additionally, SLBs will prioritise what rules to apply differently given the specific circumstances they work in. This presents both positive and (potentially) harmful effects depending on the perspective. From a bottom up perspective discretion is positive in that it strengthens significance of the policy to the client by catering to the individual client’s needs (Tummers & Bekkers, 2013). As an illustrative example, a police officer may choose not to issue a traffic citation if the individual offers a valid (in the mind of the police officer) excuse for the violation. However, discretion may be potentially harmful from a top down perspective in the sense that different interpretation of the policy by the worker may prevent citizens from being treated equally (Tummers & Bekkers, 2013). In the

same police officer example, discretion opens up the possibility for bias in decisions (e.g. choosing who they issue citations to). This bias may contribute to stereotyping and client categorisation to quickly process their large and demanding caseloads, and is discussed further as a ‘coping mechanism’ in Section 4.2.3. Furthermore, frontline workers may enjoy carrying out decisions they have helped create; however, if the SLB perceives the policy as ineffective, they are less likely to implement it (Tummers & Bekkers, 2013).

The second characteristic of SLBs is the autonomy afforded in their role. In general, they have control over the decisions they make on an individual basis, within certain boundaries, and desire to both maintain and expand this autonomy. This, however, will vary depending on the underlying motivations of the SLB and their frontline role. For example, GPs have considerably higher levels of autonomy due to their independent contractor status (Chapter Three); the impact this has on their practice is not only discussed later in this chapter, but is also a key exploration of this research.

SLBs operate under both a professional and bureaucratic status, the latter dictating compliance with supervisors’ directives (Lipsky, 2010). Since bureaucratic goals overshadow the decisions SLBs make, supervisory guidance and feedback is often geared towards meeting these goals and can be seen in the form of performance measures (i.e. measures that tell SLBs whether or not they are meeting the organisational goals, an example of which includes QOF in general practice). SLBs are aware of the limiting effect these performance measures have on their autonomy and, according to Lipsky (2010), will actively oppose their application and development. The position of SLBs thus places them in a potential conflict between meeting individual client needs and the overall organisational goals. As this chapter reveals, how GPs reconcile these conflicts is a key focus within this research.

Furthermore, SLBs have an important role in implementing/enacting policy on the frontline due to their discretionary decision-making in the interaction with citizens. This is because the individual decisions of SLBs collectively add up to agency policy. As Lipsky (2010) states “the discretionary actions of public employees are the benefits and sanctions of government programs or determine access to government rights and benefits” (p. 3). Stated another way, frontline workers provide or deny access to welfare state provisions and ultimately choose whether they treat clients in a harsh or lenient way (van Berkel et al., 2010). Face-to-face

interaction with the public allows SLBs to simultaneously access organisational rules and procedures with clients' needs, and demands (Hjorne, Juhila & van Nijnatten, 2010), consequently producing public policy as "citizens experience it" (Meyers & Vorsanger, 2003, p.154). This creates a critical, and often conflicting, role for SLBs in which they balance service delivery to citizens with meeting bureaucratic objectives (Hjoren, Juhila & van Nijnatten, 2010). In determining resources, SLBs "attempt to do a good job in some way" (Lipsky, 2010, p.82), but often find difficulty in doing so.

In general, the decisions of SLBs are both allocative and redistributive with resources. This is particularly significant in the case of fixed or scarce resources wherein the SLB decides what benefits/services the client is privy to. Given the scarcity of resources (e.g. welfare benefits, health care), SLBs are seen as rationing resources. Consequently, these decisions have significant influence on the life chances of individuals that SLBs serve. In determining citizens' eligibility for government benefits and sanctions, street-level workers are indirectly socialising citizens to government service expectations. Thus, SLBs act as 'agents of social control' and play a significant role in determining acceptable and appropriate use of public services (Lipsky, 2010). These essential public services often cannot be accessed elsewhere, meaning that clients are typically 'non-voluntary' (Lipsky, 2010). This is due to either a government monopoly on the service or the inability for clients to afford and/or otherwise access private services. Subsequently, street-level bureaucracies are less dependent on client satisfaction. SLBs are often struggling to manage large client lists as efficiently as possible and therefore might be indifferent to (and possibly rewarded by) the loss of clients and reducing their client list. However, this does not absolve SLBs of all accountability and mean the client is "helpless in the relationship" (Lipsky, 2010, p.57). Rather, SLBs are often reliant on client compliance with decisions, especially if performance evaluation and/or monitoring takes into account client behaviour.

#### **4.2.2 SLB dilemmas**

SLBs are frequently characterised by their high stress work environment, which is the product of several factors: scarce resources (e.g. time, knowledge, access to useful resources), high workload, ambiguity in work objectives, complexity in measuring performance, and non-voluntary clients. Consequently, these conditions, and SLBs' mediating role between the state

and client needs and demands result in ‘dilemmas’ for the worker (Hjörne, Juhila & van Nijnatten, 2010). This is because SLBs try to make their work meaningful while negotiating citizen rights, official (and unofficial) practices, policy, and political goals. Hjörne, Juhila and van Nijnatten (2010) sum up the three main dilemmas SLBs encounter as: autonomy versus control, responsiveness versus standardisation, and demand versus supply.

The first dilemma—autonomy versus control—occurs due to discrepancies between individual preferences and meeting agency objectives. While SLBs have discretion and autonomy (at varying levels) in their work, they still operate under bureaucratic restraints. For example, SLBs establish the quantity and quality of benefit and sanctions delivered to clients by their organisation while also overseeing a large client list. Each individual client brings a new situation, often too complex to be dealt with according to pre-established rules and procedures (Hjörne, Juhila & van Nijnatten, 2010). Since they deal with clients on an individual face to face basis, SLBs are afforded the autonomy to respond to client needs. This provides somewhat of a monopoly on decision-making and makes SLBs resistant to control from above. Consequently, job performance may be difficult to manage, but this does not prevent bureaucracies from attempting to establish, enforce, and measure adherence to standards (Lipsky, 2010). However, the discretion exercised by SLBs means that policy is not always implemented as designed.

The second dilemma occurs as SLBs try to deliver individual responses to a large client list (Lipsky, 2010). Responsiveness is a client-focused approach of considering individual wants, needs, and claims for services (Hjörne, Juhila & van Nijnatten, 2010). Conversely, standardisation is the process of treating all clients equally according to predetermined organisational rules and resource limits. The concurrence of these principles places SLBs in the situation of being accountable to both the clients’ and organisations’ preferences (Hjörne, Juhila & van Nijnatten, 2010; Lipsky, 2010). Taking into consideration clients’ wants and needs may not always harmonise with organisational rules and regulations. To compensate, individuals and their issues are frequently ‘transformed’ into objects (Hjörne, Juhila & van Nijnatten, 2010) via categorisation so that they are easily recognised and processed by the organisation. This helps adherence to standardisation, but makes it difficult for SLBs to individually respond to client needs (Hjörne, Juhila & van Nijnatten, 2010).

The third dilemma SLBs face is the result of attempting to meet high demand with inadequate resources. Demands always exceed available resources provided by organisations to workers in street-level work. Unfortunately, in most cases the resource problem is not readily solvable (Lipsky, 2010). Nonetheless, SLBs attempt to counteract the resource problem through efforts to improve the efficacy and efficiency of their work through the use of coping mechanisms.

### **4.2.3 SLB Coping mechanisms**

In order to deal with this demanding work environment and these ‘dilemmas’, SLBs develop coping or ‘survival mechanisms’ (Lipsky, 2010, p.187) to decrease work pressure. These include rationing services via queuing, paperwork, or other routines; client-processing as a way of categorising clients; ‘creaming’ wherein in SLBs strategically choose easiest clients; and client screening through receptionists or office procedures (Hjörne, Juhila & van Nijnatten, 2010; Lipsky, 2010; Raone, 2013). Service rationing is used to respond to the problem of inadequate resources and ‘creaming’ is a form of client differentiation.

Individuals come to street-level bureaucracies from different circumstances and situations, with different needs and expectations. In their encounters with SLBs, individuals are “transformed into clients” (Lipsky, 2010, p.59) via categorisation, since interacting flexibly with each individual client would be incredibly time-consuming. In this process, SLBs utilise a small number of categories, forcing individuals to be treated as if they fit standardised definitions of units, consigned to specific bureaucratic slots. Even though clients experience their needs and demands individually, SLBs are forced to aggregate and categorise client demands, i.e. mass-process clients, in order to effectively manage their work. Thus, in conditions of scarce resources, high demand, and competing objectives, Lipsky (2010) predicts that ‘good’ public policy will come into direct conflict with what workers must actually do on the frontline to ration resources and to control their clients and the work situation. In the context of inequality, the processes of routinisation, simplification, and differentiation help to institutionalise the stereotypical tendencies that pervade society (Lipsky, 2010); SLBs routinise and categorise clients, often in ways which align with their own prejudices. In other words, ‘routines and simplifications’ become the unwritten policies and perpetuate stereotypes. This does not mean all SLBs are prejudiced but rather, highlights the potential problem of bias in service quality. In exploring coping mechanisms, street-level

workers may rationalise their stereotyping as a form of simplification while in reality stereotypes “are prejudicial and inaccurate as summary characteristics for groups of people with nominally similar attributes” (Lipsky, 2010, p.142).

In a similar vein, ‘the social construction of the client’ is a process of ‘social definition’—influenced by the media, socialisation, politics, culture, history, religion, and literature—that is often subjective due to potential prejudice, stereotype, and ignorance amongst individual SLBs (Lipsky, 2010). Labelling and categorisation of clients is problematic in the sense that categories are not fixed and are entirely dependent on the discretion of SLBs. This has major implications for socioeconomically deprived individuals who are often dependent on the services (due to their ‘non-voluntarily’ status) provided by SLBs in order to access benefits of the welfare state. The impact of rationing and coping mechanisms on the poor means they are more likely to lose out in service provision not only because they are more dependent on fair treatment than individuals who are better off, but also because SLBs draw on dominant stereotypes which tend to pathologise the poor. These include ‘benefit-seeking’ and other stereotypes that dominate the media. Organisations may seek to side-step the potential bias of categorisation and labelling by standardising client processing (Lipsky, 2010); however, in certain fields where developing client relationships is vital to the outcome (e.g. Chapter Three’s discussion of continuity in primary care so that health decisions are placed in context), this is impractical.

Nonetheless, SLBs exert control through ‘client construction’. This is achieved through several mechanisms including: the distribution of benefits, structuring the context of the client’s agency interaction, training clients how to behave as clients, and allocating psychological rewards and/or sanctions associated with clients’ relationships with the SLB. Clients are ‘socialised’ into the client role as frontline workers convey the agency’s expectations. This includes ‘coaching selected clients’, or in other words teaching clients how to work the system in order to access benefits and/or services (e.g. sign-posting clients to other services). This use of discretion is problematic as ‘coaching’ and training of clients may not be universally applied since it is linked to street-level workers’ views of ‘deservingness’. In the distribution of the welfare state, frontline workers have a key responsibility in deciding who receives benefits or sanctions and why. Perceptions of deservingness, however, reveal group

status and how socially cohesive a society is (Kallio & Kouvo, 2014). In other words, perceptions of ‘deservingness’ often highlight existing inequalities if one group is seen as deserving of a service/assistance/resources over another one. Consequently, SLBs’ perceptions of the disadvantaged might have an impact on their interactions with clients and service provision, ultimately influencing a client’s access to welfare services and benefits (Kallio & Kouvo, 2014). It is important to note that the perceptions of SLBs may or may not fall in line with those of the general public. For example, Kallio and Kouvo’s (2014) study of Finnish social workers revealed that street-level workers’ attitudes towards welfare recipients were actually more positive than those held by the public. As this chapter reveals, social constructionism is a useful frame for understanding how positive and negative constructions influence GPs’ perception of ‘deservingness’ with regards to their patients, including how this influences their day-to-day decisions both in and out of consultations.

#### **4.2.4 Street-level organisations**

Extending Lipsky’s framework, Brodtkin (2013) describes ‘street-level organisations’ (SLOs) as “public bureaucracies and private agencies that do the day-to-day work of the welfare state” (p.32). This is because SLOs mediate between policy and politics and the welfare state transformation, and as a result indirectly advance political change via either governance and management initiatives or patterns of informal practices. While traditional street-level research seeks to understand how practitioners manage their work lives and the subsequent policy that is constituted through their informal practices, SLOs research extends the analysis to explore how their structural location influences the mediation between policy and politics (Brodtkin, 2013). This approach “links the micropolitics of street-level organisations to the macropolitics of the welfare state” (Brodtkin, 2013, p32). Additionally, SLOs research recognises that policy is often delivered through mixed public-private arrangements.

SLOs ‘mediate politics’ through opening opportunities for political redress, assertion of rights and advancing claims on the state (Brodtkin, 2013); consequently, they are often a site for indirect negotiations of socio-political status. This is because while SLOs are set up to do the work of the state, they are also the locations in which people, policies and politics interact. For individuals seeking benefits or services—and particularly disadvantaged and marginalised populations—SLOs provide access to the welfare state (Brodtkin, 2013). It may not be the

discernible role of SLOs to provide advocacy, but it is their duty to address and respond to claims of need, meaning they provide an avenue for making claims and realising rights (Brodkin, 2013). Consequently, SLOs not only do policy work, but indirectly perform political work due to their role in determining “who gets what, when, and how” (Lasswell, 1936, quoted in Brodkin, 2013).

### *Performance measures*

While this study does not explicitly utilise Brodkin’s SLB extension, it is worth noting in terms of the SLO research focus on performance measures (which are part of a broader suite of New Public Management devices), as they are one method for achieving particular policy outcomes (Brodkin, 2013). Brodkin (2013) argues that performance measurement can be perceived as a political strategy and utilised to selectively establish which aspects of policy matter, “but in manifestly nonpolitical terms” (p. 27). This is because performance measures dictate how SLOs are paid and evaluated. Through monitoring and rewarding or sanctioning, performance measures are intended to make organisations more accountable. While the level of accountability may be subject to debate, performance measures certainly do create incentives for organisations to pay close attention to what is or is not measured. This indirectly determines what features of policy organisations will closely adhere to (e.g. caseload reductions). These selective benchmarks appear to provide accountability to organisations, but also have the potential to further marginalise disadvantaged populations if these individuals do not fall within the aspect being measured. This is particularly evidenced in Chapter Three’s discussion of the QOF measures designed to reach 90% of defined population and the subsequent potential widening of health inequalities.

## **4.3 Street-level bureaucracy in health care**

Lipsky’s SLB framework has been applied in health care research as health care professionals make decisions that affect the individual and often have organisational autonomy in making these decisions. While a portion of the research has focused on ‘lower-level employees’, such as nurses (Bergen & White, 2005; Walker & Gilson, 2004), midwives (Finlay & Sandall, 2009), and community mental health practitioners (Wells, 1997), it has also been applied to GPs (and their US counterpart, family physicians) (Baines, Wilson, & Walsh, 2010;

Checkland, 2004; Cooper et al., 2015; Dunham, Scheid, & Brandon, 2008; Drinkwater et al., 2013; McDonald, 2002). In contrast to the general ‘low-level’ position of SLBs, GPs are seen as a distinguished and elite profession (Lipsky, 2010) with authority to diagnose and treat patients’ illnesses while also controlling the information patients receive (Dunham et al., 2008). Nonetheless, GPs within the UK fit under the street-level framework as they have considerable autonomy in the decisions they make surrounding individual patient needs—including access to secondary/specialist care via their ‘gatekeeper’ role described in Chapter Three—yet practice under the bureaucratic structure of the NHS. While they are not direct employees of the NHS, they are still subject to ‘bureaucratic goals’ through performance measures and monetary incentives.

Beyond the main SLB characteristics of decision-making and autonomy, GPs also fit Lipsky’s (2010) framework in the sense that ‘clients’ (referred to as ‘patients’ from here onward) are non-voluntary, as the universal nature of the NHS affords everyone access to a GP. In other words, patients cannot easily ‘shop’ around general practices and cannot be easily discharged from practices. This relates to another SLB characteristic, a large case-load (i.e. patient list) in relation to their responsibilities. This is typically represented by a demand greater than supply as GPs often practice under the context of inadequate resources (including monetary, time, and personnel) (Checkland, 2004; Lipsky, 2010). They are thus forced to process workloads quickly (Lipsky, 2010), which may lead to the ‘coping mechanisms’, identified by Lipsky and others, to manage their work. Consequently, Lipsky’s framework is useful for beginning to evaluate the role of GPs in implementing health policy as frontline workers.

#### **4.3.1 SLBs and GPs—emerging themes**

McDonald’s (2002) study is one of the first to use the SLB framework in relation to GPs. She specifically examined how GP decision-making in a UK Health Authority may conflict with local policy when it comes to managing patients with CHD. Utilising participant observation, McDonald (2002) explored how the commissioning process for CHD functioned at the locality and Health Authority level. She ultimately found that ‘rational decision-making models’ (i.e. theoretical models of how public policy decisions are made) did not account for GP decisions in the management of patients with CHD, which was at odds with local policy. This was attributed to the discretion GPs are afforded in how they perform their work. In their day-to-

day clinical practice, GPs act as SLBs in the processing of workloads in Primary Care Group decision-making as opposed to focusing on agency objectives from a managerial perspective. While she did not explicitly inquire about the extent to which GPs fall under Lipsky's framework, McDonald (2002) clearly showed how they can indeed be classified as SLBs.

In her study of UK GPs, Checkland (2004) did ask if GPs are 'SLBs at work', and further confirmed McDonald's previous observations. She used Lipsky's framework to analyse and explain the observed effects of practice-level responses to the National Service Frameworks (NSFs). Introduced by the UK government in 1997, the NSFs not only provided guidelines on suitable clinical care for individual patients, but also outlined preferred 'service models' providing care delivery specifications for issues including mental health, heart disease, diabetes, and elderly care. As SLBs, GPs strive to negotiate conflicts in the direct delivery of public services and the framework helped to explain why three case-study practices failed to address centrally enforced NSFs, even though they had a previous track record of adopting evidence-based clinical guidelines (Checkland, 2004). From a Lipskian viewpoint, SLBs strive for efficiency and ways to better manage their large caseloads. Since the NSFs were perceived to be too complicated and failed to "make the job easier" (Checkland, 2004, p.971) the practices had negative attitudes towards the NSFs. However, Checkland (2004) suggests 'bureaucrat' may be misleading, since although GPs work in an independent contractor status in the UK they are not actually 'self-employed'. Consequently, GPs' independent contractor status also positions them in the role Lipsky identifies as public service managers (Checkland, 2004) in that they are interested in achieving results consistent with NHS (and more specifically Health Board) objectives (Lipsky, 2010). Her research further revealed that when nurses took on some of the NSF work, GPs gladly accepted and agreed for it to carry on. The nurses, also SLBs in their own right due to their significant autonomy through direct patient interactions, allowed GPs to meet agency objectives by default, (i.e. without doing the work) (Checkland, 2004). Checkland's research also shows that in addition to SLBs, GPs simultaneously act as 'business owners'. However, she did not directly explore how GPs negotiate between the dual roles of SLB and 'business owner'.

Dunham et al. (2008) also utilised the SLB framework; however, instead of looking at organisational change they explored the advocacy role primary care physicians play in mental

health treatment for Medicaid patients in the US. From the US context, Medicaid patients are non-voluntary because they are unable to afford private health insurance and only a limited number of physicians accept Medicaid (Dunham et al., 2008). Through semi-structured interviews with 20 physicians, Dunham et al. used the framework to explain how physicians behave in their patient interactions, while paying close attention to how the physicians framed and addressed their patients' mental health problems. Dunham et al. (2008) note that, in addition to service rationing and gatekeeping, SLBs are also expected to be advocates. Under resource constraints, however, physicians may not be able to carry out best practice. Street-level bureaucracy would predict that physicians trying to act as patient advocates would directly come into conflict with their 'corporate responsibilities' (i.e. an exclusion preventing mental health services in a physician's capitated income). Consequently physicians would 'cope' by providing quick treatment incurring no cost, such as prescribing anti-depressants and/or conducting mental health referrals. Contrary to Lipsky's framework, the authors discovered physicians willingly provided mental health care even if they were not reimbursed (Dunham et al., 2008). In negotiating between both roles, physicians still prescribed anti-depressants while also trying to code in a way that allowed for reimbursement of mental health care provided. Accordingly, Dunham et al. (2008) show that physicians are ultimately, 'willing to act as advocates' (on a very small scale) for the patients but as SLBs only follow policy that accommodates their advocate and bureaucrat roles along with their corporate responsibilities. What Dunham et al. (2008) fail to explore is how this advocacy role might extend beyond individual patient encounters and (potentially) beyond the practice, an area this research seeks to address.

In the clash between policy and practice, Drinkwater et al. (2013) used the SLB framework to explore healthcare professionals' views of why patients with chronic conditions use unscheduled care and of their own role in reducing its use. This work involved semi-structured interviews with GPs, emergency department doctors, nurses and case managers. They discovered that policy aims to reduce unscheduled care use via management of long-term conditions in primary care did not fully align with GPs' understanding of their role. Instead, GPs interpreted their role as supporting patients' navigation through a complex system (Drinkwater et al., 2013). Additionally, while GPs did not consider reducing the use of unscheduled care to be within their remit, they also perceived unscheduled care services as

helping to manage workload exacerbations. This follows Lipsky's framework, in that, SLBs will often develop alternative conceptions of their work to respond to pressures. Also operating as SLBs, the nurses and case managers tried to negotiate the system in order to meet targets by reducing the use of unscheduled care. Consequently, they demonstrate the need for policy to take into consideration healthcare professionals' perceptions, particularly if they are expected to implement policy, and constraints they may face, calling for a 'whole-system approach' versus dependence on individual practitioners to reduce use of unscheduled care. While this highlights the importance of frontline workers' perceptions, it also demonstrates the need for additional research to understand how GPs view their role in other aspects of patient care and how they subsequently negotiate between these various roles.

#### **4.4 The conceptualisation of GPs under the SLB framework**

As previously noted, street-level bureaucracy is potentially useful in exploring how GPs manage their work and the policies subsequently constituted through their informal practices. The next section builds upon this by first looking at the concept of professionalism as it relates to GPs to broaden the understanding of GPs as SLBs. Following this brief examination, the next sub-section explores in turn the main 'dilemmas' GPs face as SLBs, with particular focus on the concepts of discretion, advocacy, and coping mechanisms. The final sub-section examines what this research intends to open up and add to Lipsky's framework, including whether there is a need to look beyond GPs as SLBs, and examining the scope GPs have to address health inequalities.

##### **4.4.1 GPs as 'professionals'**

Sociologists have utilised the concepts of 'profession' and 'professionalism' since the mid-twentieth century to better understand certain occupations which typically have a "dominant position in a division of labor" (Freidson, 1972, p.xvii). While the definition of professionalism is not fixed (Evetts, 2003), its general application deals with occupations based on knowledge (Evetts, 2003; Murphy, 1988), as 'professions' usually follow some degree of higher education. Beyond their knowledge-base, from a sociological point of view, professionals use their expert knowledge to deal with and assess risk, providing a medium for

clients to deal with uncertainty. Applying this definition of professionalism to medicine, GPs use their ‘expert knowledge’ to enable patients to deal with illness and disease, both of which are full of uncertainty. Furthermore, Freidson (2001) and Evans (2011) assert that other fundamental characteristics of professionalism include: commitment to service users’ needs, the prioritisation of service users’ well-being over economic priorities, and freedom and control over their work.

In contemporary medicine, physicians’ (and more importantly GPs’) main duties go beyond simply the diagnosis and treatment of illness (Freidson, 1972). As sociologist Everett Hughes (1958) stated in an essay on work and occupation:

*Not merely do the practitioners, by virtue of gaining admission to the charmed circle of colleagues, individually exercise the licence to do things others do not do, but collectively they presume to tell society what is good and right for the individual and for society at large in some aspect of life. Indeed, they set the very terms in which people may think about this aspect of life. The medical profession, for instance, is not content merely to define the terms of medical practice. It also tries to define for all of us the very nature of health and disease. When the presumption of a group to a broad mandate of this kind is explicitly or implicitly granted as legitimate, a profession has come into being (p.189).*

Hughes’ quote highlights a number of characteristics significant to the sociological construction of doctors as professionals. These include their elite status within society and their ability to define both health and illness. Freidson (1972) contributes this ‘pre-eminence’ to the prestige and expert authority the profession exerts. Not only is it an esteemed profession in the public eye, but it also carries an “officially approved monopoly to the right to define health and illness and to treat illness” (Freidson, 1972, p. 5). Consequently, like other professional ‘elite’ groups, the medical profession has potential for strong political links and connections (Evetts, 2003).

The high status of GPs is significant in terms of their relation to other SLBs as GPs can be seen as ‘above’ other frontline workers in terms of pay (and prestige). This begs the question to what extent GPs face the same or different dilemmas as other street-level workers? In

addition, they potentially have a wider influence on policy in terms of their frontline work and ‘meso-level’ role in policy implementation, i.e. “where local service delivery is managed and shaped” (Blackman et al., 2012, p.52). This is due to the role GPs also have in practice management, meaning that in addition to their position as frontline service workers, they can also be seen as decision makers within the organisation (Blackman et al., 2012).

According to Evans (2011), Lipsky fails to fully explore how professionalism and management intersect, including how professional status structures and informs discretionary practises, power, and motivations. Thus, unlike Lipsky, Evans (2011) engages with the complexities of occupational status in understanding discretion and its management. While Evans (2011) examines this interplay, it is from the perspective of management as separate from the worker (i.e. ‘two different teams’) and does not explore the intersection of practitioner and manager within the same person (e.g. a GP). In line with managerialist literature, street-level theory assumes that workers and managers are distinct and primarily antagonistic categories (Evans, 2011). This is particularly problematic in the context of GPs who are intrinsically one and the same—frontline worker and manager. Due to the influence professional status has on discretionary freedom for occupational groups (Evans, 2011), the relevance of GPs as ‘SLBs’ must be widened to explore GPs as ‘street-level professionals’.

#### **4.4.2 ‘Dilemmas’ of the GP**

GPs in the UK face the same ‘dilemmas’ as all SLBs—1) autonomy versus control, 2) responsiveness versus standardisation, and 3) demand versus supply. Two additional dilemmas arise from the clash with GP’s managerial role, the first being the overarching conflict between 4) working at the frontline and managing a practice. Furthermore, as potential ‘natural advocates of the poor’ (as noted by Rudolf Virchow in the 19<sup>th</sup> century and later Henry Sigerist in the 20<sup>th</sup> century), GPs face the dilemma of providing voice to their patients while also managing their practice. This presents an additional dilemma GPs face as 5) advocate versus manager. A final dilemma intrinsic in GPs’ work is the explicit tension between the fields of 6) primary care and public health, which Chapter Three identified as the increasing delivery of population health activities through primary care. Thus, the SLB framework, in combination with professional theory, helps to better understand the nature of GP dilemmas.

*Autonomy versus control*

The first dilemma GPs face—autonomy versus control—is closely linked with the discretionary power afforded to GPs. Professional autonomy underpins ‘professional dominance’ theories, which tend to direct the sociological narratives of the medical profession (Freidson, 1972; Evetts, 2002; Cheraghi-Sohi & Calnan, 2013). These narratives stem from the monopolistic role the medical profession has had in defining illness in western societies and is reinforced through higher education. For example, patients are highly reliant on their doctors due to the specialised knowledge needed to diagnose and treat illness. This results in asymmetric knowledge between medical professional and patient, potentially opening up issues of trust and exploitation (Light, 2010).

While freedom is considered ‘the heart of professional work’ (Cheraghi-Sohi & Calnan, 2013; Freidson, 2001; Tummers & Bekkers, 2013; Wallander & Molander, 2014), in reality GPs’ ‘freedom’ is much more controlled. Thus, professional discretion is perhaps more indicative of “modern professional organisational contexts” (Cheraghi-Sohi & Calnan, 2013, p.53), and is often used interchangeably with autonomy. The literature on professions tends to view discretion in the positive sense (versus the pejorative version in SLB literature) since it is the prerequisite for appropriate individualised treatment (Wallander & Molander, 2014). Professional discretion permits the assessment and evaluation of individual cases and conditions so that a worker can use their professional judgement to advise and treat the individual (Cheraghi-Sohi & Calnan, 2013; Evetts, 2002), and in medicine is known as ‘clinical freedom’. Given the varying needs of patients in primary care, discretion can certainly be seen from the positive, bottom up perspective as it enables GPs to adapt policies to meet the needs of individual patients. However, professional discretion does not occur in a vacuum, but demands that decisions and recommendations take into consideration all factors influencing the situation. Thus, individual client needs are not the sole basis for decisions, as they also incorporate the wider organisational, social, political, economic and bureaucratic factors which contextualise the decision through conditions and constraints.

Applying these concepts to general practice, Cheraghi-Sohi and Calnan (2013) explore how various components of professional discretion influence its application. Specifically, they examined changes to the GP contract (discussed in Chapter Three as the new GMS contract

(nGMS), including introduction of QOF and GP's ability to opt out of 24 hour care). Their research involved semi-structured interviews with 62 GPs across the north of England and focused on how the introduction of QOF had an impact on discretion via the wider elements identified above (organisational, social, political, economic and bureaucratic factors).

Ultimately Cheraghi-Sohi and Calnan found a post-QOF reduction in GP discretion compared to pre-QOF ways of working. They attributed this to the rise of a new form of 'organisational professionalism', which emerged through features including bureaucracy, managerialism, assessment and standardisation (Cheraghi-Sohi & Calnan, 2013). Thus, 'modern professional discretion' in general practice is best understood in an organisational context as individual medical freedom tempered by wider factors.

A broader study conducted by Grant et al. (2015) focused on general practice team members (including GPs) and clinical and non-clinical managers involved in the delivery of the nGMS contract in Scotland and England between 2007 and 2009. They found practices were generally supportive of the contract as a whole, as long as they maintained autonomy and independence from primary care organisations' supervision. Mutuality was also a key factor in maintaining relationships between clinicians and managers, as well as the use of clinical peer reviewers in monitoring QOF performance (Grant et al., 2015). Thus, while their study does not necessarily reveal the tension in GPs' dilemma of autonomy versus control, it does support the importance of maintaining GP autonomy and professionalism.

The nature of professionalism is such that professionals are allocated *space* for decision-making in line with their own judgement (Wallander & Molander, 2014). Additionally, discretionary power is entrusted to professionals based on the assumption that practitioners are capable of making 'reasoned judgments' and that their discretionary judgements and decisions are 'justifiable'. This means we expect professionals to act in accordance with their *best* judgement and that what they do is supported by *good* arguments (Wallander & Molander, 2014, p.3). Applying these concepts to medicine, we place our trust in GPs to make decisions based on what they think is best for the patient's health. However, it is unclear the extent to which wider contextual barriers, such as resource constraints or performance measures, may impede these judgements. Nonetheless, the expectation remains that GPs will do their best for patients given the available resources.

*Responsiveness versus standardisation*

The second dilemma of providing “individual responses or treatment on a mass basis” (Lipsky, 2010, p.44) occurs as GPs identify and respond to the needs their patients present. This is particularly important in primary care as patient needs will vary greatly from one individual to another. Often the specific rule that SLBs are mandated to follow does not align with the specific situation involved with the individual client (Tummers & Bekkers, 2013). But exactly how much space is available for GPs to cater to individual needs? For example, what is the scope for GPs to either increase or decrease the standard 10-minute consultation time for individuals presenting greater or lesser need?

Another way of stating this second dilemma, as highlighted in Chapter One, is in terms of equality versus equity; the former implies everyone receives equal shares of the healthcare ‘pie’ while the latter is based on distributive justice, i.e. shares are distributed to eliminate systematic disparities in health (or its social determinants) between more and less advantaged social groups (Braveman & Gruskin, 2003). Using the example of consultation time, from an equality perspective everyone would receive an equal time slot. This follows standardisation in the sense that everyone is treated the same, regardless of need. Conversely, an equity-based focus would necessitate fluctuating consultation times to correspond to individual need. Thus, patients presenting multiple problems (whether it be multimorbidity combined with or without multiple deprivation) would necessitate longer consultation times. For GPs working in areas of severe deprivation this second approach may not be plausible as many of their patients present multimorbidities, often with mental health co-morbidity, social deprivation, and alcohol or addiction problems. Consequently, the potential to follow an equity-based approach might only be possible in practices with mixed patient populations.

While it is clear that GPs must be able to respond to individual need, some standardisation may help with workflow. Along with the task of identifying and assessing need, it is important to understand how GPs prioritise problems within their practice and what the underlying criteria are for doing so.

*Demand versus supply*

The third dilemma—high demand with inadequate resources—is applicable to all GPs, but especially pervasive in areas of high socioeconomic deprivation. As the previous chapter highlighted, GPs working in areas of multiple deprivation endure increased workloads, through the complexity of problems their patients present, which is evidenced in high levels of multimorbidity. Thus, ‘high demand’ is not exclusive to large patient lists and can be translated to ‘high need’, as it includes the large numbers of ‘complex’ patients GPs working in deprived areas work with. This dilemma also follows the ‘inverse care law’ in its more recent conceptualisation as the stark contrast between GP resources in affluent, healthy areas with those of deprived, ill areas. This scarcity of resources may manifest in the form of time, staffing, and/or coordination or support with other services (both in and outwith the NHS).

In line with the SLB framework, GPs working in deprived areas are often forced to ration services and consequently develop coping mechanisms to ‘process’ cases quickly. These mechanisms may include routinisation and simplification methods. However there is a lack of research that specifically explores how GPs cope amidst strained resources in the context of severe levels of multiple deprivation and multimorbidity.

*Frontline worker versus manager*

As ‘independent contractors’, GPs work under the bureaucratic structure of the NHS but have considerably more freedom than their employed colleagues to set the parameters of their work (Checkland, 2004). GPs subsequently have dual roles as frontline workers and what Lipsky terms ‘public service managers’ of the GP surgeries where they practice. Lipsky (2010) suggests managers are results-oriented as it relates to organisational objectives, which may not align with frontline worker objectives of handling large caseloads in a streamlined and efficient manner.

Another point of divergence between SLBs and managers involves client interaction, presenting “varying degrees of complexity” (Lipsky, 2010, p. 22). This is because bureaucratic organisations seek to demonstrate commitment to fairness and equity, while SLBs frequently witness inequality of treatment in their work and recognise the different individual characteristics that are not always bureaucratically significant (i.e. an individual’s context

beyond standard categories of age, ethnicity, income level, etc.) (Lipsky, 2010). Accordingly, GPs understand that different patients have different needs, so a broad-based equity approach may not always be appropriate. At the same time, as ‘managers’, GPs must also maintain a certain level of consistency across patient interactions. This places GPs in the dilemma of negotiating between addressing the needs and problems patients present while also meeting organisational objectives that are directly related to their contract.

#### *Advocate versus manager*

A point of incongruity GPs face is in terms of what Lipsky refers to as ‘client advocacy’. As he states, the conflict arises due to the interaction of service delivery by people through human interaction and service delivery through a bureaucracy; the former invokes values of responsibility and caring while the latter suggests detachment and equalisation across individuals to cope with resource constraints. Drinkwater et al. (2013) point out that as SLBs, GPs are expected to be both gatekeepers (to secondary and specialist services) and advocates for their patients, a role which involves GPs’ use of skill, knowledge and position to ensure the best treatment for patients (Lipsky, 2010). Unlike other SLB professions, this form of advocacy is explicitly articulated in the tenets of the medical profession (entwined in the profession’s ‘Hippocratic Oath’, i.e. a commitment to good medical practice). However, Lipsky (2010) maintains this ‘client advocacy’ can come into direct conflict with efficiency objectives and managing large caseloads because SLBs’ ‘helping orientation’ conflicts with bureaucratic guidelines to control and judge clients. Lipsky attributes this to issues of efficiency and organisational responsibilities for two primary reasons. First, that “advocacy can only be done on behalf of single units” (Lipsky, 2010, p.73), i.e. individuals or collectives. Due to the need to process large caseloads efficiently, advocacy may be compromised as SLBs ration scarce resources without properly taking into consideration the individual’s perspective. The second reason advocacy is incompatible with SLB work is due to the tension between organisational perspectives and resource distribution such that organisations stockpile resources while advocates seek to allocate resources to individuals (Lipsky, 2010). This posits that advocating for their patients (and even for themselves) may clash directly with their organisational responsibilities. Thus, while the intersection of human interaction and bureaucratic responsibility creates a dilemma, GPs will actively negotiate. The extent to which

bureaucratic responsibilities such as performance measures (i.e. the QOF) affect patient advocacy is not known.

According to Brodtkin (2013), sociopolitical status is indirectly negotiated in SLOs as individuals decide, in Lasswell's terms, 'who gets what and why'. Frontline workers have the discretion to decide adherence to bureaucratic guidelines and to decide whose case is (or is not) put forward. This opens the door for elements of social justice and whether the workers perceive themselves to be advocates for this. GPs certainly address and respond to claims of need (Brodtkin, 2013), but do they see their role as going beyond this? As SLOs provide an avenue for "claims making and realising rights" (Brodtkin, 2013, p.32), GPs not only have a potential advocacy role, but potential role that extends beyond the practice, whether it be a community or even broader health system level. Not much is known regarding how GPs view this potential role, thus creating a gap in the literature to be explored.

#### *Public health versus primary care*

A final tension worth noting is the difference in approach between public health and primary care perspectives, which are inextricably linked to GPs' role as frontline worker. As discussed earlier, SLBs are tasked with aggregating client demands. This lends itself to the public health perspective wherein a focus on the collective population is needed for overall improvements in population health, in addition to the efficiency demands of street-level workers. However, the complexity of patient needs (combined with the rise in multimorbidity) demands a focus on disease self-management skills and improving individual patient health via the delivery of high quality patient-centred care (Showstack et al., 2003). The tension between the two perspectives does not mean a lack of support on behalf of public health for primary care or vice versa, but rather a difference in prioritisation. For example, there may be divergence in how 'need' is conceptualised between the two perspectives, with public health potentially prioritising clinical needs of an elderly affluent patient over the socioeconomic needs of a deprived patient. Consequently, as increasing public health demands are placed on GPs it is critical to explore how they negotiate between the two perspectives.

## 4.5 Expanding the SLB framework

### 4.5.1 Looking beyond GPs as SLBs

While Checkland and other researchers have highlighted the relevance of Lipsky's framework in exploring the frontline work of GPs, the application of SLB to GPs should not go without question. Instead, the possibility of other worker 'types' in relation to GPs should be explored. This includes Maynard-Moody and Musheno's (2000; 2003) 'citizen agent' and Durose's (2011) 'civic entrepreneur'. Specifically, Maynard-Moody and Musheno (2000; 2003) eschew the SLB term instead adopting 'citizen agent' to describe workers at the frontline whose work is defined by their relationships with both citizens and other street-level workers. According to Maynard-Moody and Musheno, 'citizen agents' use local knowledge or 'street smarts' to negotiate their role in interpreting, implementing, and delivering policy. Frontline workers do not perceive themselves as policymakers or decision makers (Maynard-Moody & Musheno, 2000, p. 347), but recognise the importance of working with local communities in the implementation and delivery of locally appropriate and mutually beneficial policy (Durose, 2011).

Durose's (2011) work explores how 'contemporary local governance arrangements' challenge Lipsky's idea of frontline workers as SLBs, ultimately finding 'civic entrepreneur' to be a more appropriate label as "practitioners work to reconcile policy priorities with community demands through community-centred strategies" (Durose, 2011, p.2). Using semi-structured interviews with various frontline workers—including youth workers, health improvement workers, and community development workers—in North West England, she found frontline workers to be strongly embedded in the local area and having extensive 'local knowledge'. This 'local knowledge' enables frontline workers to engage the community in decision-making as it relates to local service delivery and policy interventions on the ground level.

In particular, Durose (2011) identifies certain engagement 'strategies' that frontline workers employ with the community to build 'longer-term relationships' (which is in opposition to the Lipskian notion that frontline workers are simply trying to streamline their work). These strategies include: reaching out to marginalised and excluded groups in an effort to signpost them to available resources and services; enabling 'hard-to-reach' groups through skill-

building and self-confidence; engaging groups who are otherwise excluded from existing service provision or the wider community; and fixing governmental policy objectives to align with organisational opportunities and the priorities and concerns of the community. In this sense, frontline workers are seen as going beyond the conventional boundaries of their practice by developing entrepreneurial strategies (Durose, 2011). ‘Civic entrepreneur’ is a more expansive conceptualisation of frontline workers than Lipsky’s framework, and in turn might more adequately describe the work of GPs in the most deprived practices of Scotland. GPs certainly have extensive knowledge about their patients and patients’ families, but what is the extent of their ‘local knowledge’ of the communities in which they work and how do they use this to engage with the local community?

Another element of Lipsky’s framework that may not adequately describe GPs’ work is their role in policy. While SLB theory recognises the role frontline workers play in implementing policy, it does not extend above this. Beyond the micro-level encounters GPs have with individual patients, GPs also function, to a degree, as practice managers where they operate at the ‘meso-level’ where “local service is managed” (Blackman et al., 2012, p.52). This is important due to reforms in local governance, which has reopened neighbourhoods as a place for policy intervention (Durose, 2011). Thus, an additional way of reconceptualising GPs beyond SLBs is to avoid the “rigidity of fixed worker types” (Durose et al., 2015, p.2), and instead focus on characteristics of practitioners who make a difference in the communities in which they work, as evidenced by van Hulst et al. (2012) and Durose et al. (2015).

Looking beyond the traditional frontline worker type, van Hulst et al. (2012) studied various individual practitioners—including professionals, civil servants, and active citizens—working in disadvantaged Dutch neighbourhoods to understand how their actions catalyse social change. These ‘exemplary practitioners’ combined a mix of strategic networking, empathetic engagement, and entrepreneurialism (not in the managerial sense, but in finding innovative solutions for specific problems) to meet the needs within the disadvantaged neighbourhoods, rather than using traditional bureaucracy (van Hulst et al., 2012). While the practitioners they studied could be further categorised into worker ‘types’ (e.g. frontline workers, ‘civic entrepreneurs’, boundary spanners), as ‘exemplary practitioners’ they were able to make a difference by working outside of the typical bureaucratic guidelines.

Beyond her work on ‘civic entrepreneurs’, Durose and colleagues (2015) utilised data from their previous empirical research to analyse the statements of key informants from a variety of local practitioner backgrounds including public administrations, non-profit organisations, and elected representatives. This resulted in five ‘profiles’ based on key characteristics of neighbourhood practitioners who are perceived as making a difference, three of which are most relevant to this research including facilitating, organising, and trailblazing. Facilitating practitioners are process-oriented and are focused on connecting people and building networks to spur support within and beyond the neighbourhood. Organising practitioners have a strong commitment to social justice and focus on mobilisation within their communities to bring about social change. Like facilitators, trailblazing practitioners utilise strategic coalitions but are results-driven, looking for innovative, practical solutions.

Combining both studies provides a set of key attributes of practitioners who make a ‘difference’ in the areas they work (Table 4.1) and provides scope with which to study the GPs practicing in deprived areas. Looking beyond Lipsky’s SLB framework provides space for exploring GPs’ potential roles in advocacy (both in and out of the practice) and shaping policy through the use of local knowledge and community engagement. The extent to which GPs working in deprived communities align with Durose et al.’s (2015) profiles and/or can be reconceptualised as ‘exemplary practitioners’ (van Hulst et al., 2012) is consequently a focus of this research.

**Table 4.1 (Potential) Key attributes of GPs working in deprived communities (Adapted from Durose et al., 2015 and van Hulst et al., 2012)**

<b>(Potential) Key Attributes of GPs Working in Very Deprived Communities</b>	
<i>GPs who practise:</i>	<i>GPs focused on:</i>
Strategic networking	Connecting people and organisations within the community (and beyond)
Empathetic engagement	A commitment to social justice
Entrepreneurialism	Mobilisation within communities to bring about social change
	Finding innovative, practical solutions to the community’s needs

### 4.5.2 Multiple identities

Existing research shows that in addition to SLBs, GPs simultaneously act as ‘business owners’ (Checkland, 2004); that physicians are ultimately willing to act as advocate for their patients but as SLBs adhere to policy as long as it serves both of these roles (Dunham et al., 2008); and finally the importance that frontline workers’ perceptions play in implementing policy. While these various roles are acknowledged in the literature, it is unclear how GPs view and negotiate between their various roles, including what potential conflicts may arise (e.g. meeting practice goals and improving individual patient’s health). This is an avenue which the SLB framework does not adequately consider and/or explain but is highlighted in the professionalism literature. Under this paradigm it is suggested that increased pressure in the workplace has forced professionals to construct flexible selves and multiple identities (Evetts, 2003; Cheraghi-Sohi & Calnan, 2013; Spyridonidis & Calnan, 2011). An example of this is GPs who have “maintained, negotiated, or reinvented their professional identities as both ‘professional’ and ‘business owner’” (Cheraghi-Sohi & Calnan, 2013, p.53). While the ‘professional’ role relates to GPs’ interactions with individual patients, the ‘business owner’ role refers to GPs’ involvement in the operation and management of their practice surgeries. Adding roles of SLBs and ‘client advocate’ demonstrates a clear reason for GPs to create ‘flexible selves’. Exploring the multiple identities of GPs bridges an existing gap in the literature and creates a new avenue of exploration within the SLB framework.

### 4.5.3 Social construction of patients

Another gap in the street-level literature on GPs involves the social construction of patients. Labelling and categorisation of clients were previously highlighted as coping mechanisms employed by street-level workers to expedite the processing of work. While routinisation of client processing can help limit psychological interactions (Lipsky, 2010), psychological interactions are nonetheless imperative to GPs’ work in order to deliver patient-centred holistic care. This opens the door for subjective influences of prejudice and stereotypes. Thus, the question is not whether GPs employ methods of categorisation—which may range from the medically defined (e.g. patients with mental health co-morbidity) to socially defined (e.g. ‘drug-seeking’ patients)—but how these categories influence the interactions GPs have with patients.

Further to social constructions and issues of deservingness, ‘health-related deservingness’ has emerged as an object of analysis in various sociological and anthropological studies on health care access (Marrow, 2012; Smith, 2016; Willen, 2012). From this perspective, deservingness is contextualised in terms of access to health services and, according to Willen (2012), is considered a moral concept (as opposed to rights-based claims to health care access) based on conditionality. In other words, this places health care workers in the position of determining who is or is not deserving of health care services. Previous studies have tended to focus on im/migrants’ (both documented and undocumented) (Marrow, 2012; Smith, 2016; Willen, 2012) access to health care, but none specifically looking at citizens’ ‘deservingness’ within areas of high socioeconomic deprivation. Thus, within a universal health context such as Scotland’s NHS where everyone is entitled access to a GP, ‘health-related deservingness’ must be further nuanced.<sup>22</sup>

How GPs’ perceptions—and view of deservingness—of individuals in deprived areas influence patient interactions is especially topical in the ‘deep-end’ of Scotland’s primary, where socioeconomically deprived patients make up the majority of their practice population. Since GPs are essentially tasked to provide medical care to the best of their ability, these perceptions and stereotypes may not blatantly influence the GPs’ provision of health care services, but rather a patient’s access to secondary and voluntary services external to the practice. This might come in the form of patient ‘coaching’, i.e. sign-posting patients to other services and/or teaching patients how to access other benefits or services, or the administration of voluntary services that a GP provides such as writing benefit letters on behalf of the patient. These non-compulsory ancillary services open up a new dimension of discretion, particularly since GPs are neither required nor paid to provide them. Consequently, it is important to understand why GPs choose or refuse to provide them, with whom and in what circumstances, and whether this is universally applied. For example, are there any inherent differences in practice between GPs who socially construct their patients as deserving versus non-deserving?

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<sup>22</sup> This is not to say that im/migrants and/or refugees may not have difficulties accessing GP services (and be subject to issues of ‘health-related deservingness’), but rather that this is outwith the scope of this research.

#### 4.5.4 What is the scope for GPs addressing health inequalities?

The previous chapter emphasised the potentially important role primary care plays in narrowing health inequalities, with GPs particularly “well positioned to have a positive impact on health inequalities at a number of levels” (Hutt & Gilmour, 2010, p.5) (which, of course, is subject to individual GPs’ level of engagement both within their practice and the wider community). Tackling health inequalities is not exclusively related to improving the health of individuals in the most deprived areas; however, it is a key component to both narrowing the gap between the most deprived and better off and decreasing the socioeconomic gradient in health. GPs are positioned to identify those with greatest ‘need’ and as SLBs, they have discretion and autonomy to allocate resources according to need—but how do they practise accordingly? Consequently, it is important to understand not only how GPs construct the problem of health inequalities, but also how they view their role in tackling them and the subsequent implications for prioritisation within their practice. On one hand coping strategies of categorisation and prioritisation may potentially help to decrease health inequalities by identifying greatest need; on the other hand categorisation may exacerbate existing stereotypes, further stigmatising certain patients. Another consideration is whether—under the context of strained resources, severe levels of multiple deprivation and multimorbidity—GPs 1) have the capacity to utilise this discretionary power to address practice structure in a way that might narrow health inequalities or 2) are simply trying to keep their ‘head above water’ (i.e. working in the ‘deep end’) in managing their existing caseload.

## 4.6 Conclusions

As this chapter has discussed, Lipsky’s SLB framework is applicable to GPs working within the most deprived practices in Scotland as they have considerable autonomy in the decisions they make surrounding individual patient needs, yet practice under the bureaucratic structure of the NHS. While they are not direct employees of the NHS, they are still subject to ‘bureaucratic goals’ through performance measures and monetary incentives. Beyond the main SLB characteristics of decision-making and autonomy, GPs also fit Lipsky’s framework in the sense that ‘clients’ (patients) are nonvoluntary, they manage a large case-load (i.e. patient list) in relation to their responsibilities and as such can be seen as developing coping mechanisms

to manage their workload. The dilemmas GPs face, however, are not restricted to the three primary ones identified in the beginning of the chapter, but include the additional dilemmas of their dual roles as frontline worker versus manager, advocate versus manager and finally the tension between a public health and primary care perspective. Furthermore, Lipsky's framework is useful in understanding how primary care policy must support—and be amenable to—GPs at the frontline in order to ensure adherence to bureaucratic guidelines (Cooper et al., 2015).

Currently, there is minimal research exploring how GPs negotiate between the multiple identities in their work, understanding the 'social construction of patients' and its implications for the provision of voluntary services by GPs, and what this means in terms of the scope provided to GPs for addressing existing inequalities in health. Ultimately, this chapter shows the need to look beyond Lipsky's framework in order to fully understand how GPs reconcile individual practice and policy goals. Consequently, reconceptualising GPs as 'exemplary practitioners' and better understanding the characteristics of GPs who make a difference in the communities where they work provides space for exploring their potential role in tackling health inequalities by shaping policy through the use of local knowledge and community engagement.

The following chapter presents a discussion of the research methodology and methods used within this thesis. It operationalises the research questions and provides a description of the theoretical framework for this research. It also provides an explanation and justification for the choice of semi-structured interviews, an overview of participant recruitment for the study, a description of the methods of analysis and finally a reflection on the practical and ethical issues encountered throughout the research process.

## **CHAPTER 5 Research methodology and design**

### **5.1 Introduction**

The previous chapters demonstrate Scotland's persistent health inequalities and the challenge GPs working in areas of high socioeconomic deprivation face due to the increased prevalence of premature multimorbidity compounded by the presence of social issues and workload constraints such as shortage of time and contractual obligations. The literature suggests that primary care and GPs both have the potential to positively impact on health inequalities but, as Chapter Three revealed, there is minimal research exploring how GPs themselves view this role. Furthermore, not much is known about how GPs negotiate multiple identities in their work, including those of frontline worker and manager. As a result, this research aims to shed light on the perceptions of GPs of their work and responsibilities, not only within their practices but also within the communities where they practise (and potentially beyond). To accomplish this, this chapter discusses methodological and theoretical foundations for the study, followed by a rationale for the methods selected. A description of recruitment strategies and the sampling frame is subsequently offered before finishing with an overview of analysis and ethical considerations for the research.

### **5.2 Aims of the research**

Building on the literature, this research aims to address the overarching questions of:

1. What can primary care do to contribute to tackling health inequalities?
2. Within this context, how can GPs tackle health inequalities?

While the first question is directed at exploring the general role of primary care in tackling health inequalities, this research looks at the scope of GPs as the most powerful frontline workers within this context. A narrow focus on GPs provides a meaningful scope for this research and directly speaks to research such as Hutt and Gilmour's (2010), which highlights the potential role of general practice in tackling health inequalities. Out of this focus stems the following key objectives:

- To explore how GPs working in areas of severe deprivation view their role in narrowing health inequalities.
- To identify ways in which GPs, as front line workers (aka ‘SLBs’), see themselves coping amidst strained resources in the context of severe levels of multiple deprivation and multimorbidity.
- To gain insight into how GPs identify and tackle ‘need’ and explore what the potential is to practise according to this definition of need.
- To gain insight into how (and whether) GPs view the role of potential ‘advocates of the people’ (Sigerist, 1941) in the communities where they practise.
- To identify what the Deep End group offers, in terms of support, for GPs who work in areas of severe deprivation and are interested in advocacy on behalf of their patient populations.

These objectives further define the research focus to GPs working in areas of severe deprivation, as the literature identifies these areas as adversely affected by social inequalities in health. As frontline workers, GPs in these areas face challenges brought on by high levels of premature multimorbidity and their social determinants. These challenges present an opportunity for advocacy, harking back to Virchow’s (and later Sigerist’s) description of doctors as the ‘natural advocates of the poor’, thus establishing a need to explore how GPs themselves view this potential role. Furthermore, the research questions imply a qualitative exploration of how GPs view the work they do, including its broader implications within their practice, communities within which they practise and the health system as a whole. Consequently, the focus was not on the work they actually do, but rather their perceptions of their work and how they construct meaning through their work (Miller & Glassner, 2011).

## **5.3 Methodological & conceptual frameworks**

### **5.3.1 Methodological approach**

Establishing a coherent epistemology in research is fundamental as it dictates how you interpret your data and how you distil meaning (Braun & Clark, 2006, p.85). A phenomenological approach provided “a descriptive, qualitative study of human experience”

(Wertz, 2006, p.124) and this research was focused on the lived experience of GPs, including their perceptions of what they do and think they can achieve. Further to this, constructivism operates under the basis that research participants are co-producers of knowledge, wherein research is an active process uncovering “broader assumptions, structures and/or meanings” (Braun & Clark, 2006, p.85) and assumes that GPs are experts in their own experience. Thus, the purpose of this research is to illuminate the assumptions, structures, and meanings under which GPs working in deprived areas operate. In addition to how they construct their work, this includes exploring GPs’ perceptions of patients; in other words, how GPs socially construct patients and what GPs think they can accomplish both in and out of the practice.

### **5.3.2 Conceptual framework**

The conceptual frame and theoretical assumptions underpinning the research need to be clarified to understand how the research was undertaken (Braun & Clark, 2006). Accordingly, this research operates under the conceptual framework of Lipsky’s (2010) street-level bureaucracy, which was reviewed in-depth in Chapter Four. This assumes that GPs in deprived areas are forced to process their workload expeditiously due to the combination of large and challenging patient lists with inadequate resources in the form of money, time, and personnel (Checkland, 2004; Lipsky, 2010). According to the framework, the combination of workload and scarce resources inevitably leads GPs to develop coping mechanisms within their work (Lipsky, 2010). While this study was interested in the specific coping mechanisms GPs adopt, it was more concerned with understanding GPs’ perceptions of their coping mechanisms and, specifically, how they viewed themselves handling the stress of their caseloads. Other research investigating SLBs in health care (not exclusive to GPs) has been predominantly qualitative (Baines et al., 2010; Checkland, 2004; Drinkwater et al., 2013; Dunham et al., 2008; Finlay & Sandall, 2009; McDonald, 2002; Walker & Gilson, 2004) and this study followed suit. This is because the research aimed to uncover deeper meaning beyond the SLB assumptions, including how GPs understand and negotiate dilemmas and multiple identities stemming from their work. Thus, it was crucial to talk to GPs about their experience in order to understand how they “create and construct narratives” (Miller & Glassner, 2010, p.132) regarding general practice in deprived communities.

This study also aimed to evaluate the application of the SLB framework to GPs working in areas of severe deprivation, with a view to understand the framework's limitations in its application to an elite group of frontline workers. As Chapter Four highlighted, GPs working in Scotland operate under the bureaucratic control of the NHS, but have a considerable amount of autonomy due to their independent contractor status. Consequently, while the SLB framework might shed light on GPs' frontline work—including coping mechanisms—it fails to speak to their managerial duties within the practice. Beyond the use of Lipsky's framework to inform the study, social constructions of 'deservingness' was an important addition to the conceptual frame. Specifically, this involved exploring how GPs' description of patient encounters offered insight into underlying social constructions of their patient populations. As a result, a further aim of this study was to understand how these constructions of deservingness were linked to GPs' views and understandings of health inequalities (and their social determinants), including what they could individually do to tackle inequalities.

## **5.4 Research strategy and design**

### **5.4.1 Research strategy**

This research utilised in-depth, semi-structured interviews in order to gain direct access to GPs' 'experiences' (Silverman, 2013). While previous qualitative studies have sought to understand GPs' attitudes towards poverty (Bloch, Rozmovits & Giambone, 2011; Loignon et al., 2010; O'Brien et al., 2011; Willems et al., 2005), few have focused directly on health inequalities in addition to bringing to light GPs' perceptions and experiences. Within the small subset of the latter group, Blane et al. (2013) conducted focus groups with Glasgow-based GP trainers, exploring their attitudes surrounding health inequalities and how changes in training might contribute to tackling them. However, the aim of this study was to go beyond attitudes and to gain deeper insights into what it is like to work in a deprived area. Consequently, in-depth interviews were chosen as the research method in order to gain insight into individual GP's perceptions and experience. In-depth interviews (as opposed to other qualitative methods such as observation) were the ideal method for eliciting perceptions and identifying what meaning the participants attach to their experience (Silverman, 2013). GPs are trained to treat the problems patients present in addition to encouraging patient self-management to prevent

future problems; consequently, their work may not encourage opportunities for self-reflection. Furthermore, in-depth interviews are valuable in exploring the complexity of social issues within a health care setting (Dicicco-Bloom & Crabtree, 2006). They also enable a wide range of questions to be covered, through a focused lens, in order to draw out a collective experience across the participant interviews, in addition to individual narratives (Dicicco-Bloom & Crabtree, 2006). The focus of the interviews, subsequently, was on encouraging GPs to take a reflective look at the work they do and how their work fits within the scope of tackling health inequalities. While the mixed-methodology was appropriate for Checkland's (2004) SLB research, as she was examining practice-wide responses to the national service delivery changes, this research focused solely on the perceptions and experience of GPs to provide a manageable scope for PhD research. Since the focus was on how they 'construct realities', interviews were seen as an appropriate methodology to elicit this information.

Qualitative research can be considered a 'two-way' street (Ramazanoglu, 2002) as opposed to a "one-way pipeline for transporting knowledge" (Holstein & Gubrium, 2004, p.141).

Consequently, this research focused on meaning-making conversation wherein interviewing is unavoidably interactional and knowledge construction is active. It also sought to gain the insight of GPs' to understand how they reconcile their multiple roles as SLB, including manager and (potential) patient advocate. Understanding how SLBs negotiate between conflicting roles is a noticeable gap in the literature. This included providing voice to their experience rather than treating them "as mere mines of information to be exploited" (England, 1994, p.243). This research was also conducted under the assumption that research participants are social agents who are experts in their own right (Cornwall & Jewkes, 1995). This means GPs are not simply 'experts' in treating patient's medical problems, but also experts in their experience regarding working in a deprived area. As a result, in-depth interviews enabled the research to remain 'participant centred' (i.e. with flexibility to explore the work and experience of each individual GP) by gathering meaningful data informed by the participant themselves.

The use of an in-depth format also allowed for "actively constructed 'narratives'" (Silverman, 2013, p.47) to emerge, which in their own right demand analysis. This means not only looking for common threads between interviews, but also performing analysis within individual

interviews to draw out narrative threads, thereby maintaining the integrity of the participant's experience. From a constructionist perspective, there is a certain amount of active 'work' that interviews do in producing answers (Silverman, 2013). By organising the interview around a set of predetermined open-ended questions, flexibility was allowed for other questions to emerge from the dialogue between myself as the interviewer and the interviewee (DiCicco-Bloom & Crabtree, 2006).

#### **5.4.2 Sample**

While there is no 'magic number' for qualitative interviews, a "medium size subject pool offers the advantage of penetrating beyond a very small number of people without imposing the hardship of endless data gathering, especially when researchers are faced with time constraints" (Adler and Adler, 2012, p.9). The original interview target was 30 GPs and the achieved sample was 24 semi-structured interviews with GPs working within the Greater Glasgow and Clyde (GGC) and Lothian Health Boards in Scotland. Nonetheless, this sample size provided meaningful data within the scope of PhD research.

Unlike quantitative research, qualitative studies are theoretical, not random in their approach to sampling. They are designed to provide detailed, close-up accounts "which are relevant to or appear within the wider universe" (Mason as cited in Silverman, 2013, p.390). The goal of this study was not to provide generalisable findings, in the sense of being representative of all GPs working in deprived areas, but to understand how participants' experience represents a broader class of phenomena (Silverman, 2013); in other words, do participants' experiences provide an accurate description of what it is like to work as a GP in a deprived area? This latter interpretation of generalisability in qualitative research has been referred to as 'transferability', meaning that findings can be transferred from one context to a similar situation (Holloway & Wheeler, 2010; Lincoln & Guba, 1985). It is also helpful to replace 'generalisation' with 'extrapolation', as qualitative research aims to understand how the analysis relates to things beyond the material at hand (Silverman, 2013, p.156). Thus, this research aimed to broadly describe the experience of GPs working in deprived areas and 'extrapolate' key themes that can be applied within a similar context of high levels of deprivation and premature multimorbidity. To accomplish this, participants were recruited

through purposive sampling, which involves selecting participants to study based on their relevance to the research questions and theoretical position of the research (Silverman, 2013).

Since research objectives focus on how GPs cope amidst high levels of deprivation and the role of the Deep End Project, participants were recruited based on three characteristics: 1) Health Board locale, 2) deprivation of their practice (i.e. their 'deep endedness') and 3) their individual level of involvement with the Deep End Project.

At the time of research, the top 100 practices (i.e. the 'deep end') were comprised of 85 located in Glasgow City, 9 within the NHS GGC Health Board area outside of Glasgow City, and 5 practices in Lothian. In the next 50 practices, there were 23 in GGC and 5 in Lothian. Considering that the majority of practices in the top 100 (~85%) were located within the GGC Health Board area (and approximately 40% of the next 100 within the GGC area), the decision was made to recruit participants from within this area in addition to the Lothian Health Board area. This enabled comparison between the two areas, including identifying whether there are health board specific practices that make GP action surrounding health inequalities more or less likely at the practice level.

Practice deprivation level was the second characteristic applied to constitute the sampling frame. This was achieved by compiling a list of practices in the top 100 and next 50 most deprived practices in Scotland, based on the proportion of patients with postcodes in the 15% most deprived data zones (according to the SIMD). Deprivation information is publicly available from ISD Scotland (<http://www.isdscotland.org/Health-Topics/General-Practice/Practices-and-Their-Populations/>) through a display of practice codes. These codes can then be linked to practice details (including address and contact details), which are also publicly available from the same website.

For the sampling frame, practices within the GGC (including within and outside of Glasgow City) Health Board area was subdivided into halves, recruiting participants from the top 50 and next 50. Although the top 100 forms the basis of the 'deep end', this is an arbitrary cut off point as rank and patient population vary from year to year. For example, one of the practices fell within the top 100 at the time of data collection (based on the 2013 SIMD) but has subsequently moved just outside of the top 100 according to 2014 and 2015 SIMD rankings.

Given this arbitrary cut off, recruiting from the next 50 was necessary to effectively explore the extent to which GPs' views within the Deep End vary from GPs working in a similar context of high deprivation, but with no Deep End group available for support. Since only a small number of practices in Lothian fell within the sampling frame, GPs were recruited from each of these practices for participation in the study. One participant fell outside of this sampling frame due to the nature of their practice, which works with individuals who are in precarious housing arrangements and thus may have difficulty accessing mainstream general practice. The deprivation context is similar to other Deep End practices, but does not fall within the SIMD ranking system due to the transient nature of patients' postcodes. Nonetheless, they were matched according to the third characteristic described below.

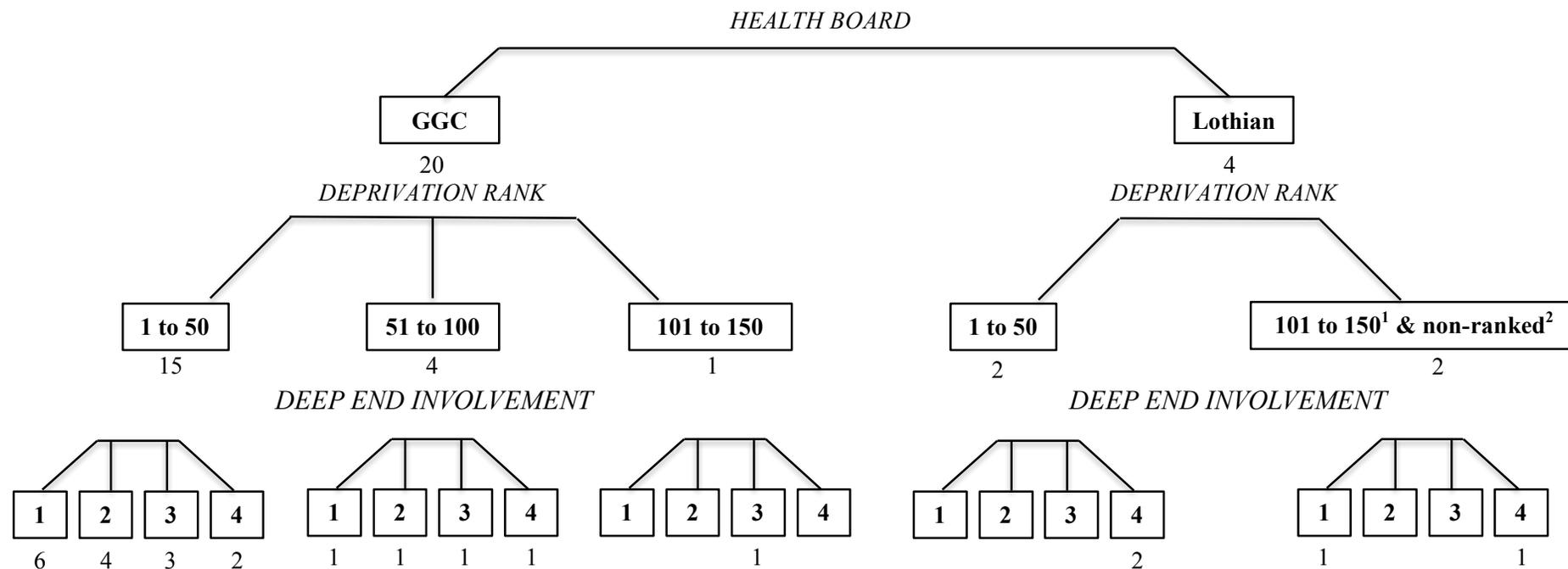
The third characteristic, level of involvement in the Deep End Project, was divided into four categories for recruitment: 1) leading members of the Deep End steering group (active in terms of group advocacy, writing reports and projects), 2) other members of the steering group who may be less active and/or recently joined in the project or non-steering group participants with attendance at four or more meetings, 3) participants with Deep End meeting attendance of three or less but not in the steering group (e.g. attended 1 or 2 of the national and/or roundtable meetings), and 4) no participation in the Deep End Project (although their practice falls in the top 100 and is designated as being in the 'deep end'). Following data collection, these categories were later re-named for analysis as: 1) significant involvement, 2) some involvement, 3) minimal involvement, and 4) no involvement. The third and fourth categories were also indicative of the GP's practice overall; in other words, a participant with no involvement in the Deep End project also meant that their practice (including other GP partners) had no involvement in the project.

Any potential GP participant falling within the sampling frame was categorised based on the three characteristics. All leading members of the Deep End steering group—at the time of data collection—were selected for participation in the study, including the individual who fell outwith the sampling frame. Participants were purposely selected from the other three categories of Deep End involvement to fill potential gaps according to Health Board and deprivation level.

Ethical approval was obtained from the University of Glasgow Social Sciences Research Ethics Committee during April 2014 (Appendix A). It should also be noted that prior to any participant recruitment, informal ‘approval’ from the Deep End group itself was given during one of their regular roundtable meetings. Obtaining this acceptance was important in opening up the initial bridge of communication.

The breakdown of participants is documented in Tables 5.1 (participants according to the sampling frame), 5.2 and 5.3 (participant characteristics outwith the sampling frame), with Deep End group participation further nuanced in Chapter Eight. Additionally, while pseudonyms are used in the subsequent findings chapters, participants are not listed according to all of the characteristics identified below in order to maintain anonymity.

**Table 5.1 Participant breakdown by sampling frame**



**Lothian**  
4  
*DEPRIVATION RANK*

**1 to 50**  
2

*DEEP END INVOLVEMENT*

**1**

**2**  
2

**3**

**4**

**101 to 150<sup>1</sup> & non-ranked<sup>2</sup>**  
2

*DEEP END INVOLVEMENT*

**1**  
1

**2**

**3**

**4**  
1

**\*See next page for 'Deep End Involvement' key**

<sup>23</sup> No participants were from a Lothian practice ranked within the 51 to 100 most deprived practices

<sup>2</sup> Indicates the participant outwith the first characteristic of the sampling frame (deprivation rank), but still within the Lothian Health Board

<b>Deep End Involvement</b>	
1	Leading members of the Deep End steering group (active in terms of group advocacy, writing reports and/or projects)
2	Other members of the steering group who are less active or non-steering group participants with attendance at 4 or more non-steering group meetings or
3	Participants with Deep End attendance at three or less non-steering group meetings
4	No participation in the Deep End project

**Table 5.2 Participant experience within general practice**

<b>Experience within General Practice</b>			
<b><i>Early Career (10 years or less)</i></b>	<b><i>Mid-Career (10-20 years)</i></b>	<b><i>End of Career (20+ years)</i></b>	<b>TOTAL</b>
4	5	15	24

**Table 5.2 Participant breakdown by gender**

<b>Gender</b>		
<b><i>Female</i></b>	<b><i>Male</i></b>	<b>TOTAL</b>
10	14	24

### **5.4.3 Recruitment**

Selection of potential recruits followed categorisation according to the sampling frame described above. After potential participants were identified, recruitment followed a two-stage procedure. After GPs were identified and selected, according to the above criteria, they were first approached by letter (or email if an address was available) via a ‘gatekeeper’, defined as someone “who controls research access” (Saunders, 2006, online). Since gaining social research access can be problematic, a gatekeeper can be useful in negotiating access to participants. In this instance the gatekeeper was an academic GP who is not only involved in the Deep End group itself, but also one of my PhD supervisors. His involvement in the Deep End group did not place him in a position of authority over GPs; thus, potential participants had no obligation to take part in the study. Rather, using him as a gatekeeper accessed his existing rapport with GPs, making participants more comfortable with the study (i.e. knowing that the research is connected with someone they know). This potentially improved response rates from GPs who had existing contact with the Deep End group. For example, all eight leading members of the Deep End steering group agreed to participate in the study. This is in contrast to the 16 GPs—out of 26 (64%) contacted—who agreed to participate and fell within the other Deep End involvement categories. In total, 33 participants were contacted and 24 agreed to an interview. Not all participants had existing professional relationships with the

gatekeeper but all of them did have some awareness of the Deep End group. Furthermore, the gatekeeper's involvement with the Deep End group also allowed me to categorise potential participants according to the sampling frame, including their engagement with the Deep End project (third characteristic for selection).

The initial contact letter 1) briefly explained the study, 2) asked if they would be interested in taking part in the research, and 3) also asked how to best make contact with them. GPs' details were not passed on to me directly unless they indicated their willingness to participate in the research. After GPs' details were passed on to the researcher, an official invitation to participate in the research was then sent via their selected method of contact (letter or email). This included the Information Sheet (see Appendix B) and Consent Form (Appendix C). As each practice is composed of 3-4 GPs, on average, only one GP per practice was approached for participation in the research. If no response was given and/or participation was declined, another GP from the same practice was selected.

## **5.5 Research collection**

Prior to the main collection of data, the Interview Schedule was piloted with two non-research GPs, who fitted within the sampling frame but were not actively involved in the Deep End Project. This allowed for slight revisions to improve both appropriateness of the questions and overall flow of the interview. For example, rather than asking participants about advocacy directly (as GPs might not necessarily consider themselves to be 'advocates'), questions were focused on how GPs viewed their professional role extending beyond individual patient encounters. It was also determined that to maximise the value of the interview time, a 'prompt sheet' would be discussed at the outset of the interviews. This was designed to explore commonly known issues affecting practices serving the most deprived populations in Scotland. This list was informed both by the literature and Deep End reports and included issues such as shortage of time, multimorbidity, professional stress, and less willing patient engagement. GPs were asked if there was anything on the list that they disagreed with or found to be especially prevalent in their practice and then provide examples of such. Utilising this prompt sheet enabled an efficient coverage of a wide range of issues and the interview proper was able to explore a set of these in more depth. It also alerted the GP that I had pre-

existing knowledge of common issues that many deprived practices face, thus establishing a level of common knowledge between researcher and participant. The final version of the Interview Schedule is available in Appendix D; the prompt sheet is available in Appendix E.

### **5.5.1 Building rapport through baking**

As opposed to ethnographic or observational studies, interview studies necessitate the rapid development of a positive relationship (DiCicco-Bloom & Crabtree, 2006). This process of building rapport involves establishing trust and demonstrating “respect for the interviewee and the information [they] share” (DiCicco-Bloom & Crabtree, 2006, p.316). Going into the interviews as a non-clinical ‘outsider’ meant I had to quickly establish a connection with the GPs. During the interviews this was primarily achieved by having participants tell me about their background to start, including their clinical experience, and their views of the community they practiced in. Asking interviewees then to reflect on their own caseload, including how the nature of their work might differ from other areas (i.e. less deprived) was also valuable in accessing their ‘lived experience’. Overall, this process seemed to be successful in opening the lines of communication given that all but one of the interviews lasted an hour or more (which, for means of comparison could accommodate 4-6 patient consultations). The interview which lasted under an hour had a late start due to the GP's surgery running over. To compensate the GP offered only 30 minutes for the interview; however, after stopping the Dictaphone at 37 minutes, the GP proceeded to ‘chat’ for an additional 10 minutes about my research and background.

In addition to building rapport during the interviews, I also wanted to demonstrate gratitude to the GPs for participation. Incentivising GP participation through means such as a £10 gift card seemed impersonal and insignificant. Bringing home baked biscuits, however, proved to be a valuable way of demonstrating my appreciation of their time and opened the lines of communication. One of the participants even acknowledged the cookies during the interview, suggesting that GPs often just wanted acknowledgement from middle management and policymakers for the hard work they do, and small tokens such as cookies go a long way in doing this. In total 17 dozen cookies/scones/biscuits were baked during the course of fieldwork.

### 5.5.2 Operationalising the research questions

In order to avoid what Silverman (2013) refers to as “lazy research” (p.206), it is important not to ask participants the research questions directly. This avoids descriptive analysis, i.e. simply reporting back what you were told. Research questions must be operationalised in a way to elicit participant experience and perceptions. Thus, subsequent questions in the interview schedule aimed to gather meaning and elicit open responses from the participants. Interview schedule themes were structured around issues highlighted in the review of the literature related to health inequalities, SLB, and patient advocacy.

In order to understand how GPs view their role in health inequalities, it was first necessary to gain insight into their understanding of health inequalities and how they function. Stemming from this, questions sought to comprehend how, as GPs, participants saw themselves making a difference in narrowing health inequalities and what could be achieved both in and out of the practice. The interview then delved deeper into their experience of working in a deprived area amidst scarce resources. These questions reflected an SLB lens, seeking to understand how the participants prioritise problems within their practice and how performance measures might influence the way they practise. Building on their practise experience, the interview moved on to how GPs view their role beyond individual patient encounters, invoking reflection on patient advocacy. Finally, for those with any engagement with the Deep End group, participants were asked to reflect on their experience of working with the project and how it might have influenced their views and/or perceptions. This last part was important not as an evaluation of the Deep End group, but rather in understanding how the group might influence GP’s understanding of the ‘problem’ of health inequalities and what they can do about it.

Overall, the use of a semi-structured format allowed for both flexibility and consistency across interviews. The interview guide was useful in maintaining overall comprehensiveness of the data, making the data collection process more systematic for each participant while also keeping the interviews informal and situational (Willems et al., 2005). This latter part was particularly important in establishing the participant narratives identified in the analysis.

### 5.5.3 Researcher Reflexivity

From a researcher's perspective, it is extremely difficult to be cognisant of the way you ask questions, in addition to your own position as the researcher. It was essential to recognise my own research position, rather than aiming for non-bias as a quantitative study might do. Reflexivity on the part of the researcher is essential in qualitative work. This involves giving thought to my own role since "respective social roles always shape the interview process" (DiCicco-Bloom & Crabtree, 2006, p.317) and includes acknowledging the power differentials between the interviewer and interviewee, and "integrating reciprocity into the creation of knowledge" (DiCicco-Bloom & Crabtree, 2006, p.317). During the interviews, the power differential came in the form of professional position and asymmetry of knowledge.

The power differential of professional position stemmed from the fact that although I am a doctoral student, I am still just that, a student. Unlike research with vulnerable populations, GPs are considered 'elites' with a well-respected (and compensated) job. Thus, a barrier was not in my potential dominance in the interviews, but whether or not participants would view me as an equal and be open to talking candidly about their experiences. In order to assist in negotiating power dynamics between the GPs and myself, the gatekeeper sent out a brief biography—including my educational and research background—with the initial invitation email. The purpose of this was to convert their impression of me from an unknown, to someone with an interesting and relevant background. It also served to establish my competence as a researcher—someone with whom it would be worthwhile sharing their story.

Just as there is asymmetry in knowledge between a doctor and a patient, there is also asymmetry in knowledge between the GP, as the participant, and me, as the researcher with a non-clinical background. In order to compensate for this, I avoided a focus on the semantics of clinical experience, seeking to understand more about how they view and understand the work they do (e.g. the relationship with their patients). However, my non-clinical background also prevented my bringing assumptions into the interviews which I might otherwise have made about the work of GPs.

Underlying all of this was a 'cold-context' at the start of my research to both Scotland's NHS and general practice. This was especially challenging given my background in the US

healthcare system, which is considerably different from the NHS. Consequently, a year and a half of preliminary research was fundamental before undertaking fieldwork. Even with this preparation there was a significant amount of learning and clarification that took place during the fieldwork in terms of GP functions, GP payment, and GP responsibilities that are not readily discernible through research.

#### **5.5.4 Interview logistics**

In order to accommodate the busy schedules of GPs, the interviews were conducted at their practice, unless they chose otherwise. Out of the 24 interviews, only five took place outside of the GPs' practice, including four at the University and one at a health board building. In attempts to gain familiarity with the neighbourhoods, I cycled to the practices (weather permitting) or took the bus.

Interviews ranged from 37 minutes to 85 minutes, with an average of 68 minutes. To enhance familiarity with the data, I transcribed a total of nine interviews (including the first six). The remaining 15 interviews were transcribed by a professional agency employed for this purpose. These transcripts were crosschecked against recordings for accuracy.

#### **5.5.5 Informal Deep End attendance**

During the course of fieldwork (and beyond), I had the opportunity to attend informally a number of Deep End group events including over ten evening steering group meetings, two daytime meetings, four focus groups with GP trainees, and the group's third national conference in November 2015. This attendance was extremely beneficial in providing an overall context to the Deep End group in addition to gaining insight into the group's concerns, objectives, and overall ambitions. How this influenced the research is discussed in further detail during the final chapter of this thesis (Chapter Nine).

### **5.6 Methods of analysis**

For theoretically defined data analysis, the focus shifts from what is said by the participants (descriptive) to exploring and distilling the underlying essence and meaning (Rapley, 2011, p.276). In short form, analysis involves identifying how main elements within the data are

linked together according to some theoretical scheme (Silverman, 2013). This necessitates both a clear methodology of analysis and an understanding that the process is recursive—rather than linear—starting during the data collection and moving back and forth between data gathering and analysis (Braun & Clarke, 2006; Wertz, 2011). Starting data analysis concurrently with data collection provides an opportunity to improve understanding of the research questions, which “inform both the sampling and questions asked” (DiCicco-Bloom & Crabtree, 2006, p.317).

Qualitative analysis can take a deductive, theory-driven approach (primarily used in quantitative analysis), or an inductive, bottom-up approach. While collection and analysis of the data were both informed by theory, this analysis focused on an inductive approach, wherein analysis is data driven and identified themes are strongly linked to the data (Braun & Clarke, 2006). However, researchers bring with them their own “theoretical and epistemological commitments” (p.84) and data is not “coded in an epistemological vacuum” (Braun & Clarke, 2006, p.84). Consequently, the analysis was not exclusively inductive, allowing engagement with the literature to not only enhance analysis but also provide “sensitivity to subtleties within the data” (Braun & Clarke, 2006, p.86). For example, how the social construction of patients linked with discourse on health inequalities was only revealed during the analysis, as was the need to look beyond SLB as a framework for characterising GPs’ work (explored in depth in Chapters Seven and Eight).

The data generated from the interviews were analysed with the aid of NVivo software, which is useful in coding and organising large amounts of data (Silverman, 2013). The ability to attach bits of information to files (e.g. gender, practice location, Deep End Project involvement) also ensured that the data was viewed in context of the participant as a person, rather than some detached piece of data. Data analysis for this research primarily utilised thematic analysis. This iterative process involved critical evaluation of the interview transcripts in conjunction with an organic process of categorisation (Evans, 2011).

### **5.6.1 Thematic Analysis**

According to Braun & Clarke (2006), thematic analysis can be seen as foundational in qualitative analysis. While it is often used as a tool across other analytical methods, it is also

sufficient as a standalone method (Braun & Clarke, 2006). Thematic analysis has the flexibility to take a constructionist approach (i.e. examining how meanings, experiences, etc. are socially produced) without producing a “fully worked-up grounded theory analysis” (Braun & Clarke, 2006, p. 81). This is particularly important as it is often difficult to set aside both conscious and unintentional assumptions about what should be found in the data.

Using thematic analysis was a two-fold process: such as reading through transcripts taking a ‘naturalist’ perspective (i.e. examining factual characteristics) (Silverman, 2013) followed by a deeper inquiry into the data from the constructionist perspective that “interview participants actively create meaning” (Silverman, 2013, p.240). The first phase of thematic analysis focused on the semantic (i.e. surface) level and was more descriptive in nature, such as: practice size, level of involvement in the Deep End group, what constraints they faced in their practice, and coping strategies they used to address them. This was a helpful way of becoming more comfortable and familiar with the data. The second phase involved delving under the surface to the latent (i.e. hidden) level. It was at this level that analysis began to identify “underlying ideas, assumptions, and conceptualizations—and ideologies—that are theorised as shaping or informing the semantic content of the data” (Braun & Clarke, 2006, p. 84). By asking the ‘what’ and ‘how’ questions during the interviews, the ‘why’ begins to emerge when analysing the data. It was at this stage underlying assumptions about patients living in deprived areas and how they conceptualised health inequalities emerged. Additionally, this added layer of analysis revealed the wide range of discretionary boundaries GPs operate in, including how they perceived their professional scope extending beyond individual patient consultations.

Thematic analysis relies on searching across the data set to find “repeated patterns of meaning” (Braun & Clarke, 2006, p. 86). This research primarily focused on identifying cross-sectional themes (i.e. across participants). These ‘themes’ begin to materialise as being significant to the description of the phenomenon (Braun & Clark, 2006). Thus thematic analysis is a dynamic process of deciding how to code the data to allow categorisation, eventually leading to the themes. Themes capture something significant about the data relative to the research questions, representing patterned meaning across the data set (Braun & Clarke, 2006). While the interview schedule was divided into sections, this analysis moved beyond

using these sections and the questions put to the participants to uncover themes; in other words, coding did not rely solely on preconceived categorisation but emerged from interaction with the data (Wertz, 2006).

In addition to cross-sectional themes, it was important to conduct analysis within the participant context to maintain integrity of their ‘lived-experience’. This is why GPs are referred to with pseudonyms, rather than participant numbers, in the subsequent findings chapters. It also allowed for the construction of ‘pen portraits’ in the culmination of the findings, providing a holistic overview and interaction of the themes explored throughout the analysis.

While the overarching research questions remained the same during the coding process, there were slight revisions to some of the key objectives to better reflect GPs’ perceptions and reflections of their work. For example, rather than exploring how GPs working in deprived areas cope amidst strained resources, the objective shifted to how GPs see themselves coping working in this environment. Again, this nuance shifted the focus to GPs’ perceptions of their work, since their actions were not measurable within the scope of this research.

## **5.7 Ethical considerations**

As Diccio-Bloom & Crabtree (2006) note, the four main ethical considerations for health research are:

1. Minimising the risk of unanticipated harm,
2. Protecting the participant’s information,
3. Effectively informing participants about the nature of the research, and
4. Minimising the risk of exploitation.

Consequently, it was imperative to ensure the participants were aware of my research intent through the information sheet. As Reiman (1979) notes, the outcome of research should not be to enhance the researcher’s career, but rather give voice to the participant’s experience. During the whole process I was also extremely aware of confidentiality and protection of the participants’ information. This includes storing the information in a secure location, password

protected files on the computer, and the removal of identifiers before sharing the transcripts, which was limited to only supervisors. This last step was particularly important since one of my PhD supervisors was used as a gatekeeper to help recruit the GP participants.

Given the elite position of GPs, there was minimal (if any) risk of harm or exploitation for the participants. Additionally, limitations identified within the research will be discussed in Chapter Nine.

## **5.8 Overview of findings chapters**

The following three chapters not only present the major findings within the research, but also present an unfolding narrative examining how GPs working in very deprived areas perceive their professional role and what work they feel is within their remit. This narrative starts off by first exploring how GPs perceive their patients and conceptualise the problem of health inequalities, including how they see their role in tackling health inequalities (Chapter Six). Chapter Seven builds on this thread by demonstrating linkages between GPs' social construction of patients and what they perceive to be constraints within their work. Imagining the GP as a SLB allows for a comprehensive examination of coping strategies and negotiating dilemmas, but also uncovers gaps in terms of how GPs perceive themselves 'going the extra mile' to mitigate the impacts other determinants of health have on their patients. To address this, Chapter Eight rounds out the narrative by offering an examination of GP advocacy, at various levels, in areas of severe socioeconomic deprivation, and what the Deep End group offers to support this.

## **CHAPTER 6 Conceptualising the ‘problem’ of health inequalities and how to tackle them**

### **6.1 Introduction**

The problem of Scotland’s persistent inequalities in health is widely acknowledged. However, there is a lack of consensus regarding what role—if any—general practice plays in tackling this problem. Chapter Two reviewed the theoretical explanations for health inequalities. While it is commonly accepted amongst health researchers that health inequalities are largely the result of wider inequalities in power and income structures (McCartney et al., 2013) there is a lack of research exploring how GPs view the causes (Blane et al., 2013). Nevertheless, the literature in Chapter Three identified that, within primary care, GPs are seen as particularly ‘well positioned’ to positively influence health inequalities (Hutt & Gilmour, 2010, p.5) in several ways including: their patient-centred approach, their potential advocacy role, their ability to take a population health approach, their potential for addressing non-health issues, and their potential for utilising a ‘proportionate universal’ approach. However, as the chapter pointed out, not much is known about how GPs themselves view these various roles.

The overarching aim of this thesis and one of the main research questions is to determine what primary care can do to tackle health inequalities and, more specifically, how GPs working in areas of severe deprivation view their role in narrowing health inequalities. Consequently, this chapter has four main objectives to explore, and is structured as follows: Section 6.2 sets the foundation for how GPs socially construct their patient populations; Section 6.3 then explores how GPs view the ‘problem’ of health inequalities and how they think it can be tackled; and, Section 6.4 addresses how they perceive their role (if any) in tackling health inequalities. In brief, the chapter concludes that GPs’ perceptions of their patients (either positive or negative) are not only closely linked to their conceptualisation of the problem, but are also critical in understanding their views on what can be done to tackle health inequalities.

## 6.2 The social construction of patients

The interviews revealed wide variation in how GPs discussed and described their patient populations. GP discourse ranged from negative to positive in their attitudes, understandings, and sympathies with which they perceived patients in deprived areas. As Chapter Four discussed, social constructionism is a useful frame for understanding the delivery of benefits and obligations, particularly in terms of how patients are treated and their perceived ‘deservingness’ of access to health care services. Consequently, this chapter utilises social constructions to offer insight into GPs’ perceptions of patient ‘deservingness’ in deprived areas according to how they were discussed during the interviews. The most significant patterning according to GPs’ patient constructions (and throughout the majority of analysis) was by level of Deep End involvement, providing a structure for the discussion below.

### 6.2.1 ‘They just basically like to abuse drugs’—negative constructions of patients

Negative accounts of patients were constructed most frequently via ‘victim blaming’ discourses. First appearing in academic literature in the 1970s, ‘victim blaming’ describes the tendency to overemphasise a behavioural model of health while disregarding the influence other social determinants, such as environment and structures, have on an individual’s health (Crawford, 1977). As Crawford (1977) notes “it instructs people to be individually responsible at a time when they are becoming less capable as individuals of controlling their health environment” (p.97). Placing responsibility on individual patients was notable amongst several of the interviewees, none of whom were actively involved in the Deep End group, but are exemplified by Dr Calum Fraser.

*A lot of it is I think they just basically like to abuse drugs. It’s the same with alcohol, they just like to abuse alcohol and that’s it. (Dr Calum Fraser, male, end of career, some Deep End involvement)*

Dr Fraser also described his patient population as ‘tablet-oriented’, particularly when it came to mental health problems. This comment was echoed by younger GP Dr Lucy Carroll, who described her patient population as frequently asking for the quick fix of a tablet.

*But it's more to do with 'I should have [tablets]' ...it's not something that would actually solve the problem. 'My child should be diagnosed with ADHD so I can have this [tablet]'. It's not getting to the root problem of it. So if you say, go to this thing that will teach you about eating healthily and doing more exercise, they're not really that keen. But if they know there's a tablet...I think our patients are more tablet-orientated than an affluent practice. An affluent practice, they don't want tablets, and do everything they can to avoid it. But ours, you know, if they feel depressed, they want a tablet...but a more affluent practice wouldn't want a tablet. (Dr Lucy Carroll, female, early career, no Deep End group involvement)*

Dr Fraser criticised the use of antidepressants while not considering potential barriers his patients may face in accessing mental health services. Similarly, Dr Carroll's victim blaming discourse of patients as prescription seekers who are averse to exploring alternative or complementary treatment regimens is particularly problematic when contrasted with affluent populations. This is because neither of these accounts explores the inequality in resources between affluent and deprived areas to seek mental health services, alternative treatments or adopt healthy lifestyles. Taking the stance that patients in deprived areas simply do not want to engage in healthy behaviours fails to recognise the potential financial and material barriers that may be prohibitive and contribute to a lack of agency. While it is possible that GPs use prescribing as a way to cope with short consultations and quickly bring discussions to a close, the interviews did not offer evidence of this or reveal other underlying explanations for these prescribing behaviours. How GPs cope with shortage of time in other ways, however, is discussed in depth in Chapter Seven.

The negative assumption that patients prefer the easy fix of a tablet was similar to other discussions of patients failing to take responsibility for their own lives. From a social construction perspective, this negatively portrays patients living in deprived areas as potentially undeserving of additional time or resources. Moreover, framing patients negatively as responsible for their poor health is presumptive in the sense that patients in these areas have resources for change at their disposal. This was the case for Drs Claire Findlay and Stuart Booth, both GPs with some Deep End involvement:

*But a lot of the time they don't follow through on things. (Dr Claire Findlay, female, end of career, some Deep End involvement)*

*No I think people, it's cruel thing to say but they [the patients] don't often own their problems. There's a sense of wanting to hand it on to someone else, [for example] their financial problems. (Dr Stuart Booth, male, mid-career, some Deep End involvement)*

In a related thread, Drs Agnes Gillies and Cecilia McCullough—who like Drs Findlay and Booth also had some Deep End group involvement—described their patients as ‘fatalistic’, which was offered as an explanation for why patients fail to take responsibility for their health.

*When we started doing cardiovascular screening, we had patients with ASSIGN scores of 50<sup>24</sup>, and they'd be saying to us, 'That's not bad! It's not bad, doctor, I thought it'd be worse.' And you're thinking, that's terrible, we'd like to try and change this! And patient's view is, 'I'm older than my dad was'. And well, yeah, but you're still younger, you're still likely to die below the national average. So trying to get them to, instead of being fatalistic, to actually make choices to take control of their health more. It's difficult. (Dr Agnes Gillies, female, end of career, some Deep End involvement)*

*We've got a high prevalence [of COPD patients], but we've got a really high prevalence of smoking and I think a lot of our patients have probably got COPD but just dismiss that as a...say a smoker's cough, whereas if you were in maybe an affluent area, you would be like, 'Oh I've had this cough for, like, a year. I should probably see someone about it.' So I think a lot of our patients are much more fatalistic. (Dr Cecilia McCullough, female, early career, some Deep End involvement)*

According to Davison et al. (1992), ‘fatalism’ describes an individual’s sense of lack of control over their environment and circumstances. The term has also been associated with ignorance, irrationality and even primitivism (Davison et al., 1992, p.677). Dr Gillies

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<sup>24</sup> ASSIGN is a tool used to estimate a person’s risk of having a coronary event in the next ten years. A score of 50 equates to 50%, or a 1 chance in 2. A high score is considered 20 or more.

perceives her patients as avoiding taking control of their health, instead accepting low standards of what ‘healthy’ is. Similarly, Dr McCullough contrasted her patients with those in an affluent area, suggesting that those in the latter category would be more likely to follow up on potential health concerns. Their perception of patients in deprived areas as less likely to seek help for problems and the ‘normalising’ of poor health is in line with Richards et al.’s (2002) Glasgow-based qualitative study. In their comparative research, not only were patients from deprived areas more likely than affluent patients to perceive increased vulnerability to heart disease, they were also more likely to normalise chest pain and thus not seek help. Similarly, Savage et al. (2013) also found a large degree of fatalism in their qualitative study of cardiovascular disease amongst low-income Canadian men. Fatalism in and of itself is not a negative construct. However, failure to recognise the root of the ‘fatalism’ blames the individual for poor health, ignoring why taking ‘control of their health’ may be difficult. This difficulty stems from the starkness of their current situation including physical limitations, financial realities, and lack of social networks (Savage et al., 2013). Alternatively, fatalism might represent a sense of realism from both the GP’s and patient’s perspective of what can be achieved during short consultations given the patient complexity (similar to offering prescriptions to quickly bring a consultation to a close). However, the underlying factor is *how* a GP confronts and responds to patients’ concerns, since fear of blame may deter patients in deprived areas from seeking help (Butler et al., 1998).

Another negative construction of patients in deprived areas was related to ‘excessive’ ‘place attachment’, or failure of their patients to go outside their neighbourhood. Several of the GPs specifically acknowledged this place attachment and attributed it to the high ‘did not attend’ (DNA) rates for secondary consultations typically associated with deprived areas.

*We’ve got people complaining about traveling to the Western [a hospital in the West End of Glasgow] from here. Now I reckon it’s about 4, 4.5 miles to the Western. I can cycle to Gartnavel [another hospital in the West End of Glasgow] in 20 minutes, but people won’t go...So our DNA rates are high despite our best efforts...And DNA rates, it’s massive, it’s one of the biggest inefficiencies of the NHS...because the patients don’t value the free service that they have. (Dr Stuart Booth, male, mid-career, some Deep End group involvement)*

While Dr Booth's discourse describes 'place attachment' from a victim blaming perspective, not all GPs took this approach. Dr Gillies recognised that why patients in deprived areas have a higher default rates for hospital appointments is often "because they don't have the money for the bus the day they're going to the hospital." Additionally, Dr David Gallacher noted that Glasgow has "a lot of tribalism" which acts as a barrier to some patients in deprived areas leaving their neighbourhoods. This is similar to the concept of 'territoriality', which Kintrea et al. (2008) define as "a social system through which control is claimed by one group over a defined geographical area and defended against others" (p.4) and has been observed to occur with young people in very deprived areas. Its deeply rooted origins are important to acknowledge, especially in Glasgow where there is a history of gang-related boundaries (Kintrea et al., 2008), in order to fully understand why a patient may fail to attend services in another area, beyond transportation issues.

### **6.2.2 'Just trying to live their lives never mind look after their health'—positive construction of patients**

In general, GPs who described their patients in a more positive light also acknowledged the issues patients face stemming from social deprivation. Specifically, this meant acknowledging their 'low power' position and the potential effect this has on acquiring life skills that may be more attainable in an affluent area. For example, several of the GPs, ranging in experience, described a "lack of confidence" (Dr Kenna Anderson, mid-career) amongst their patients in addition to a lack of other skills such as "coping strategies" (Dr Fergus Lindsay, end of career, some Deep End involvement) and "negotiating skills to work their way round things" (Dr Alistair Fleming, mid-career, significant Deep End involvement). Others noted that often it simply came down to a lack of education, as Dr Duncan Macleod (end of career, minimal Deep End involvement) explained, "we have to acknowledge, sometimes, that they maybe do not have the skills to know what they do when they do get unwell."

Positively constructing their patients as deserving subsequently made it easier to understand why their patients might have difficulty changing lifestyles or adopting healthy behaviours. Dr

Helen Reilly explained that her patients were likely to be aware of what a ‘healthy’ lifestyle was, but that perhaps this was restricted by current life conditions.

*The problems people have, just trying to live their lives never mind look after their health...I mean they also are aware that they should be changing the lifestyles, should try and stop smoking or they should be drinking less or whatever. (Dr Helen Reilly, female, end of career, significant involvement in Deep End)*

‘Fatalism’ was also described amongst GPs who positively constructed their patients. However, unlike those who tended to negatively construct patients, these GPs offered explanations as to why patients have difficulty taking control of their life, such as feelings that “the future is just for the middle classes” (Dr James Henderson). As Dr Robbie Bannigan explained this results in a “feeling of genuine hopelessness” (in addition to general pessimism on behalf of the GP himself) as he described a recent patient encounter:

*The conversation I had [with a] man, who has been found fit for work, I mean, his conversation was something like, ‘I might as well just buy some fucking heroin and finish it all, because there’s no fucking point’. I’m, like, okay, and actually I’ve got nothing to counter that argument it’s, like, yes, I know where you’re coming from. What have I got to offer? Nothing to fix it that’s for sure. (Dr Robbie Bannigan, male, end of career, significant involvement in Deep End)*

Thus, GPs who positively constructed their patients were more likely to demonstrate empathy. This has important implications regarding patient enablement, a term closely associated with empowerment, which means that a patient is better prepared to not only cope with and understand their illness, but also to manage it (Howie et al., 1999; Mercer et al., 2012c). Previous research has shown physician empathy to not only be a prerequisite to patient enablement (Mercer et al., 2012c), but also improved outcomes when patients perceived empathetic consultations (Mercer et al., 2016; Mercer & Watt, 2007). Furthermore, Mercer et al. (2016) found patients in deprived areas—despite knowing their GPs better than patients in affluent areas—were more likely to perceive their GPs as less empathetic and less interested in shared decision-making. Collectively, this demonstrates the importance of GPs’ social constructions of patients in demonstrating empathy.

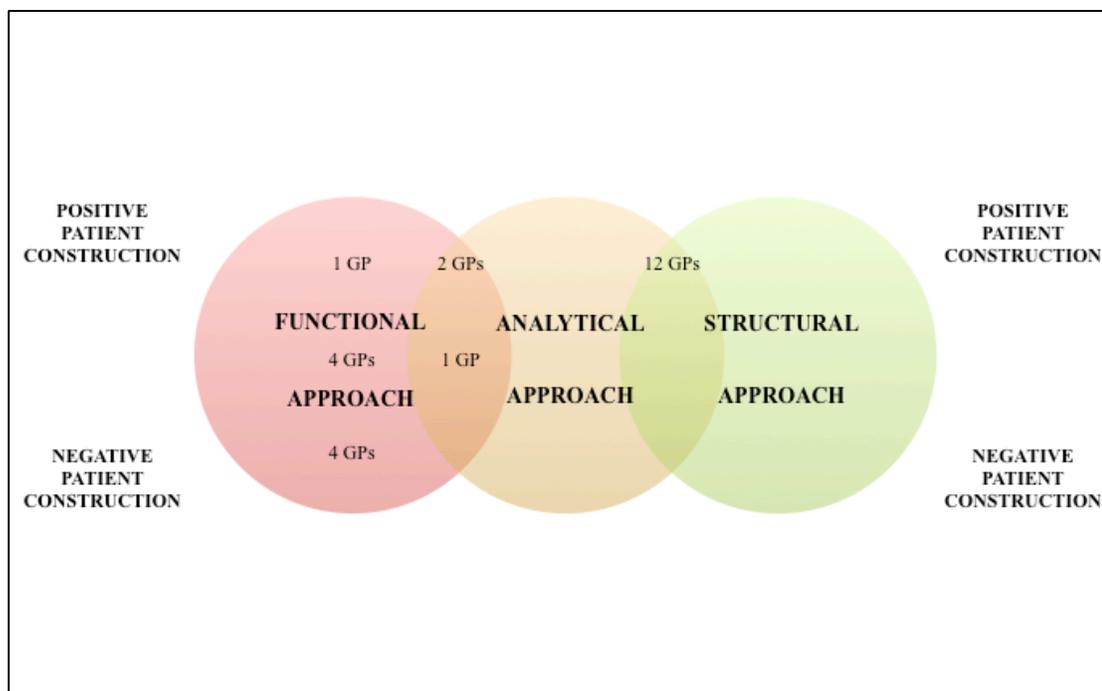
Overall, this research found GPs' perceptions of patients to fall on a spectrum and not entirely reducible to positive or negative constructions. However, the use of social constructions sheds light on how GPs consider their patients and, as the next section reveals, how they construct causes of health inequalities.

### **6.3 Conceptualising the problem and what can be done—dominant discourse amongst GPs working in deprived areas**

As highlighted in Chapter Two, understanding the ways in which GPs construct and frame health inequalities is important as research and professional practice—including activity and funding priorities—are largely dictated by these constructions (Raphael, 2011). To facilitate this exploration and deepen understanding of GP discourse, Raphael's social determinants of health (SDH) discourse levels and Brassoloto et al.'s (2013) further categorisation of these levels are used to classify individual GPs based on their description of the 'problem'. As explained in Chapter Two, Brassoloto et al.'s work builds on Raphael's initial discourse categorisation, essentially simplifying the seven discourses into a three-stage categorisation: 'Functional', 'Analytical', and 'Structural'. In a Functional approach (which corresponds to Raphael's discourse levels 1-2), health determinants are used to identify individual risk factors for those in need of health and social services. Alignment with this approach implies a focus on targeted services programmes for vulnerable groups' lifestyle and behaviour change. An Analytical approach (Raphael's discourse levels 3-4) recognises that life circumstances affect health and may systematically differ by group memberships. Consequently, this implies a focus on improving living conditions that impact on health. In contrast, a Structural approach (Raphael's discourse levels 5-7) takes a broader perspective and acknowledges how public policy, social structures, political environments, and power distributions affect health. Thus, public policy advocacy and public education strategies are targeted at addressing inequalities in the social determinants of health (see Table 2.1 for a more detailed delineation of Raphael and Brassoloto et al.'s frameworks).

There was variation in how the GPs described the 'problem' of health inequalities. Nine of the GPs aligned with a predominantly 'Functional' approach. Three expressed a combination 'Functional'/'Analytical' approach. The discourses of the remaining twelve GPs combined

‘Analytical’/‘Structural’ approaches in their description of the problem. How GPs socially constructed patients—either positively or negatively—was also closely linked to how they described the problem. This patterning of GP discourse according to patient constructions is illustrated in Figure 6.1. Within this distribution, GPs significantly involved in the Deep End group were more likely to align with an Analytical/Structural approach (seven GPs), while the other groups had a mix of Deep End involvement.



**Figure 6.1 Distribution of participants according to ‘discourse approach’ (Brassoloto et al., 2013; Raphael, 2011) and patient social construction**

Furthermore, the conceptualisation of the problem had significant implications in terms of what solutions were offered to tackle health inequalities outwith general practice. This is discussed below. In general there was more consensus amongst all participants, regardless of discourse, in terms of the role of general practice and GPs in tackling health inequalities as Section 6.4 reveals. There was no significant patterning according to clinical experience or gender to describe the discourse approach of participants. However, GPs with significant involvement in the Deep End group (defined as attending more than 6 meetings, in addition to steering group meetings) were more likely to describe the problem from either an Analytical or Structural approach. While it is unclear whether more socially aware GPs are more likely to

be involved in the Deep End group or if the Deep End group encourages GPs to be more socially aware, it is an important point nonetheless and further explored in Chapter Eight.

### **6.3.1 ‘Cultures of smoking and drinking’—GP discourse aligning with a Functional approach**

For the GPs aligning with a Functional approach, their description of the problem was largely attributed to lifestyle and cultural preferences. This is highly indicative of the ‘cultural/behavioural’ explanation for health inequalities outlined in the Black Report (1980) and Raphael’s discourse level 2. As noted in Chapter Two, this explanation—as set out and discredited in the Black Report (1980)—rests on the idea that health is patterned due to cultural differences and lifestyle preferences and is not inherently the result of structural inequalities. Conceptualising the problem as lifestyle and/or behavioural-related was also indicative of their solutions offered to tackling health inequalities, as the research reveals below.

Lifestyle was the most frequently cited reason, amongst interviewees aligning with a Functional approach, for what causes inequalities in health outcomes. Specifically, these GPs described their patients as ‘choosing’ to follow unhealthy lifestyles. Unsurprisingly, these were also the GPs negatively constructing their patients through their victim-blaming description of patients.

*We’ve got the Sir Chris Velodrome [within the area]. It’s a brilliant facility. But the people that are using it are from Bearsden. So it’s £8 if you want to go cycle on the track. But yeah, I’ll fork out £8 to do that, but that’s almost 2 packs of cigarettes...I mean we have the Live Active scheme where you can refer people, and some people do use it, but um, the general case is if you see someone out running here, there’s normally a police car following them. You cycle home and you start getting through town, and there’s people running all over the place. And they’re running because for their own health. But, no...you don’t see people jogging [here]. So, it’s just not part of people’s lives. (Dr Stuart Booth, male, mid-career, moderate Deep End involvement)*

For mid-career Dr Stuart Booth, who works in one of Scotland’s 20 most deprived practices, poor health outcomes in deprived areas were attributed to personal preference and the

prioritisation of unhealthy behaviours (e.g. smoking) over exercise. In addition to exercise, lifestyle explanations for the ‘problem’ also focused on healthy eating, although two end of career GPs had contrasting opinions on whether their patients recognised what this meant.

*So people say, ‘Yeah I’m eating healthy’. That means they’re grilling bacon three times a day and sticking it in a bun, as opposed to frying it. It’s not the frame of reference that maybe you or I would have about what we think is healthy eating. (Dr Neil Ferguson, male, end of career, minimal Deep End involvement)*

*I mean, diet and exercise, changing behaviours is very, very difficult. And everyone, sort of, goes on and on about how it’s about education. I don’t think there’s anybody on the planet that thinks smoking is healthy, or eating Mars bars is healthy. It’s not about education. It’s about changing behaviours, which is very difficult and I don’t really know how you do that. Because most people in the east end of Glasgow will know what a healthy diet is. It’s just that they can’t quite see themselves doing it. I think the trouble is that most people actually prefer sweet things and crisps, and they don’t want to have an apple, or whatever. (Dr Janet Campbell- female, end of career, no Deep End involvement)*

Dr Neil Ferguson suggested that his patients did not fully understand what ‘healthy eating’ meant, establishing an ‘us versus them’ dichotomy, even though obesity rates are on the rise across the social gradient (Devaux & Sassi, 2013). In contrast, Dr Janet Campbell proposed that difficulties with health behaviour change, rather than health education, was the underlying explanation for the inequality of poor health outcomes in deprived areas. In her view, there was a widespread understanding of what it meant to eat ‘healthy’ but, similar to Dr Booth’s view, it came down to the individual preference of sweets and crisps to healthier options. In their suggestions regarding what could be done to tackle health inequalities, both GPs identified policy affecting healthy lifestyles and behaviour, including minimum unit pricing on alcohol (Dr Ferguson) and the smoking ban (Dr Campbell), as ways to address the problem of health inequalities. While population health strategies should not be discounted entirely, it is important to understand how they are delivered, and this is further explored in Section 6.4.2.

Beyond lifestyle considerations, GPs aligning with a Functional approach also cited cultural issues as an explanation for the existence of health inequalities, primarily referring to the transmission of poor health behaviours across the generations from parents to children. Rather than suggesting that wider political and/or structural mechanisms might be the cause for unemployment, lack of education—and their subsequent effect on health—their view was that it was largely cultural lifestyles of smoking and drinking. Whether this was stated as “cultures of smoking and drinking” (Dr Findlay), “inbred attitude[s]” around alcohol (Dr Fraser), or “watch[ing] mum and dad [drink alcohol, smoke and do drugs]” (Dr Stewart), the emphasis was on families as the mechanism for transmitting unhealthy lifestyles and cultures of worklessness, a theme that is explored further in the next section. Focusing on the alcohol and drug problems of their patients further frames them as the architects of their own poor health, rather than looking at the underlying reasons for why there is no work in the area or why alcoholism heavily affects their patient population.

### **6.3.2 ‘Many of our patients are on such a low wage I don't know how they survive’—GPs aligning with a Functional/Analytical approach**

The three GPs who straddled the Functional and Analytical groups in their description of the problem referred to unhealthy-lifestyles and a behavioural focus in deprived areas, but also highlighted how living conditions such as poverty and early childhood development disproportionately affect health in deprived areas. This is indicative of Raphael’s third and fourth SDH discourse levels wherein material living conditions shape health (level 3) and systematically differ according to group membership such as class (level 4). For example, Dr Lucy Carroll, who had been practising for less than 10 years, attributed unhealthy lifestyles to financial barriers.

*I offer suggestions [to try and promote health and wellbeing], you know, ‘Go out for meals, go to the cinema’ and they're, like, ‘I can't afford it’. You know, ‘Eat more fruit and veg’. ‘I can't afford it.’ ...Many of our patients are on such a low wage I don't know how they survive. (Dr Lucy Carroll, female, early career, no Deep End group involvement)*

While Dr Carroll identified low wages as contributing to the problem, she did not provide further explanation for *why* her patients were on such low wages, such as wider structural and income inequalities. Similarly, Dr Rory MacGregor noted issues with unhealthy lifestyles, such as “smoking, drinking, lack of exercise”, but also described the impact significant changes in the economy including shipyard closures had on his patient population.

*We know that people who work generally keep better health, but the problem [here] being there's not much work, you know, out there. (Dr Rory MacGregor, male, late career, no Deep End involvement)*

Dr MacGregor's discourse, however, failed to reflect Raphael's higher discourse levels (5-7) as there was no mention of public policy decisions or power structures that influenced the shipyard closures. Dr Simon Alexander, whose practice population is a greater mix of deprived and middle-income patients than other practices in the Deep End, also attributed part of the problem to the decline of the building industry without mentioning the influence of policy and political decisions. Furthermore, his discourse subscribed to a cultural explanation for why deprived areas are disproportionately affected by poor health.

*We're now seeing people who are coming through who are maybe in their late teens, early 20s, who are now coming in looking for sick lines to be signed off, from looking for work. Because that's maybe what's happened with their parents, maybe even their grandparents, who might have worked...Traditionally this has been an area that's been involved with shipping, heavy industry, which has now completely gone. And I think that initial generation, who did work very, very hard, then had nothing. Then the next generation after that have maybe been battling with it, and now we're onto this third generation coming through, where that's maybe all they've know, is somebody who's either been on benefits, or on sick. And I can remember a patient, vividly, coming in, who was 19 years old, who was looking for his sick line. And when I asked why he actually signed off, had there been something, he couldn't give any answer. He was going on holidays, he was playing football with his friends...And then the next day, he jumped out of a first storey window ...fractured both of his ankles, and then got signed off. (Dr Simon Alexander, male, early career, minimal Deep End involvement)*

In Dr Alexander's view, requesting 'sick lines' (i.e. a patient asking the GP for an 'unfit for work' letter due to illness in order to claim benefits) had been passed down generations from parents to kids. His extreme—and potentially exaggerated by the patient—account of a patient self-injuring to receive a 'sick line' attributes the problem to generations of worklessness, which is in line with the cultural explanation Drs Findlay, Fraser and Stewart offered for poor health behaviours in the previous section. What this explanation does not fully explore, however, is why generations of patients may be consistently out of work, including changes in the benefits system (discussed further in the next section) and changes in the labour markets (Kintrea et al., 2015; Macdonald et al., 2013). Dr Alexander lightly references this in terms of declining industry and later in the interview acknowledges poverty as a key driver of health inequalities, including the dilemma some patients face between work and the receipt of benefits.

*But I think even here, you can still have people who have to make the decision, which I think is a problem of, 'Okay, well if I go back to work, my money [from benefits] might actually go down and I might lose out on areas' ...Because for me, the big part would be poverty and deprivation. Why are they in poverty and deprivation – is it because of an educational issue, or are they not going through their education because of the poverty? Is it, like I was kind of alluding to before, a lot of environmental problems, where you see the repeated generations. And you know, if you or I stayed in one of these horrendous high rise flats, where you're surrounded by folk who are not working, who will never work, who are drinking, who are drug using. If that's all you see, and that's all you know, it's gonna be really difficult to break out of that. (Dr Simon Alexander, male, early career, minimal Deep End involvement)*

However, his return to cultures of drug use and worklessness echoes recent neoliberal government ideology surrounding the issue. As Wiggan (2012) notes, the discourse in the 2010 White Paper 'Universal Credit: Welfare that Works' perpetuates the pathologies of worklessness and benefit dependency which blame the individual—and negatively construct the patient—rather than focusing on wider structural causes such as poverty and changing labour markets. Thus, Dr Alexander's description of how employment can negatively affect the receipt of benefits, in response to the interviewer's question on what are the key drivers of

health inequalities, implies a preliminary exploration of how public policy decisions (discourse level 5) potentially impact on health. Unlike Dr Ferguson's 'us versus them' dichotomy, it also shows empathy and understanding of the patient's position. This highlights the fluidity of GP discourse across levels, an important observation that carries through later in the chapter on social construction of patients and methods of tackling health inequalities within general practice.

### **6.3.3 'What is it like, as an unemployed young man, trying to live on £57 per week?'—GPs aligning with an Analytical/Structural approach**

As previously noted, GPs actively involved in the Deep End group were not only more likely to positively construct their patients and demonstrate physician empathy, but also to identify policy and structural conditions as explanations for health inequalities. Within this group there were several interviewees who made note of lifestyle and health behaviours, but rather than citing these as a cause of health inequalities instead emphasised that these were symptoms of underlying issues such as material deprivation and adverse living conditions. For example, end of career Dr Fergus Lindsay empathised with his patients, questioning why someone would want to change their lifestyle if that is their solace for stress related to adverse living conditions.

*I think that's part of the stresses and strains of living a life in a more deprived area, and having inequality in material, social...Yeah, I mean it's more difficult. You have to be motivated, you have to have insight, and there has to be, you know, incentives to do it. And where's the incentives to stop smoking, if your life is falling apart around you, and the only thing you have is the relief you get from your cigarette, or your alcohol, or cannabis? (Dr Fergus Lindsay, male, end of career, some Deep End involvement)*

In addition to living conditions, Dr Robbie Bannigan, another end of career GP, emphasised the inadequacy of dealing with lifestyle issues if wider structural inequalities were not addressed. For him lifestyle factors were not the problem but rather a manifestation of much larger inequalities.

*I'm unhappy with lifestyle factors. I don't know anybody who does everything that they should, and doesn't do anything they shouldn't...And so, that one bothers me, but it's*

*the [other SDH] underneath that, if we dealt with those then I'm happy to take on board trying to deal with the lifestyle stuff. If we don't deal with [wider structural inequalities] we're stuffed...the real determinants [of health] are getting worse and worse, and so, although we are making some changes, the things that are being done to our patients outside of that, are greater. (Dr Robbie Bannigan, male, end of career, significant Deep End involvement)*

Moreover, Dr Bannigan stressed that unhealthy lifestyles were not unique to deprived areas, but rather a widespread occurrence. This is an important point to highlight, as solely focusing on poor health behaviours in deprived areas is likely to perpetuate the victim-blaming discourse and further stigmatise individuals living in these areas.

Dr Alison Kelly, another GP significantly involved in the Deep End group, suggested the problem could be tied to a decline of social mobility.

*There is much more a low self-esteem culture and that really comes from living, I think, in an area where you've got such [major] inequalities and [life] chances are shrinking. The chances for people now to go from the 99 percent to the one percent...[are] probably nil. In an area like this, forget it. A young kid coming out of school, if they're lucky, might get an apprenticeship; the chance of them getting onto some sort of housing ladder, very, very difficult now. So, it is becoming more and more remote...it's different from my parents' generation who, if you were aspirational, you could move from [deprived neighbourhood of Glasgow], you could move up on the next rung of the ladder. I think it's very difficult for them here now. (Dr Alison Kelly, female end of career, significant Deep End involvement)*

She suggested it was now more difficult to move out of deprived neighbourhoods in comparison to previous generations. This resonates with Raphael's discourse level 4, wherein group membership such as class can adversely affect living conditions. By discussing why social mobility has declined, which she does at a later point in the interview in terms of income/wealth inequalities, it also reflects discourse level 6 in terms of the influence economic structures have on health inequalities. Overall her emphasis was not that declining social

mobility causes health inequalities, but rather that the two go hand in hand due to a reduction in opportunities afforded to deprived areas as a result of structural inequalities.

As aforementioned, how the problem is defined will have significant implications in how it is addressed; thus, identifying wider structural inequalities (discourse level 5) as the root of the problem implies solutions to tackling health inequalities must address income and power inequalities. Unsurprisingly, GPs aligning with either an Analytical and/or Structural approach were also more likely to suggest solutions tackling wider SDH, policy and wealth distribution. In terms of SDH, housing, employment and education were the most frequently cited social determinants needing to be addressed. As Dr Helen Reilly, an active member of Deep End group, noted, these determinants “are far more important to people [in deprived areas].” The SDH were subsequently tied to policy and politics (Raphael’s discourse levels 5 and 6) by several of the GPs actively involved in the Deep End group in addition to Dr Martin MacPherson, who had no Deep End involvement.

*I suppose you could look at the different levels. I think it’s well recognised some of the major health improvements have not come about through GPs working in certain ways, [but rather] national, social policy decisions about benefits and housing and that sort of thing. (Dr Martin MacPherson, male, end of career, no Deep End involvement)*

Dr MacPherson does not necessarily discount the importance of general practice but rather suggests the need to focus outwith primary care in improving overall health outcomes. His view is far from radical, given Chapter Two’s note that health care, in comparison to other SDH, has historically been considered marginal in improving population health (Bambra et al., 2010; Mckeown, 1978) and in tackling inequalities thereof.

Higher up on the list of social determinants, several GPs within the Analytical/Structural approach group identified the need to tackle income inequality in order to reduce health inequalities. Tackling income inequality is very much in line with a *Spirit Level* approach, wherein Wilkinson and Pickett (2010) suggest that countries with higher income inequalities also have higher health inequalities amongst other social issues. The specific ways in which income inequality could be lessened included improvements in living wage and restructuring

taxation. This was suggested by Drs Reilly and Lindsay, and was reinforced by socially progressive political views.

*It's taxation—increased taxation you know, we need to reduce this massive divide in income, um, and you know, we need to increase, yeah, all sorts of local taxation on folk in posh houses compared with those in rotten housing, and make sure that this society's much less unequal. (Dr Helen Reilly, female, end of career, significant Deep End involvement)*

*And looking at taxation, looking at everything, trying to reduce the inequality...I think that would have made a better impact, that would have helped to make a better impact on the patients that I treat, and also the people that I see, than the current system, where we are, you know, where it's, society has been eroded, by the principles of consumerism, and right wing politics. (Dr Fergus Lindsay, male, end of career, some involvement in Deep End group)*

Political commentaries were more likely to come from GPs describing the problem from an Analytical/Structural approach, including Dr Lindsay, who indicated disappointment in the 2014 Scottish Independence Referendum result. He suggested that a ‘yes’ vote would have “seen us break away and create a more socially integrated society, with justice...tackl[ing] the issues by focusing on the collective and not the individual.” For him, bridging social divisions in society was seen as an integral part of the solution. A few of the other GPs specifically mentioned the Referendum as a missed opportunity in tackling health inequalities, including Dr Chris Wallace. Rather than taking a pessimistic view of the outcome of the Referendum, he was hopeful that there was “a general will to try and look at how we can improve the health of the poorest and reduce inequalities” which had yet to be fully imagined through policy. He felt that being “in the debate” better positioned Scotland to tackle health inequalities “in a way that we couldn’t be down south [i.e. England]” due to the proximity of the Scottish Parliament and the difference in political environment.

Overall, there was minimal discussion surrounding those who benefit from health and social inequalities (level 7), which is on par with Brassoloto et al.’s (2013) and Mackenzie et al.’s (2015) research wherein participant discourse tended to focus on discourse levels 1-5. Dr

Bannigan, one of the GPs demonstrating greater empathy in his positive constructions of patients, was the only one who referenced this in his discussion of addressing the inverse care law (although several other GPs referenced the inverse care law generally in terms of the mismatch of resources to patient needs in deprived areas).

*The biggest thing that will get in the road of doing anything with the inverse care law is the profession, because there's no way that the vast majority of GPs, who don't work in deprived areas, are going to say, well, that's fine, you can have more GPs and we'll have less. They're not, I mean, that's turkeys voting for Christmas. They're not going to do it so, you know, how's it going to be addressed? So, I think a lot of them don't see it, and those that do see it don't actually, and probably most of the time you can turn a blind eye. (Dr Robbie Bannigan, male, end of career, significant Deep End involvement)*

In his view, the GP profession was the primary barrier to achieving a distribution of GP resource that more closely matches need. In this sense, GPs working outside of deprived areas potentially stand to benefit from existing inequalities through the current pay structures and therefore inhibit addressing them. Dr Bannigan was also one of the few GPs to demonstrate a level of self-awareness in recognising their position of power (e.g. in relation to their high status and relatively well paid jobs) and proposing that this awareness was critical to working in a deprived area.

*Doctors are now coming from affluent, middle class families. They've been in a private school, they've got no idea what it's like, and if they don't work in a deprived area they're completely divorced from reality... It's so arrogant, and I think you have to be able to step back and say, 'what is it like as an unemployed young man trying to live on £57 per week? How do you do that?' That means that you don't get nice things, you can't afford them, and I think you have to be able to do that, because if you don't do that then it can seem... You know, if we're making major life decisions, what wine will I have for tea? Major life decisions for some of my patients are, 'Will I have tea?' (Dr Robbie Bannigan, male, end of career, significant Deep End involvement)*

Like Dr Alexander in the previous section, Dr Bannigan demonstrated a willingness to ‘walk in others’ shoes’ as opposed to the ‘us versus them’ discourse, which demonstrates for them why a strictly lifestyle and health behaviour focus is inappropriate. Social empathy, defined by Segal (2011, pp.266-267) as “the ability to understand people by perceiving or experiencing their life situations”, provides insight into structural inequalities and can give rise to action influencing social justice and overall wellbeing. Thus, constructing patients living in deprived areas as ‘deserving’ has significant implications in the commitment to improving living conditions and reducing wider structural inequalities. How empathy might influence the daily activities of GPs working in deprived areas—including perceptions of professional stress—is further explored in Chapter Seven.

## **6.4 Crossing discourse boundaries in tackling health inequalities**

In terms of tackling health inequalities both in and out of general practice, there were some themes that crosscut all of the discourse approaches. This includes changes in the benefits system (outwith general practice), health improvements, and continuity of patient care (both considered within GPs’ remit). An additional theme of advocacy emerged from all of the interviews; however, given its complexity and depth it will be discussed in Chapter Eight as part of a wider discussion of the social responsibility of GPs. While these themes crosscut discourse approaches, the specific group (Functional, Functional/Analytical, or Analytical/Structural) in which a GP was described still had an influence on how these themes were discussed and is highlighted below.

### **6.4.1 Changes in the benefits system**

Outwith general practice, GPs across all approach categories identified the need for changes in the benefits system. This is possibly due to the fact that GPs working in deprived areas often have a direct role in patient’s benefits in the form of support letters (e.g. fit for work or housing letters), a topic which is discussed in further detail in the subsequent chapters on street-level work and patient advocacy. Recent changes (at the time of the interviews)

involving benefits, and more specifically the Bedroom Tax<sup>25</sup>, were highlighted by several of the GPs, noting the direct impact it has had on their workload (Dr Bannigan) and patient stress (Dr Fraser). Dr Agnes Gillies provided a historical overview of the ‘pendulum’ of the benefits system, in addition to a contradictory remark about one of her patients.

*We’ve had the era where people got lots of benefits and lots of money... We’re now in the downcycle of that where the pendulum’s swung too far the other way...but there’s a balance in there, it was too easy for awhile for people just to get benefits and think they would be on benefits for the rest of their life. And nothing can change that. Whereas now it’s almost swung too far, and you hear patients saying they’re now sanctioned, so they’ve got sanctions because they missed an appointment, and they’ve got no money...even the Bedroom Tax, which has upset people, it’s not fair and it’s partly not fair because there aren’t single room houses, and if there aren’t those I don’t think people should be punished. But, one old lady said to me recently, she had hoped she’d be able to stay in her 3 bedroomed house and have her grandchildren to stay, and that made me think no, if that was me and my income was dying and I’m sitting in a big 3 bedroomed house I would be moving. (Dr Agnes Gillies, female, end of career, some Deep End involvement)*

The perspective of Dr Gillies is particularly interesting due to its negative construction of patients beyond her account of the specific patient. While she started to cite the Bedroom Tax as ‘unfair’ due to the lack of single room houses, she went on to criticise a woman for staying in her 3 bedroomed house. For her, the benefits system was previously overgenerous for low-income groups leading to ‘benefit dependency’ (a term used to denote an overreliance on the welfare system). However, recent changes had created an environment of over-sanctioning and placing individual’s benefits at risk. Her commentary on the Bedroom Tax was particularly double-edged, noting that while the Bedroom Tax was ‘not fair’ she still perceived one of her patients to be exploiting the benefits system. While she fails to recognise the role of

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<sup>25</sup> As noted in Chapter Three, “Bedroom Tax” refers to the changes to housing benefit rules as of 1 April 2013 for working-age adults renting in the social sector which reduces their housing benefit if ‘under-occupied’ (reduction of 14% for one extra room and 25% for two or more extra bedrooms)

governmental policy during the 1980s and onwards to reduce unemployment figures by deliberately boosting the category of incapacity benefits (Beatty & Fothergill, 2013); Dr Claire Findlay picks this up below.

GPs describing the problem from a Functional or Functional/Analytical approach were more likely to describe the benefits system as creating a “financial incentive to be sick” (Dr Booth) due to the discrepancy between Jobseeker’s Allowance (JSA) (income support for individuals actively searching for work) and Employment Support Allowance (ESA) (income support for individuals who are unable to work due to illness or disability). This was not without critical insight into the politics of welfare benefits during the last several decades amongst other GPs, including Dr Findlay.

*There are public policy things that could change. One thing that’s gonna, or is changing is the welfare reform, where patients were almost colluded with to be workless to kind of take on a sick role. Em, and now, you know, because it doesn’t suit the government to show that they’re unemployment figures, they want to show that they’re getting people off sick benefit, em, cause it doesn’t suit them, so these people that were, in fact, as I say, the most encouraged in some ways into that sick role are now being told ‘you actually have to work’. And that will have, is already having impact on patients. So these are not public health policies, but political policies. (Dr Claire Findlay, end of career, some Deep End involvement)*

As Dr Findlay noted, there was a changing position of the government—what Dr Gillies failed to identify above—first encouraging patients to go on ESA but now finding individuals ‘fit for work’ who were previously on support. While Drs Gillies, Booth and Findlay all described the problem from a Functional or Functional/Analytical approach and tended to negatively construct their patients, the above accounts showed some insight into how policy might negatively impact on their patients. This suggests that GP discourse fluctuates and does not entirely fit within any of the categories.

#### **6.4.2 The 3 P’s of health—protection, prevention, and promotion**

Regardless of discourse type, participants were generally in consensus about the role of general practice in tackling health inequalities, and these were discussed as health

improvements in lifestyle and behaviour change, and continuity of patient care. This was the case even for GPs who acknowledged the problem of health inequalities from an Analytical and/or Structural approach because when it came down to it, they ultimately felt these were the areas within their scope to positively address. Within this health improvement/lifestyle/behaviour change scope, there were three primary ways in which GPs felt they could positively influence health inequalities: acting as healthy role models, health prevention/protection/promotion strategies, and continuity of patient encounters.

Given their role in promoting health and overall wellbeing for their patients, a GP's focus on lifestyle and health behaviour change is not inherently bad; however, contextual factors remain an important consideration and this is displayed by comparing Drs Gallacher and Booth. Dr Gallacher, who aligned with an Analytical/Structural approach demonstrated a large degree of empathy in his social construction of patients and felt that while he could positively impact on a patient's lifestyle, this needed to consider his patient's circumstances. For example, he described asking patients how he might support them in addressing social issues—which often overshadowed medical issues—so that the patient then might feel enabled to tackle health behaviour changes to support weight loss and healthy eating. Conversely, Dr Booth took a predominantly Functional approach in his problem discourse and described acting as a 'healthy role model' as one of the main ways he felt he, as an individual GP, could help tackle health inequalities. Specifically, he felt that having his bike in the office would act as a "conversation starter" by prompting patient discussions on health lifestyles. In contrast to a more empathetic patient approach, the 'lead by example' mentality is potentially problematic as it presumes that unhealthy behaviours are primarily responsible for a patient's poor health. This is because certain 'healthy' behaviours such as active commuting may not be easily adopted due to financial/time/mobility constraints or childcare duties. From this perspective, a 'lead by example' approach fails to acknowledge the difference in privilege between the GP and their patients living in deprived areas.

For Dr MacGregor, who aligned with a Functional/Analytical approach, his role in health protection was seen as particularly important to start from a young age. The barrier for him in this, however, was the lack of contact he had with his patients during their adolescent years because, "You'll see the kids when they come for the immunisations, but then they're off and

away, ‘til maybe they’ll get to teens [when] they’re comin’ in with their acne.” Once he did see young patients later during their adolescent years, Dr MacGregor felt that part of his role in working in a deprived area, aside from medical care, was to promote education.

*The kids come in and I’ll chat away to them, talk to them about sports and try and encourage them [towards] other academic things, you know and send myself up. ‘He went to ordinary school, was completely stupid, but managed to get to medical school.’ So if I can do they can it! I know it’s not quite as easy as that, but kids come in, we’ll try, you know if they come to the work clinic you’ll try and chat to them and about what their aims are, what their dream is, what they want to do with life. Even though you know you’re not gonnae make a difference, but if you can make a difference to one, [it helps]. (Dr Rory MacGregor, male, late career, no Deep End involvement)*

This included using himself as an example of someone who grew up in a working class family in a deprived neighbourhood of Glasgow but went on to medical school. While he was doubtful how much difference this would make in terms of the overall health inequalities picture, his sentiment that making a “difference to one” was still important.

Several of the GPs suggested prevention, particularly with early detection of illness and chronic disease management, played a key role in tackling health inequalities.

*They’ve [i.e. researchers] looked at if you put extra money into secondary care, it’s almost like a black hole that, you know, you might get your knee replacement a little bit earlier, but it’s not going to stop you dying any sooner, but as far as I read in studies, if you invest more money in general practice, then patients will get seen quicker, we should pick up health problems quicker and cancer survival statistics and everything else should improve. So I think we [i.e. GPs] are well placed to do that. (Dr Cecilia McCullough, female, early career, some Deep End involvement)*

Dr McCullough proposed that further investment in general practice, as opposed to secondary care, would enable GPs to identify health problems sooner. This could subsequently help mitigate existing health inequalities through overall improvements in health, provided additional resources are distributed by socioeconomic need. GPs citing their role in health

promotion as a means of tackling health inequalities indicate the increasing role of public health activities in general practice since the end of the 20<sup>th</sup> century. Public health activities (e.g. immunisation and smoking cessation programmes) delivered through primary care can help to improve population health; however, they do not necessarily reduce health inequalities and may actually widen them if they do not address the social gradient. As Chapter Two highlighted, a proportionately universal approach may be the most effective intervention approach at combatting health inequalities. In practice this means that public health interventions delivered via general practice would be universally applied across all GP surgeries, but with increased focus (potentially in the form of additional resources) on practices serving populations suffering from high levels of premature multimorbidity. Additionally, *within* practices this translates to increased focus (such as longer/more frequent patient consultations) on patients with complex needs. Recently qualified Dr Katie Stewart supported this, suggesting GPs are well positioned to identify need within their patient populations because, “We’re the people in the best position to get to know our patients,” and thus identify vulnerable individuals. While this focus on identifying vulnerable individuals and using health services to improve health is in line with Raphael’s discourse level 1, scope remains to mitigate existing health inequalities if efforts are proportionate to need. Furthermore, activities related to population health planning involve additional time and resources that, as the next chapter reveals, are not always available to GPs working in deprived practices.

### **6.4.3 Continuity in general practice**

The final crosscutting theme, with respect to how GPs might influence health inequalities, evidenced in the interviews was through continuity of patient care. As Chapter Three highlights, this is one of Starfield’s four main attributes of primary care. As Dr MacGregor emphasised, “We’re a constant in their life and we’re always here.” Most of the GPs described continuity as a way to positively impact on the health of their patients over time through influencing lifestyle and for opportunistic care.

End of career Dr Lindsay, who described the problem from an Analytical/Structural approach, explained that the essence of general practice lies in the individual patient consultation because it is, “All about what happens on a one to one [basis].” As he explained in the

following patient example, the consultation is a time for interaction and to develop a relationship with the patient, something that is particularly beneficial in a deprived context.

*I had a girl in the other day...the family are maybe gonna get made homeless 'cause they're behind in their rent. She's keeping down two jobs, she can't, she's really not coping with it, 'cause her husband is unemployed. The husband is unemployed...He gets no benefits whatsoever, 'cause she's working, she has to keep him. And she's doing two jobs to hold down him, the family, and they're now getting into – so it's this spiral. And she's now depressed and having to take time off work, which is gonna impact on their finances, so on and so forth...So for her, for example, what would it really mean to, you know, exercise, stop smoking? She hasn't time and the space in her life, you know, it's just not gonna happen at this moment in time. So you've just got to say, look, I play the longer game here, I play the longer game. (Dr Fergus Lindsay, male, end of career, some Deep End involvement)*

Dr Lindsay explained that patients' difficult lives stemming from problems related to multiple deprivation are not always conducive to behaviour change. He recognised that if a patient has multiple social issues going on they may not be in a place for health behaviour changes. Consequently, he described playing the 'longer game', wherein health behaviour change occurs at a time conducive to the patient's life and circumstances.

Mid-career Dr Anderson, who also described the problem from an Analytical/Structural approach, noted that she, "Never give[s] up," on her patients through the following patient vignette.

*Like last week, I had a woman who suddenly said, 'Can you take a smear today?...You have discussed it again and again and again.' So if you don't discuss it again and again and again, that woman will never approach you... Yeah, and [it's important to] constantly offer opportunities [to the patients]. 'Are you ready to go out?', 'Would you be ready to see an employability worker?' without calling it like that. 'Can we get you out of the house?', 'What do you feel comfortable with?' (Dr Kenna Anderson, female, mid-career, significant Deep End involvement)*

In this example, Dr Anderson discussed the benefit of continuity in preventative care *and* in addressing social issues, as she perceived her GP role going beyond a patient's clinical care. How GPs perceived their scope extending to individual social issues (and beyond) is important to highlight and will be covered in further detail in Chapter Eight.

Several of the GPs, including Dr Campbell, who aligned with a Functional approach to the problem, described 'chipping away' at health problems in the sense that change did not happen overnight but over the long-term. To support this, Dr Alistair Fleming, a GP aligning with an Analytical/Structural approach, provided an example of 'chipping away' to improve a patient's chronic pain management.

*So, I've got one person who when she first started coming, when she first joined the practice, she was on morphine and diazepam and two different antidepressants, and still feeling terrible, pain was not controlled, it's all awful; and I'd kind of worked quite hard at explaining long-term pain and so on, felt like I got absolutely nowhere; but actually about five years later she said something along the lines of, 'I thought you were completely crazy when I first met you but actually I now realise what you were saying makes sense.' And she is actually getting by on very little medication now [though] she's still got lots of problems. (Dr Alistair Fleming, male, mid-career, significant Deep End involvement)*

For him, the realisation that he had helped the patient came five years after he initially started working with her. While she still had continuing social and mental health problems, Dr Fleming saw success in the fact that her pain management had improved to where she was on minimal medications.

Providing an element of stability for patients with complex—and often chaotic—lives was viewed by most of the participants as an important GP role. This was linked to not only being able to provide opportunistic care, but also a level of support for the patient's overall wellbeing. As the next chapter shows, it is also a fundamental coping mechanism in terms of what GPs can achieve in the context of time constraints (Watt, 2015).

#### 6.4.4 Part of the 'bigger picture'

Considering their narrow scope, working with individual patients, a few of the GPs expressed uncertainty regarding the role individual GPs played in tackling health inequalities. Dr Elizabeth Duggan, for example, described tackling health inequalities as a 'social issue' outwith the scope of primary care. However, for the majority of interviewees there was a general consensus that they played some role. One of the participants, Dr Duncan Macleod, specifically related general practice's widespread coverage as a way of narrowing health inequalities.

*General practice has comprehensive coverage of people and their illnesses, and everything... you've got a blanket in the UK that covers all of that. (Dr Duncan Macleod, male, end of career, minimal Deep End involvement)*

As Chapter Two highlighted, this 'comprehensive coverage' is a key factor in general practice's ability to address health inequalities via a population health approach.

For Dr Stewart, however, the reasoning offered for general practice's involvement in tackling health inequalities was a matter of default—if GPs did not take some responsibility in tackling health inequalities, then who else?

*No, I think the role of the health service is very important in tackling this inequality. Em, the people that would disagree with that, I suppose my question would be, well who do you think should have responsibility? Or who do you think could make a difference? (Dr Katie Stewart, female, early career, no Deep End involvement)*

As this chapter has demonstrated, how this role in tackling health inequalities was operationalised was variable, but still an important part of the overall picture. This was primarily due to GPs' understanding that healthcare services were only one avenue to tackling health inequalities.

*I think we can all do our own bit. But we are only part of the whole picture. So I think people who say, 'Oh we can't do anything,' are denying a chance to change bits of your own area. But likewise, we can't change education, we can't change social work,*

*[we can't implement a] fair living wage. And so, we have to see it in that context, basically. (Dr Kenna Anderson, female, mid-career, significant Deep End involvement)*

*Just looking at the much bigger picture, you know, I don't think in the next 10 years that the average life expectancy for a man in the east end is gonnae have changed drastically? But I'm hoping that somehow, you know, and with more education and more funding in the right places that maybe in, yeah, 50 years time people here will be living as long as people 10 miles up the road. (Dr Katie Stewart, female, early career, minimal Deep End involvement)*

Specifically, Dr Anderson acknowledged limitations of the GP role in changing other SDH while Dr Stewart described the huge undertaking of tackling health inequalities, noting that it would likely take several generations for average life expectancy to improve. As this chapter has highlighted, this is primarily due to the role of the health service—and more specifically general practice—in mitigating, but not necessarily preventing, health inequalities (RCGP, 2015; Starfield, 2004). When followed up with a question of what the ‘right places’ would be, Dr Stewart was unable to clarify. However, a few of the other GPs expressed the need for the NHS to be, “At its best where it’s needed most,” (Dr Wallace) and for general practice to, “Provide the best possible service for our patients,” (Dr Campbell) to ensure that health inequalities were not further exacerbated by the healthcare system. This is in line with Deep End Report 20 (2013), which suggests health inequalities can be addressed via general practice by increasing the “volume, quality and range of services provided” (p.4) in areas of high deprivation. However, a barrier to achieving this, explained by Dr Campbell, was that resources in deprived areas—in terms of GPs and primary care staff—failed to reflect need. Whether or not increased human resources would actually help the problem, however, was questioned by two of the GPs—both of whom aligned with an Analytical/Structural approach—with more radical ideas.

*Practices don't have really the capacity to engage in a meaningful way with their communities; and that partly led me to think about the contract that we work in and to feel that I would strongly wish that to be a different type of contract that valued community-based support and linkages to the community...I suppose I don't think it's*

*as simplistic as reverse the inverse care law, put more doctors into deprived areas, more time and all that kind of thing. (Dr Alistair Fleming, male, mid-career, significant Deep End involvement)*

*I think a lot of GPs still think the traditional model is the right model, if only you could better resource it, whereas I think I am pretty clear that the traditional model has very little to offer, even if it was adequately resourced. So even if you give me 20 GPs I don't think it will make any difference to the health of my population... And it's a false split as well because there are no doctors, so if you think of all those guys across central Scotland who are going to retire in the next couple of years, there is nobody to replace them... And there's an ethos problem in the health service. They're all trained on continuous improvement models, and that's fine if you're starting from a good place, but if you're starting from a completely wrong place then a continuous improvement model nine times out of ten isn't capable of getting you out of that. (Dr Hamish Mackay, male, mid-career, no Deep End involvement)*

For Drs Fleming and Mackay, a complete overhaul of the current system was needed to effectively tackle the problem. Dr Fleming described the need to better link general practice to the community and suggested the GP contract might be a way to do this, a topic that is further discussed in Chapter Seven. Dr Mackay was referring to continuous quality improvement (CQI), which the King's Fund describes as a paradigm for systems change and is commonly referred to as 'quality improvement' or 'improvement' (Dawda et al., 2010). It is primarily data driven and focuses on setting goals and planning, implementing and measuring change. Not only was he critical of its potential to support health improvement, given the existing inequalities in health, but he also highlighted the current GP recruitment crisis (BMA, 2015).

## **6.5 Conceptualising GP 'Scope'**

Most of the GPs envisioned a role they could play as part of the solution to addressing health inequalities in very deprived areas; however, as the next two chapters reveal this was not limited to individual clinical care and included individual social issues and higher levels outside the practice not characteristically considered within a GP's scope. To capture this,

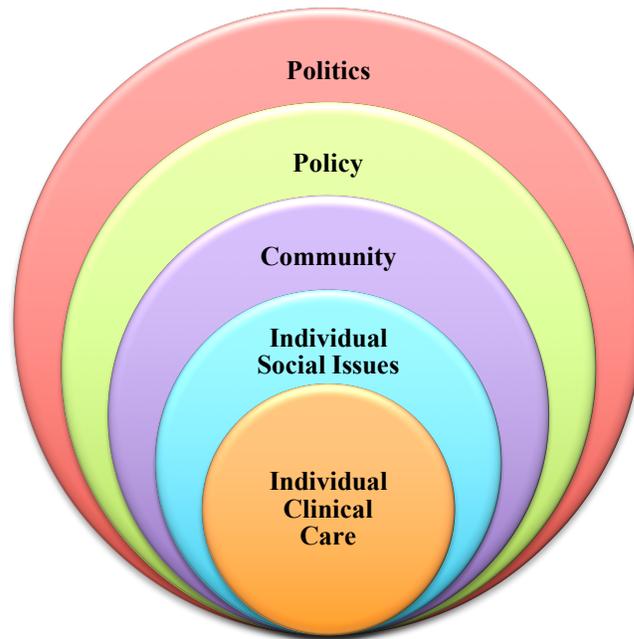
Figure 6.2 is a hierarchical overview of the levels at which GPs perceived their professional role, starting with individual patient levels.

*Individual Levels* – From this perspective GPs may operate in two ways – one, entirely clinically where symptoms are dealt with individually (‘Clinical Care’ level); two, with a focus on some of the social determinants of health (e.g. housing and welfare benefits) as played out in the lives of individual patients (‘Social Issues’ level). While clinical care is strictly limited to a Functional approach (Raphael’s discourse levels 1 and 2), focusing on individual social issues extends higher up to an Analytical approach (discourse levels 3 and 4). Action at these levels will have minimal impact on the social gradient in health, but may work to mitigate health inequalities if care is provided from a proportionately universal approach. In other words, this would mean an additional focus (such as through additional consultation time) on complex patients.

*Community Level* – Moving up, the perception of scope extends beyond individual patient care to the ‘Community’ level, exploring how GPs view their role within the communities where they practise. For example, do they involve themselves in community organisations and/or events or is the practice the only place they attend in the community? Depending on the type of organisation or community involvement (for example if it addresses SDH related to living conditions or life circumstances), this may be in line with an Analytical approach, but is unlikely to impact on health inequalities unless done on a large scale.

*Policy and Politics Levels* – Lastly are the highest levels of ‘Policy’ and ‘Politics’, which capture GPs’ role in working for policy change in relation to the SDH. These levels are in line with a Structural approach (discourse levels 5-7) and are the most likely to have the greatest impact on the health gradient. Specifically, working to address inequalities in money, resource, and power not only have the potential to prevent the harmful effects of social

determinants, but also to undo the fundamental causes (Macintyre, 2007).



**Figure 6.2 Hierarchical overview of GP ‘Scope’**

This framework supports the analysis in the subsequent chapters on street-level bureaucracy (Chapter Seven) and advocacy (Chapter Eight) as each level is further explored.

## 6.6 Conclusions

The analysis of GP discourse in the interviews provided valuable insight into how they perceive their patients and the contexts they operate in. Within GPs’ descriptions of patients, the underlying issue of power was a constant—they viewed patients living in deprived areas as having low political power and generally not in a position to argue for more resources or self-advocate for preferential policies. What did vary amongst participants, however, were their social constructions of patients as positive or negative. Positive patient portrayals meant that GPs understood their patients as targets of wider social injustices; in other words, their situation was not a consequence of their actions but rather due to structural inequalities. As a result, GPs demonstrating positive constructions were more likely to display empathy towards their patients and show a broader understanding of how their complex lives makes behaviour change difficult. Conversely, GPs who negatively constructed their patients were more likely

to place blame on individuals for failing to take control of their lives. While this does not suggest that GPs operating from the perspective of negative constructions would withhold clinical treatment, it may provide insight into perceptions of patient ‘deservingness’ for support beyond individual clinical care. This is an important consideration for Chapter Eight by revealing potential underlying motivations for why GPs ‘go the extra mile’ to advocate on behalf of their patients and/or patient populations.

This chapter has demonstrated clear linkages between GPs’ perceptions of their patients, how they defined the ‘problem’, and what they thought could be done to tackle health inequalities (both in and out of general practice) in deprived areas. These findings also echo that of Raphael, as GP discourse tended to fluctuate between discourse level and approach categories rather than strictly fitting within one; while GPs were labelled according to their dominant discourse during the interviews, this does not mean there was not evidence of other discourse levels during the interviews. Specifically, GPs who framed their patients negatively as ‘undeserving’ were more likely to take a Functional approach (identifying lifestyle and cultural issues as the main explanations for health inequalities) in their description of the problem compared with GPs who took an Analytical or Structural approach in their description of the problem. Consequently, their discussion of what could be done to address the problem outside of general practice focused on the SDH and policy affecting healthy lifestyles and behaviour. Conversely, GPs who positively constructed their patients were more likely to align with an Analytical and/or Structural approach in their conceptualisation of the problem which meant identifying living conditions, policy, and/or structural decisions as the main explanations for health inequalities. While some of these GPs also identified the need to address SDH, such as employment benefits, in tackling the problem, these GPs were also more likely to suggest tackling wider inequalities in the wealth distribution as critical to addressing health inequalities.

Overall, there was more convergence on how interviewees viewed their individual role in tackling health inequalities. This was discussed primarily in the form of health improvements and lifestyle and behaviour change, largely because these were areas within a GP’s remit. Evidence given as to how they might affect the problem from this perspective included acting as healthy role models, health improvement strategies, and continuity of patient encounters.

While this chapter was focused on what GPs can do to help individual patients, it is important to note many of the participants perceived their role extending beyond this scope in terms of changing local systems and higher-level policies, and is further discussed in Chapter Eight under the umbrella of GP advocacy.

While various actions are needed to tackle health inequalities, health care services are limited in their ability to merely mitigating existing health inequalities, provided they are delivered according to need. This thesis set out to understand how GPs viewed their role in tackling health inequalities, and this analysis demonstrates a general acknowledgement of this role at various levels, as portrayed in Figure 6.1. Perhaps one of the most significant ways they might impact on the social gradient in health is their ability to identify need and thus potentially take a proportionate universal approach in their practice. This suggests that ‘need’ is easily discernible and GPs have both the resources and motivation to respond accordingly, neither of which is always feasible in the context of a deprived practice, as Chapter Seven reveals. However, action tackling health inequalities must not only prevent them from occurring, but also undo the fundamental causes. This denotes a focus on wider structural inequalities, which several of the GPs (most of which were involved in the Deep End group) pointed out. While it is clear how GPs viewed their role at an individual level (as shown in Figure 6.1), how this scope extends to higher levels is explored in further detail in Chapter Eight’s focus on advocacy. The next chapter discusses GPs as street-level bureaucrats, exploring in depth how they identify need—and the potential to practice according to this definition—and how they cope amidst strained resources in the context of severe levels of multiple deprivation and multimorbidity.

## CHAPTER 7 GP as SLB

### 7.1 Introduction

Individuals living in Scotland's socioeconomically deprived areas face higher mortality rates, worse health outcomes, and higher incidence of multimorbidity at younger ages than their affluent counterparts (Barnett et al., 2012; Macintyre, 2007; Marmot, 2010). Consequently, GPs working in these areas can be seen as struggling to meet patient demand with the resources available. A key focus of this research is to explore how GPs cope amidst strained resources in the context of severe levels of multiple deprivation and premature multimorbidity. To do this, the GPs involved in this research are examined through the lens of Lipsky's SLB framework in combination with theoretical underpinnings from a wider literature on professionalism, as set out in Chapter Four. While previous research into the GP profession has applied Lipsky's (2010) framework as a means to understand how GPs negotiate between organisational guidelines and professional patient care (Baines, Wilson, & Walsh, 2010; Checkland, 2004; Dunham, Scheid, & Brandon, 2008; Drinkwater et al., 2013; McDonald, 2002), no studies have exclusively looked at SLB from the context of GPs working in areas of severe deprivation. Using an SLB perspective provides opportunity to better understand how GPs working in deprived areas (i.e. in areas where patient demand is greatest) try to manage workload and negotiate constraints in ways that do not further exacerbate existing health inequalities.

This chapter presents findings from the fieldwork as they relate to key concepts of street-level bureaucracy and professionalism. It first provides an overview of the constraints GPs face working in areas of extreme deprivation. Section 7.3 then explores how GPs negotiate between conflicting roles, based on the dilemmas identified in Chapter Four, including autonomy versus control, responsiveness versus standardisation, and manager versus frontline worker. This then leads into a discussion of GPs' coping mechanisms deployed both within and outwith patient consultations. In Section 7.5 the chapter then moves on to understand how GPs prioritise work and what scope this allows them to identify need within their practice

populations. Finally, the extent to which proportionate universalism is a useful concept within primary care, and subsequently how GPs might adopt it within their practice, is considered.

## 7.2 Constraints of ‘deep end’ GPs

Large workload and inadequate resources characterise the working conditions of street level bureaucrats (SLBs) (Lipsky, 2010) and this research confirmed that GPs participating in this study and GPs working in deprived areas fit within Lipsky’s framework. During the interviews, participants provided detailed accounts of struggling to cope with constraints, stemming from their large and challenging patient lists, combined with inadequate resources in the form of money, time, and personnel. This is supported by recent findings—highlighted in Chapter Three—from McLean et al. (2015) that general practice funding in Scotland fails to reflect clinical need related to definitions of multimorbidity. Many of the interviewees noted the impact the mix of large workload and inadequate resources had on professional stress within the practice due to challenges of keeping up with work commitments and patient demands. Thus, it is important to explore the context that GPs working in very deprived areas operate within. In order to accomplish this, this first section of findings focuses on understanding the day-to-day work of GPs serving deprived areas including what they perceived to be workload constraints in terms of time, complexity of caseload, and contractual obligations.

In describing his workload, Dr Fergus Lindsay, whose practice falls within the top 25 most deprived practices in Scotland, set out the structure of a typical day:

*I have today had, you know, three hours face to face consultation, I'm gonna have another three hours face to face consultation this afternoon, which is six hours face to face. And I've had four house calls I've had to go and do, which took me an hour and a half. And in between this, while grabbing lunch, trying to do paperwork. (Dr Fergus Lindsay, male, end of career, some Deep End involvement)*

The scenario that Dr Lindsay described—of combing through ‘piles’ of administrative work when not in consultations—was common amongst all the interviewees. GP workload in a typical day consists of seeing patients in face-to-face consultations, patient house calls, sifting

through surgery results (e.g. blood work and test results), making phone calls to secondary care providers, writing referral letters to specialists, and post-consultation administrative work. This range of activity can be considered standard GP work regardless of the deprivation level; in other words, GPs in affluent practices and deprived practices alike have a combination of patient encounters and administrative work during a typical day.

To substantiate this, many of the GPs discussed feelings of working to capacity and beyond, describing the workload as ‘never ending’, and that they were constantly working through lists and chasing things up. Since much of this work could not be done during surgery hours, many described arriving early to work, leaving late, and working on the weekends, thus establishing the most commonly discussed constraint of time.

*My paperwork...I'll be working tonight till 9 or 10 o'clock, so yes...and I don't mind the work load but what I do mind is if the workload I don't think is actually connected to any health outcome. I think I'm really busy for no particularly obvious reason other than the system seems designed to generate lots of busy-ness for no particularly obvious reason. (Dr Hamish Mackay, male, mid-career, no Deep End involvement)*

As Dr Hamish Mackay noted, this ‘busy-ness’ stemmed not only from keeping up with patient demand, but was inherently tied to other, largely bureaucratic, factors, the details of which are explored later on. It is important to note that most of the GPs recognised their workload and time constraints were not unique to working in a deprived area, as most GPs would likely describe a similar scenario. Where practice deprivation level significantly impacts on the workload, however, is through the volume and type of patient consultations. This manifests as shortage of time both during patient consultations and throughout the day due to the complexity of addressing patients suffering from multimorbidities.

*Shortage of time, I think that's universal. Any GP that you speak to, wherever they're working would say that that is the case...[working in a deprived area] it's very rare to see a patient who, you know, is in their 40s who say, doesn't already have quite a few conditions like COPD [chronic obstructive pulmonary disease], diabetes going on in the background. (Dr Katie Stewart, female, early career, no Deep End involvement)*

*Time is a problem definitely. Multimorbidity is also...because most of our patients do not come in with the one thing. And even if they do come in with one thing, they discover quite a lot of other things at the same time, and I prefer to try and sort things when I see people. (Dr Janet Campbell, female, end of career, no Deep End involvement)*

In terms of individual consultations, the majority of the GPs noted the inadequacy of a standard ten-minute GP consultation in addressing individual patient health care needs. For several of the GPs this necessitated specific coping strategies, which are further explored later in this chapter.

Dr Simon Alexander, who works in a less deprived practice just outside of the top 100, further broke down, minute by minute, the difficulty multimorbidity brings when working in a ten-minute consultation:

*My pet hate with the ten minute appointment is that if you, let's say...its ten minutes...let's say you're very efficient, and you give yourself a minute to type things up, or two minutes to type things up, let's say. So it's eight minutes for an appointment. If somebody comes in, very typically, with two or three separate issues, you're then thinking, okay, you're giving yourself two and a half minutes per issue...That's to be able to get an adequate history, to examine a patient appropriately, to prescribe any appropriate medication...To then discussing with the patient how you use it, and why you might be using it, or to discuss why medication isn't appropriate. And for me, that's just gonna be, from the patient's side of things, so ridiculously rushed and haphazard. And from my side of things, you might miss things. (Dr Simon Alexander, male, early career, minimal Deep End involvement)*

In processing work expeditiously the worry of ‘missing things’ was not exclusive to Dr Alexander, but identified by several others, some of who felt that they might not be doing the ‘best’ they could. Consequently, GPs have an element of discretion in their work, deciding how ‘deep’ they want to go into patient problems that are presented to them (Watt, 2015), including those issues that may not be overtly identified by the patient. As Dr Duncan Macleod put it, sometimes, “You might not choose to go there,” in terms of underlying patient

problems. For several GPs practicing 20+ years and in smaller practices (three GPs or less), the ten-minute appointment was acknowledged as less of a constraint due to in-depth knowledge of their patient caseload, which translated into appointments as ‘serial encounters’ (Watt, 2013) rather than starting from the beginning each time. Presented in Chapter Six as a way in which GPs might positively impact on health inequalities, this ‘continuity’ in general practice is explored in depth later in the chapter as a coping strategy.

### 7.2.1 Implications of workload on stress

Workload, time constraints and multimorbidity have a compounding effect on GP stress for those working in deprived areas. This is supported by the previous work of Mercer and Watt (2007) showing the increased incidence of ill health and multimorbidity in deprived areas, which results in: increased demands on general practice, poorer access to care, less GP time, increased GP stress, and—as Chapter Six emphasised—lower patient enablement. Cumulatively, this negatively effects whether GPs are able to keep up with patient demand *and* also places pressures on the quality of care they deliver, as pointed out by mid-career Dr Kenna Anderson.

*Because I think our big conflict at the moment is, how can we still practice safely, and cope with demand...And for me, the big challenge is, I always felt I could practice safely with our setup. But like this week, where we have school holidays, and partners are on holiday, everything becomes, just exponentially, more. More scripts, more letters to read, more patients to see, and it's just not possible anymore, to say we are safe all the time. (Dr Kenna Anderson, female, mid-career, significant Deep End involvement)*

For Dr Anderson, who works in one of the top ten most deprived practices, it is not simply a worry of ‘missing things’, but that she will not be able to practice clinically safe medicine at all times due to demands of the job. This has critical implications for the GP workforce in terms of recruitment and retention in the sense that unmanageable patient demand and inability to practice safe medicine may (and arguably is) discourage GPs from working in deprived areas. Patients living in deprived areas, however, are the most likely to suffer from

the negative impacts of GP stress and unmet health and social care needs will contribute to a widening of health inequalities.

While all of the interviewees identified increasing demands in general practice, perceptions of ‘professional’ (job-related) stress were in the ‘eye of the beholder’; in other words, not all GPs considered stress to be a significant problem within their work. This patterning was not directly linked to practice deprivation level, but instead showed variation with how participants socially constructed their patients, as discussed in Chapter Six. Specifically, interviewees who positively constructed their patients were more likely to discuss having higher levels of stress than GPs who negatively constructed their patients. For example, Dr Booth, who works in one of the ten most deprived practices and negatively constructed his patients, described professional stress as “more of an individual practice issue,” that was tied into “how you run your practice.” In contrast, Dr Bannigan, whose practice falls closer to the middle of the 100 most deprived practices and demonstrated high levels of patient empathy, explained “I love the job, I love the patient contact, but it is so sapping,” due to the physical and psychological demands of the job. Besides differences in practice deprivation levels, Dr Bannigan was also significantly involved in the Deep End, as opposed to Dr Booth’s infrequent attendance. Thus, perceptions of professional stress might potentially be linked to levels of patient empathy—including their ability to ‘walk in their patients’ shoes’—and how high GPs ‘set the bar’ (Watt, 2015). In other words this preliminary finding suggests low expectations means low stress, high expectations results in high stress.

### **7.3 Negotiating dilemmas and conflicting roles**

Workload and time constraints were not only indicative of GP’s professional stress, but also inherently tied into what Lipsky refers to as ‘dilemmas.’ As discussed in Chapter Four, these dilemmas result from the combination of a demanding work environment and the SLBs’ mediating role between the state and client, which, for GPs translates into the mediating role between the NHS and the patient. While Chapter Four introduced six dilemmas GPs face in their work, this chapter focuses on three primary ones which emerged from the data: autonomy versus control, which occurs due to discrepancies in meeting bureaucratic objectives and individual patient needs/preferences; responsiveness versus standardisation, as

GPs try to deliver individual treatment “on a mass basis” (Lipsky, 2010, p.44); and manager versus frontline worker, wherein GPs operate under the bureaucratic structure of the NHS as ‘independent contractors’<sup>26</sup>. These dilemmas were primarily the result of trying to meet patient demands not only within the context of scarce resources (e.g. time) but also from working to contractual requirements. While this fieldwork did not capture the micro-level encounters that occur between patient and GP, to understand how they negotiate between conflicting roles, interviews did reveal elements of the thought process GPs go through when negotiating dilemmas. From a broad perspective the common negotiation approach adopted almost exclusively by all GPs relates to the individual patient. This can be summarised as ‘putting the patient first’ (or at least attempting to) and/or practicing according to ‘what’s best for the patient’. Whether it was negotiating the dilemmas of professional autonomy versus bureaucratic control or negotiating between manager and frontline worker roles, the default, as described, usually fell back to patient-focused practice wherein the patient’s interest typically won out over bureaucratic conflicts. Moreover, a ‘patient first’ mentality was not patterned according to how GPs socially constructed their patients (Chapter Six), but was evident throughout the majority of the interviews.

### **7.3.1 Professional autonomy vs. bureaucratic control**

The most frequently discussed dilemma of working at the frontline was that of professional autonomy versus bureaucratic control. As Chapter Four noted, professional autonomy is often interchangeable with discretion and is considered a vital element of GPs’ professional work. Issues with bureaucratic control were attributed to the most recent 2004 General Medical Services (nGMS) GP contract and particularly the introduction of the Quality and Outcomes Framework (QOF)<sup>27</sup>. Specifically, the clinical indicators of the ‘pay for performance’ QOF were perceived to impede their ability to take a holistic view of the patient. The ‘tick-box-

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<sup>26</sup> The additional dilemmas mentioned in Chapter Four were demand versus supply, advocate versus manager (further explored in Chapter Eight), and public health versus primary care.

<sup>27</sup> QOF payments (i.e. ‘pay for performance’)- These performance measures are based on ~150 quality indicators including both organisational (e.g. staff-related training and patient satisfaction) and evidence-based clinical measures (e.g. 90% of patient population must reach a specified clinical target such as blood pressure). Practices achieve ‘points’ based on these measures, which translate into variable payments according to the number of points achieved. QOF payments have the potential to contribute to less than 20% of practice income (Audit Scotland, 2008).

exercise' produced feelings of frustration amongst the majority of the GPs that all their work had to be measured or 'fitted into a box' as opposed to taking a patient-centred approach in consultations.

*The GPs are very angry! And it's about an 89-year-old who's got a cholesterol of 5.1. Well, it really doesn't matter whether her cholesterol is 4.9 or 5.1, she's 89... You know clinically I am able to make the judgement, and I should be able to... That an 89 year old with a cholesterol of 5.1—I probably shouldn't increase their statin because it will just make them have nasty side effects. And it's probably 4.9 when I do it next week anyway. (Dr Elizabeth Duggan, female, end of career, significant Deep End involvement)*

As Dr Elizabeth Duggan—who had been in practice for over 20 years—noted, trying to 'fit' patients into a specified blood cholesterol range directly conflicted with her clinical judgement, a theme which was common throughout many of the interviews. In response to restrained autonomy, some of the interviewees explained circumventing this imposed structure by choosing to ignore QOF requirements if they conflicted with their clinical judgement, since the financial risk to the practice was minimal. In these instances, patients came first, the bureaucratic guideline second. So if guidelines stood 'in the way' or did not 'seem necessary', "We forget to do it," as Dr Lucy Carroll put it.

However, a further consideration between bureaucratic control and GP autonomy was the perceived impact on workload. There was general recognition amongst participants that bureaucratic guidelines often increased workload, which many GPs are loath to do. Mid-career Dr Cecilia McCullough exemplifies the negotiation of this dilemma in her example of Health Board pressures to reduce hospital admissions:

*[The Health Board] wants us to reduce emergency admissions of patients and so one way of doing that is if I have a patient that I think, well, they kind of need to go in, but maybe I can avoid that in some way by speaking to a consultant, then I will do that. But, in some ways it's easier to admit someone, because if I'm trying to speak to a consultant neurologist, then it can take me most of my day to try and get a hold of someone...but you know by doing that...it's much better for the patient rather than*

*throwing them in A&E, knowing that they're going to spend all day in there...You want to do it in the best [interest of the patient] but you know it's just going to be so time consuming.* (Dr Cecilia McCullough, female, early career, some Deep End involvement)

Dr McCullough acknowledged a willingness to follow bureaucratic guidelines—and consequently increase workload—if it was seen as beneficial for the patient. As one of the GPs who had a tendency to negatively construct their patients Dr McCullough's statement presents a stipulation to the evidence presented in Chapter Six. Regardless of patient constructions, the majority of GPs maintained a patient first mentality. However, 'going the extra mile' in addressing patient problems is subject to individual professional discretion (Watt, 2015) and avoiding an increase in workload may sometimes win out. Thus, underlying motivations, such as perceived benefit to the patient, for how GPs exercise discretion (e.g. choosing to follow bureaucratic guidelines that also increase workload) are an important consideration of this research. Previous research on Dutch SLBs involved in immigration and integration found a similar willingness to help clients when specific conditions were met including: "high client motivation, extreme personal distress of the client, and negative assessment of existing policies and policy instruments" (Belabas & Gerrits, 2015, p.15).

As independent contractors<sup>28</sup> to the NHS, GPs are subject to a high degree of autonomy. The fieldwork demonstrates a reliance on this autonomy, with an overwhelming majority of GPs stating a preference for independent contractor status as opposed to being a salaried employee of the NHS. GPs that preferred independent contractor status saw it as beneficial not only for their work and practice but *also* for their patients. This may be attributed to the sense of ownership that results from their independent status, which is inherently tied to the professionalism within medicine. Emphasised in Chapter Four, this professionalism implies that GPs have the freedom and control to decide how they use their 'expert knowledge' to address patient concerns. In practice, this autonomy extended to the perception of working more than if they were salaried, as Dr Stuart Booth suggested:

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<sup>28</sup> Not all are 'independent contractors' per say as a small percentage of GPs are directly employed by Health Boards.

*I think if we were all salaried we wouldn't do half the stuff that we do. I think the NHS runs on, it's still running, because of goodwill...cause if a salaried workforce would work to rule, they'd say, 'Right, I'll do what's written in my contract.' We do so much more than what's written in our contract. And we do it because we know that our patients need us to do it because we're their only advocates a lot of the time. (Dr Stuart Booth, male, mid-career, some Deep End involvement)*

This reaffirms two key points. The first is that GPs who had a tendency to negatively construct their patients (e.g. Dr Booth as evidenced in Chapter Six) also had the perceptions of doing what is best for the patients. The second key point is the reasoning behind why they work above what is written in their contract, in that the patients are the impetus behind working more hours. The 'goodwill' the NHS runs on is based on doing what is best for the patient, which often results in going beyond contractual requirements. Thus, the feeling is that salaried posts would be detrimental to the patients who, "Wouldn't be as well looked after as we do at the moment," (Dr Anderson). Dr Carroll conveyed this sentiment in her contrast between salaried and independent contractor GPs:

*I've worked in salaried and private. Salaried, there tends to be more of an attitude of just turn up and do your job, and don't worry about the bigger problems. And there were more patients that didn't have anyone owning them. Like this model, because we're paid...I don't know, because of the way we were paid, sort of, feeling ownership for the patients in my name, and go much...I feel a much more sense of responsibility. I stay much later. I work much harder. (Dr Lucy Carroll, female, early career, no Deep End involvement)*

Thus, a sense of ownership for patients and for the practice is attributed to the independent contractor status, which also results in the view that they do more work than if they were salaried. This is perhaps tied into GPs' professionalism through a willingness to work more, as long as it is at their discretion, rather than through contractual obligation. However, whether this is the case in practice is unclear. For example, one of the GPs in a salaried position also described working more than their contracted hours by doing paperwork at home until 9 or 10pm. Independent contractor status may provide GPs the *perception* that they do more work

than salaried counterparts, via the sense of ownership, but more research is needed to draw a full comparison.

Furthermore, preference for independent contractor status was not unanimous amongst all participants, as summarised in Table 7.1.

**Table 7.1 Participant distribution by practice contract type and preferred contract type**

<b>CONTRACT TYPE</b>	<i><b>Favour Independent Contractor Status</b></i>	<i><b>Favour Salaried Position</b></i>	<b>TOTAL</b>
<b>17J</b>	15	2	17
<b>17C</b>	5	0	5
<b>2C</b>	0	2	2
<b>TOTAL</b>	20	4	24

Out of the four who favoured salaried positions, two (including the GP working until 9-10pm) were currently employed directly by the Health Board and did not feel they suffered a significant loss of autonomy (although one did suggest that they likely suffered from a loss of income in comparison to non-salaried GPs). According to the other salaried GP, he felt a salaried position actually gave him greater control to “change the system” since immediate pay in the short term was not dictated by his every day performance, thus providing more scope to think creatively about practice needs. For the two independent contractor GPs who would prefer salaried posts, they saw working directly as NHS employees as an opportunity to work less and avoid the managerial duties and financial risks that come with being an independent contractor.

In addition to perceiving that they work more than salaried GPs, those who favoured independent contractor status identified the practice implications of flexibility afforded to cater to their individual patient populations and to ‘have a say’ in the running of the practice:

*So, we can say what we like about the services that we currently have to deliver or what we feel is the problem and, because we're independent, we've got no line*

*management to slap us down. They don't have to listen to us but they certainly can't shut us up.* (Dr Alison Kelly, female, end of career, significant Deep End involvement)

This demonstrates that while GPs typically do not have direct line managers they report to, their autonomy is still somewhat constrained by the contracts with the Health Board. Thus, having a 'voice' to express concerns does not mean the Health Board listens to (or addresses these concerns). Other GPs noted strained relations with the Health Board, and in particular linked this to the introduction of Community Health Partnerships (CHPs) following the 2004 contract. This period of disengagement between the GGC Health Board and some of the Glasgow-based deprived practices was attributed to the Health Board failing to work with general practice as partners, but was not explored in depth during the interviews.

In extolling the benefits of autonomy the independent contractor status affords, there was a sense that this had decreased over the last several years as the contract became more rigid, which is in line with previous research (Cheraghi-Sohi & Calnan, 2013). This was particularly common amongst GPs who had been practicing well before the 2004 new General Medical Services (nGMS) contract was established, as end of career Dr Calum Fraser suggested, "I think when the contract was simpler [i.e. pre-2004 contract] we could devote more time to patients." Post 2004 contract, there had been a sense that their work was restricted, with constrained ability to make practice changes how they see fit.

*There's very few things that we can change. I think that's one of the things that's changed dramatically in general practice. General practice in the mid-eighties, when I started, there was no ceiling to what you thought was possible. It was fantastic, limitless was the feeling. Now, the new contract has so constrained what we do, so we're very limited in how we can change things.* (Dr Robbie Bannigan, male, end of career, significant Deep End involvement)

It is unclear how this 'limitless' space might have been used to reduce inequalities. However, there is an argument to be made that reducing bureaucratic constraints might open up time for planning practice population activities related to health prevention and promotion, which were key ways identified in Chapter Six that GPs felt they could positively impact on health inequalities. Beyond constraints on professional autonomy, the interviews also revealed that

contractual obligations had a significant impact on the second dilemma of responsiveness versus standardisation, as explored below.

### 7.3.2 Responsiveness vs. standardisation

In addition to feeling that introduction of QOF had become a ‘tick box exercise’ that infringed on GPs’ clinical discretion, many interviewees also expressed frustrations that it inhibited their ability to address the ‘real’ patient problems presented during consultations. Since a portion of practice income is tied to QOF performance, GPs are often confronted with the dilemma of adhering to the contract or letting patient needs guide the care. Chapter Three identified this portion as approximately 20% of practice income. However, QOF conditions in 2012/13 only accounted for 12.7% of GP consultations according to Practice Team Information data (ISD Scotland, 2013). This presents an example of externally imposed work adding to the dilemma of responsiveness versus standardisation. Furthermore, this dilemma is especially problematic for practices with smaller populations as work can become income driven if they rely on QOF points. It also correlates with the SLB dilemma of responsiveness versus standardisation.

*[QOF] makes us be systematic about our approach to a lot of our patients, but it does not encourage you to try and address the problems of those who are in the most need... We're dependent on [QOF] because we have a low number practice, we need to get good points—we can't ignore it... And it also pushes you to, you know, exclude folk, so your diabetics who are housebound can't get included? We still need to be caring for our diabetics who are housebound, or the folk who haven't turned up 3 times for an appointment, as long as we've offered their appointment 3 times then you can exclude them. Now those are the people that we should be chasing up, you know? So there's no recognition that actually it's the folk who don't turn [up] that need our attention and our care. (Dr Helen Reilly, female, end of career, significant Deep End involvement)*

Dr Reilly felt that QOF, while systematic in practice, inhibited their ability to respond to practice needs and further excluded individuals who were already most at risk, the latter being fundamental in ensuring health care does not widen health inequalities. Since Dr Reilly's practice was heavily reliant on QOF points for income, they did not have the ability to respond adequately to patient need while maintaining a standard approach in their practice. Dr David

Gallacher reiterated this point by suggesting a focus on practice income uses, “our agenda, not the patient’s agenda.”

A focus on standardisation and contract adherence was not only about losing sight of the patient’s agenda, but also the difficulty of fitting holistic work into a ‘tick box exercise’, since not all of what GPs do is ‘measurable.’

*And often, listening actively and being empathetic and compassionate is, for me, that’s really, for me, the important bit. But the problem is, it’s hard to measure these things when government politics wants to tell you what you should be doing. (Dr Duncan Macleod, male, end of career, minimal Deep End involvement)*

Chapter Six highlighted the importance of patient empathy in improving patient enablement and health outcomes (Mercer et al., 2012c; Mercer et al., 2016). However, feeling that all their work has to be measured or ‘fitted into a box’ has a constraining impact on GPs’ clinical discretion to respond appropriately to individual patients. Not only was this evident in Dr Duggan’s remark above (Section 7.3.1) regarding how angry GPs were about imposed guidelines for giving an 89 year old statins, but also with several other participants’ comments on the issue. This is because of the seeming high cost versus low benefit of prescribing a very elderly patient cholesterol lowering statins that will have unintended side effects and might not necessarily prolong their life.

The influence of the QOF was not only evident in terms of GP's clinical decisions, but also how they utilised consultation time. Specifically, several GPs noted that adhering to QOF guidelines left little time to focus on other parts of the practice, including how it might be tailored to their individual population needs. This comes into direct conflict with putting the patient first and a practice’s ability to prioritise population needs, which can be very different in deprived areas as compared to affluent areas. The result is work driven by the contract and QOF as opposed to patient needs. A key example provided by a few of the GPs is the contract mandate to provide extended appointment hours to cater to working patients.

*So we’re made to open up at 6:00 in the morning on a Tuesday, but because so few patients, the practice population [are in paid employment and in need of extended opening hours] ...it’s an example of the government, you know, the way that you run*

*your practice isn't tailored, it's not like, for us we could say well there's no point, there's no need for us, but we have to do it.* (Dr Robbie Bannigan, male, end of career, significant Deep End involvement)

Another side effect of QOF leading to feelings of decreased autonomy stems from the increased time spent “in administration rather than face to face with patients, with staff, in the situations that we should be in” (Dr Reilly). Consequently several GPs were concerned about the implications constrained time –resulting from the 2004 contract—had on innovation strategies within the practice, in addition to the role of the practice within the broader community.

*And then obviously QOF drives some of our work as well...And I suppose that is one problem for us, is by the time you've done all the things you need to do, there is not masses of thinking time, or time to look at doing something new.* (Dr Agnes Gillies, female, end of career, some Deep End involvement)

The lack of ‘protected’ time for planning and strategising within the practice (in addition to constrained clinical time) was a common theme throughout the interviews. Most of the GPs noted they would like to explore ways of running their practice more efficiently and in ways that better responded to their patient population needs (and potentially plan for health prevention and promotion activities as identified at the end of Section 7.3.1), but contract demands and administrative work often took up what little time they had outside of patient consultations. Thus, while standardisation through QOF adherence may be seen as improving workflow, it was ultimately seen as infringing on GPs’ clinical discretion and their ability to respond to the needs of their patient populations. Consequently, QOF has been criticised for taking a single-disease approach, which directly conflicts with the pervasive, premature multimorbidity GPs in deprived areas often deal with. Similar to their response to restrained autonomy, interviewees noted circumventing this imposed structure by either ignoring QOF or switching to a 17c contract, which is discussed later as a coping mechanism. Accordingly, putting patients first proved to be a significant underlying factor for understanding how GPs negotiate dilemmas.

### 7.3.3 Manager vs. frontline worker

The final SLB ‘dilemma’ emerging from the interviews is that of manager versus frontline worker. In comparison to other street-level workers, Chapter Four recognised this dilemma as unique to GPs due to their managerial role in the running of the practice, in addition to their frontline work.

*I mean, I guess a lot of the time I think it would be quite good if we didn't need to think of the business side of things, because that wasn't what I was trained for. (Dr Cecilia McCullough, female, early career, some Deep End involvement)*

Dealing with the ‘business side of things’ can be difficult for GPs who have had years of clinical, not managerial, training. This is because GPs out of training straight away have the option of becoming a partner in a practice. Even if they locum first or work as a salaried GP following training, they are not likely to gain any experience in running a practice and the duties that entails. One of these ‘unique’ duties a few of the end of career GPs discussed was purchasing (and managing) the buildings for their practice.

*Yes, I mean, there was help [from the Health Board] but yes, I had to go and get the mortgage. I had to get the architect. I had to buy the land. Yes, when I say me, me and my partners, the business. Yes, so that was a big investment we put into this area.*

*So we built our own premises and it took years, um, it must have been about a 12 year process... we had to organise the loan and had to do it all, but with the support of the Health Board, and the Health Board funds the payments on the loan. Um, but we are still as partners individually responsible for that. And have to pass that on when new folk come in.*

Both GPs noted there was a degree of support from the Health Board in the process, but ultimately the responsibility of organising the loan, land purchase, and building of the practice lay with the GPs and their partners. Having a financial liability such as the practice premises may also place increasing focus on income-generating activities related to the GP contract and QOF, with potential unintended consequences of decreasing patient-focused activities. Moreover, both interviewees (pseudonyms purposefully withheld) mentioned above were

amongst the participants who described feeling high levels of stress in their work. As a result, additional managerial obligations may conflict with supervising the care of their patient population *and* provide an added layer of professional stress.

Another way GPs face the dilemma of ‘manager versus frontline worker’ is through hospital admissions and re-referrals of patients to secondary services. Dr Janet Campbell, who also does hospital work as a specialist, provided an example of this:

*There’s a pressure not to admit and there are pressures not to refer. That can be difficult, because I can see it from both sides. I was at a presentation at the Southern General about someone who had headache and the GP hadn’t referred for several months. They’d done direct access, CT and stuff. It turned out to be some weird and horrible diagnosis. But I could see it from the GP side. You know, you go to meetings and you’re told there are far too many headache referrals, don’t refer. (Dr Janet Campbell, female, end of career, no Deep End involvement)*

From a managerial point of view, the pressures from the Health Board and Scottish Government to reduce hospital admissions, as indicated in one of the NHSScotland HEAT targets<sup>29</sup>, means that patient care may be overlooked to keep the practice in compliance (in addition to increasing workload as previously noted). In a similar vein, GPs are asked to reduce re-referrals to secondary services for patients who failed to attend as their practice may be audited for this. However, from the frontline view of working in a deprived area, there is also a need to acknowledge patients’ chaotic lives, stemming from complex health and social issues. Thus, GPs often have to choose between what is perceived to be in the interest of the practice versus the patient.

*But then again, I suppose this is our practice, so you do have a real sense of ownership. And to be honest, not that I want an analogy of this to be more of a business analogy but it does, I think if you’ve got ownership of, well: This is our practice, we want to do the best we can for our patients, we want it to run efficiently*

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<sup>29</sup> HEAT Targets are NHSScotland targets for performance in the areas of: health improvement, efficiency, access, and treatment.

*and if it runs efficiently, we're less stressed, therefore we have to put the hours in to do that. So we do run almost...if somebody's got a business, that's the way they run it.* (Dr Duncan Macleod, male, end of career, minimal Deep End involvement)

Ensuring that the practice runs efficiently and doing what is best for the patient may not always align, although Dr Macleod suggests that 'ownership' helps negotiate between the two. Lipsky's framework, however, fails to capture how GPs balance their conflicting roles of manager and frontline worker since traditional SLBs do not often face this dilemma. Instead, this falls in line with the literature on professionalism wherein professionals construct flexible selves and multiple identities to manage workplace pressures (Evetts, 2003; Cheraghi-Sohi & Calnan, 2013; Spyridonidis & Calnan, 2011). This research suggests that GPs are able to balance manager and front-line worker roles, particularly if a patient-focused practise anchors their work.

The interviews revealed that rather than getting 'caught up in all the contract stuff,' there is a need to determine practice priorities and strategies. However, what is often missing is sufficient time to adequately engage in these activities amidst the demanding workload of practicing in a deprived area. According to Lipsky's framework, SLBs subsequently adopt 'coping mechanisms' to expeditiously process work and keep their heads above water. Thus, the next section explores in further detail the various coping strategies GPs working in deprived areas have adopted.

## **7.4 Coping strategies in the 'Deep End'**

One of the primary research objectives this thesis set out to explore is how GPs cope amidst strained resources in the context of severe levels of multiple deprivation and multimorbidity. Regardless of individual perceptions of stress, all of the GPs reported adopting coping mechanisms to manage workload. These ranged from personal, non-work ways of mitigating professional stress such as exercise and planned holidays, to work-related strategies such as practice-level modifications for coping with patient demand, including negotiating a new kind of contract with the Health Board. Since this analysis was primarily interested in how GPs

cope *within* their practice, findings pertaining to work-related coping strategies are examined at both a personal and practice level.

#### 7.4.1 Practice routinisation & client constructions

One particular strategy of managing patient demand was through ‘client constructions’, which Lipsky (2010) offers as a mechanism for SLBs to exert control over their work through training clients how to behave as clients. This fieldwork revealed evidence of this as several of the GPs acknowledged training their patients to conform to practice procedures as a way of reducing demand, and was usually seen as taking a firm stance with patients in addition to saying ‘no’ to patient requests that did not align with GP priorities. While this mechanism was not fully aligned with how GPs socially constructed their clients, there were subtle differences in how they described training their patients to conform to practice rules, as exemplified in the contrast between Drs Booth and Anderson.

*I think we've trained our patients. Over the last 5 years I think we've worked hard and our demand management has meant that we are not chasing ourselves...The doctor that I replaced...had their own way of doing things and then there was a lot to fix...Prescribing was all over the place. So people were getting antibiotics for the cold, so every time you'd [catch a] cold you'd go and see the doctor. Whereas [if] you treat them properly [and] you explain the situation, they now don't come and see me with a cold...[This] means that the next time a patient has the same problem, they self-manage it. So, I suspect actually our patients are self-managing things quite well. (Dr Stuart Booth, male, mid-career, some Deep End involvement)*

As one of the few GPs who did not feel overly stressed due to the demands of the workload (even though he works in one of the most deprived practices in Scotland), Dr Booth attributed this to ‘demand management’ of tight prescribing combined with promoting self-management amongst his patients. His negative patient constructions came across as paternalistic in the sense of telling the patient what to do rather than working with the patient in a partnership. Dr Booth’s smaller practice of only two GP partners also made it easier for him to enforce his tight prescribing.

Dr Anderson equally works in one of the most deprived practices and described similar training of patients, but in a less severe form, by adhering to practice policies.

*Because we have fairly robust procedures in the practice, the patients who have been with us usually know that we do certain things, and do not do other things. And that it might not be as fruitful to try [testing the GPs], even with our new doctors. Because we quite often refer to practice policies. (Dr Kenna Anderson, female, mid-career, significant Deep End involvement)*

For her, there was less focus on ‘training’ patients how to behave but rather enforcing practice policies to manage patient expectations of what could be done in the practice, in addition to maintaining consistency across the four GP partners. In contrast to Dr Booth, Dr Anderson’s interview discourse demonstrated greater patient empathy, in addition to struggling to meet workload demands. While both GPs work in two of the most deprived practices in Scotland (i.e. top 10), there is not sufficient evidence to suggest this is exclusive to high deprivation levels. Furthermore, routinisation and client constructions as coping mechanisms might potentially conflict with GPs’ ability to provide responsive, individualised care (as highlighted in the dilemmas above).

#### **7.4.2 Time-management**

Amongst all of the GPs, shortage of time was pervasive, working in areas of high deprivation, and necessitated various coping mechanisms. These coping strategies did not vary according to deprivation level but did show patterning by practice size. One such strategy for medium (e.g. four to seven GP partners) to large (e.g. eight or more GP partners) was the use of empty catch-up slots or breaks in case consultations run over.

*I have catch-up slots. So in the afternoon I have 30 minutes' worth of spaces, spaced throughout [the session]...So it means I think everyone gets, like, 11 or 12 minutes or something...[If] I think anyone is complicated, I take about 20 minutes with [them]. (Dr Lucy Carroll, female, early career, no Deep End involvement)*

*We've developed our own style; we do four appointments an hour, so theoretically they're 15 minutes, but they're not booked in that way. So we have ten-minute*

*appointments and then a 20-minute break, which gives us flexibility.* (Dr Alistair Fleming, male, mid-career, significant Deep End involvement)

Falling in the middle of the 100 most deprived practices, Dr Fleming's practice presumably has a larger proportion of patients suffering from complex multimorbidities than Dr Carroll's, whose practice rounds out the top 100. Therefore, it is unclear whether this strategy would succeed in a more deprived context where over 80% of their patients fall within the most deprived 15% of datazones (using the SIMD). Additionally, this strategy might be disadvantageous for smaller practices (less than four GPs) where there are fewer GPs to share appointment slots.

Another GP, from a medium sized practice, described how their overall strategy to cope with demand involved eliminating patient appointments entirely and instituting a call-back system. This GP noted that every practice has to find a way to deal with demand and for them the call-back system “filters out the nonsense” by only having about one third of the patients brought in to the practice for an in-person follow-up. Otherwise the patient's problem is dealt with over the phone. This single case presents a coping mechanism worthy of further exploration in terms of demand management and if patients within the practice feel their needs are adequately met.

In general, GPs from smaller practices (e.g. 1-3 GPs and under 3,000 patients), regardless of deprivation level, described coping with time constraints better—but not necessarily feeling less stressed—because patients regularly see the same GP in contrast to larger practices where a patient may see a different GP each time.

*A big part of [managing patient demand and time constraints] is working in a small practice as well, because you get to know them, you know them by face, you know what medications they're taking, without looking at their notes. You know their family, usually, most of the time as well. And I think that leads to sort of developing a really good sort of trust there.* (Dr Katie Stewart, female, early career, no Deep End involvement)

*[Working at the practice for 16 years] is great for sort of shortcuts, 'cause, you know, if I see someone, I know that's Mrs. So and So, and I'll remember some things about her, you know, eh, and some of the, some of the things you don't necessarily write down, you know? You'll know this is Mrs. So and So and her daughter's just been diagnosed with breast cancer, she lost her son last year. These kind of things that are important at a kind of personal level. (Dr Claire Findlay, female, late career, some Deep End involvement)*

GPs from smaller practices attributed this to patient continuity. Highlighted in Chapter Six for its potential role in mitigating health inequalities, continuity was perceived as making the job more 'manageable'. This is because familiarity with the patients and their families cuts down on time reviewing a patient's notes and medical history (in addition to encouraging the growth of trust in the doctor-patient relationship). While continuity is not exclusive to small practices, it is potentially easier to utilise as a 'shortcut' to managing time constraints if there are only few GPs who the patient might see. Furthermore, while this coping strategy was common amongst—but not exclusive to—end of career GPs, it is difficult to tease out whether manageability for them was due to increased efficiency or potential disengagement, with retirement on the horizon.

A final time-related coping strategy potentially patterned according to practice size (and possibly deprivation level) is the use of 15-minute consultations as an attempt to better address patient needs. Drs Bannigan and Anderson, the two GPs who adopted this strategy, have practices that fall within the 30 most deprived practices in Scotland, were both actively involved in Deep End activities, and demonstrated higher levels of empathy (Chapter Six). For them, 15-minute consultation slots had several benefits including the ability to work more effectively with complex patients, more time for patients needing an interpreter for consultations, and more time to attend to administrative duties if a non-attendance results in an empty slot. Dr Anderson's consultations generally did not run over time, attributed to the increased flexibility 15-minute appointments opened up overall since time left over from 'quicker' patients could be used for more complex patients. In contrast, Dr Bannigan explained that he still had surgeries that frequently ran over:

*[In describing the last patient appointment in a recent surgery] By this time I'm running, like, an hour and 15 minutes late, and [the patient] was in for 35 minutes. She's chronically got terrible esteem issues, and I pointed out to her...despite running massively late, 'I'm delighted to give you 35 minutes, because you're worth it. Repeat after me, you're worth it.'* (Dr Robbie Bannigan, male, end of career, significant Deep End involvement)

Both GPs positively constructed their patients and suggested that more consultation time equated to further development of patient relationships, in addition to better addressing more complex patients. Dr Bannigan's seemingly more relaxed perspective of consultation times could potentially be attributed to his end of career status (as opposed to mid-career Dr Anderson). It is important to note that 15-minute appointments were not seen as a panacea amongst all the GPs for the shortage of time constraint as this would reduce availability for appointments. This is because demand was perceived to be infinite; even if a patient presented only one problem during the consultation there were often other underlying health and social issues needing to be dealt with.

How coping strategies related to time-management vary according to practice size are further summarised in Table 7.2. This does not suggest certain strategies are exclusively used according to practice size, but instead reflects the interview data.

**Table 7.2 Summary of time-management coping strategies according to GP's practice size**

	Catch-Up Slots	Call Back System	Continuity	15-Minute Consultations
<b>Small Practice</b> (1-3 GPs)			X	
<b>Medium Practice</b> (4-7 GPs)	X	X		X
<b>Large Practice</b> (8 or more GPs)	X			

### 7.4.3 Part-time and Portfolio GPs

Out of the 24 GPs interviewed, only seven of them—from practices ranging from the 7<sup>th</sup> to 95<sup>th</sup> most deprived practice—worked full-time as a clinical GP within their practice (considered 8-9 sessions per week). This is because most of the GPs perceived working full-time in a very deprived practice to be unsustainable due to the high-pressure nature of the job. Consequently, many of the GPs worked part-time to avoid professional burnout.

*I started off at five [sessions], then went up to seven. And then cut down to six, because...and I would say, the intensity of the workload, the way it is now, is we are now at breaking point...And there would be no way I would consider working a session more here, because it would not be possible. (Dr Kenna Anderson, female, mid-career, significant Deep End involvement)*

*I think I cope only because I have three days where I work really, really hard and I do nothing but work. I have a child but there's childcare, and in the evenings I will just do work-related things. But then I have those days to recover, so by the time I go back*

*again, I feel refreshed. So that's my main way.* (Dr Lucy Carroll, female, early career, no Deep End involvement)

For Drs Anderson and Carroll, working part-time was seen as the only option to cope with the demanding workload—and subsequent physical and psychological demands—attributed to these areas. Interestingly, while both GPs perceived high stress within their work, their practices fell at opposite ends of the 100 most deprived practices (Dr Anderson's practice is in the 10 most deprived while Dr Carroll's practice is near the 100<sup>th</sup> most deprived). To put this in context, over 80% of Dr Anderson's patients live within the most deprived quintile in Scotland, compared to less than 50% for Dr Carroll's patient population (which is still a significant percentage of deprived patients). This suggests that deprivation level is not a reliable indicator of professional stress.

In addition to working part-time as a coping strategy, most of the GPs were what is referred to as 'portfolio' GPs, i.e. taking on professional roles outwith the standard general practice responsibilities. This was used as a way to diversify GP responsibilities and included clinical speciality work, academic teaching, professional group involvement, and GP training. Additionally, end of career GPs were more likely to work less than 7 sessions per week and supplement income with another professional role.

*I've been involved in university teaching for about 10 years. And training, and the trainer's group...So something outside [the practice], still within your professional scope, that is another thing that helps you cope.* (Dr Agnes Gillies, female, end of career, some Deep End involvement)

*Working nine sessions I think would be...I mean, it's not like [working at a Glasgow-based hospital] is easy, it's not. It's just different and it's busy as well with clinics and whatnot. But it's not the same pressure as here.* (Dr Janet Campbell, female, end of career, no Deep End involvement)

Professional roles outside of the practice were not seen as 'easy', as Dr Campbell noted, but rather involved a different level of pressure and demand compared to working in a deprived practice.

Out of all of the GPs, one had decided at the time of interview to leave general practice entirely for a non-clinical professional role. When prompted as to why they were changing careers within 5 years of retirement, they responded:

*I've done 30 years, or 31 years, in general practice. I don't want to fizzle out and burn out. I love seeing patients, I hate how [I'm] increasingly, getting irritated by all the crap, other crap around. (male, end of career, no Deep End involvement)*

For this GP, who had been working full-time at 8 sessions per week, working in a deprived practice had become unsustainable not due to complexity of the patients, but rather as a result of the increasing bureaucratic constraints placed on GPs. When further pressed, he did not fully expound on the 'crap' he had to deal with in general practice, but did add that personal/family reasons also factored into his decision to leave general practice.

#### **7.4.4 Practice-level structure**

##### *17c Contracts*

As previously noted, several of the GPs adopted 17c contracts, to side step QOF and the 2004 nGMS contract, in response to contract demands and pressures. This was seen as a coping strategy which opened up practice flexibility to focus on prioritising practice needs as opposed to being “driven by patient demand and by the GP contract” (Dr Fleming).

*We've always followed QOF, but this year we've contracted out, and it's much easier now, not hitting targets. [QOF] certainly seemed a waste of our time, sometimes, and channelling our scarce resources into the wrong direction. Now, I feel we can much more pick and choose what we think is necessary, that gives you more professional independence, and I feel our patients benefit as well. (Dr Kenna Anderson, female, mid-career, significant Deep End involvement)*

Thus, a 17c contract provided the ability to regain some control and align practice work with practice priorities, thus recovering some of the lost professional autonomy since the 2004 contract. Ultimately, however, it was seen as a way to cope with scarce resources by aligning services with the needs of the practice population. For example, one of the GPs' practices set

up a more proactive COPD clinic, involving multiple members of the primary care team, as a way to better align services with practice population needs.

### *GP Income*

Another strategy for coping with scarce resources, identified through the interviews, was to reduce the size of the patient list, ipso facto reducing GP income as well. This was the decision two of the GPs'—both significantly involved in the Deep End group and who described high levels of stress in their work—practices made to better cope with workload pressures.

*I mean we are a smaller practice...we are 3.5 full time equivalents for a practice of 4,100 patients. So that means our income is lower than average and we accept that...I think my partners, and also I do think that GPs are overpaid compared with nurses, reception staff—everybody's working hard. (Dr Helen Reilly, female, end of career, significant Deep End involvement)*

*I mean, if I have less patients I have less income and that's not a big deal for me...[but one of the problems is if] we leave and we're trying to attract a new doctor in, well, they're going to get half the income that they might get in Kirkintilloch [more affluent area]. (Dr David Gallacher, male, end of career, significant Deep End involvement)*

Both Drs Reilly and Gallacher work in practices that fall within the 20<sup>th</sup> and 40<sup>th</sup> most deprived practices. This suggests both GPs have patient caseloads with a presumably high prevalence of complicated multimorbidity. It is important to note that neither GP felt this decision left them hard-pressed for income; rather, they felt they were in a privileged position due to GP's generous pay so that a pay decrease did not have a significant impact.

## **7.5 Prioritisation in the context of scarce resources and multimorbidity**

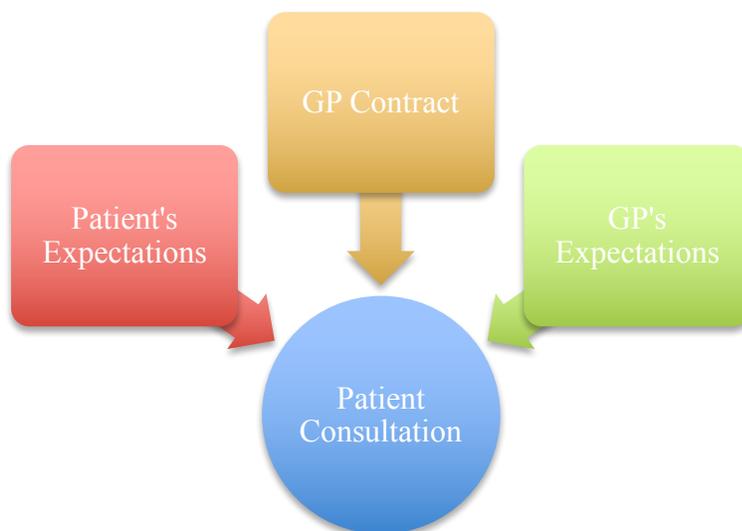
A major component of GP's ability to cope with scarce resources and complex patient populations relates to how they prioritise both within the practice and during individual patient

consultations. This largely involves balancing patient need versus patient demand with contract requirements and available resources. While patient demand is easily discernible through patient problems presented during consultations, patient need is more difficult to decipher as this includes patient problems not presented to the GP either due to a patient's lack of engagement with the practice or hidden problems not discussed during consultations, often due to time constraints. Thus, GPs working in very deprived areas are faced with both meeting existing patient demand *and* identifying patient needs that should be addressed. All of this is influenced by GPs' willingness to 'go the extra mile', including the extent to which GPs actually act as advocates for their patients, and is explored in depth in Chapter Eight.

Regardless of deprivation level, the interviews revealed that at a practice level, identifying patient need proved challenging in a deprived context as many of the GPs described their work as 'firefighting' to keep up with existing patient and workload demands, as opposed to prioritising based on need. This has already been discussed in the context of the GP contract and QOF requirements, wherein GPs have either chosen to ignore QOF or side step it completely with a 17c contract as an attempt to align practice strategies with practice needs. Those who chose the latter felt this opened up more time and flexibility to identify patient needs from a practice population-perspective through clinical audits, which then led to practice-specific strategies (e.g. COPD clinics).

### **7.5.1 Patient consultations**

In terms of the patient consultation, one of the GPs suggested there were often three things needing to be balanced: the GP's opinion, the patient's opinion, and the contract (Figure 7.1). Thus, in the context of the patient consultation, it is up to the GP how each element is prioritised. Amongst the GPs, prioritisation strategies ranged from compromising and/or negotiating with the patient to choosing to address all of a patient's presented problems versus asking them back in for a follow up appointment.



**Figure 7.1 Three principal priorities influencing GP's decisions during patient consultations**

When asked whether they found tension between what they thought was best as the GP and what the patient wanted, many of the GPs—including those who positively constructed their patients—described the patient consultation as a process of compromise, as they were conscious of not taking a paternalistic approach to the patient encounter. Descriptions of patient compromise did not vary by deprivation level, but were more common amongst GPs who positively constructed their patients, such as Dr Reilly.

*It's a negotiation between what they've come looking for and what you feel might actually be more helpful for them.* (Dr Helen Reilly, female, end of career, significant Deep End involvement)

As Dr Reilly pointed out, compromising was especially important because the problems identified by the patient were not always what the GP perceived as the most pressing issue. Several of the GPs noted that compromise was often reached in terms of prescribing. The difficulty of balancing the patient's opinion, GP's opinion and the contract was outlined by end of career GP, Dr Bannigan, in terms of prescribing the anxiety-reducing/muscle relaxant diazepam. For him, the contract came third and it was instead a negotiation process between the GP and patient until agreement was reached.

*We've recently been told [by the NHS] to stop prescribing 5mg diazepam, so everybody is to get 2mg diazepam instead. Now, we've got several people who take shed loads of diazepam, along with the methadone and stuff like that. I've got a guy who is on 600ml of methadone, and takes 30mg of diazepam a day...So, we finished up [the appointment] having a, kind of, 'I want to stay on fives', 'No you have to move to twos, it's not my decision but that's what we're going to do.' He said, 'Can you not just give me the fives for another month?' I said, 'Well, I tell you what, how about if I give you to them for another two weeks.' So, he goes, 'Three weeks.' And, I say, 'One week.' He says, 'Okay, two weeks,' so I gave him two weeks of fives and then twos. (Dr Robbie Bannigan, male, end of career, significant Deep End involvement)*

Dr Bannigan's willingness for patient compromise is likely tied to his high degree of patient empathy. Additionally, unlike most of the other interviewees he was on 15-minute appointment times, providing slightly more time for negotiations. Even so, this necessitates a relatively quick negotiation between GP and patient, which is why some GPs noted they often asked the patients back in for follow up appointments. If this was the case, it was typically the most pressing physical ailments that were addressed first, as Dr McPherson pointed out in his example of addressing an acute infection first. Similarly, mid-career Dr Carroll also noted that "medically dangerous" problems came first, followed by the issue most important to the patient.

*We do have the luxury of being able to bring people back as often or as little often as we feel we need to. We can't just bring everyone back every week because there isn't the capacity, but where it's necessary, so you don't need to deal with everything in ten minutes, and quite often you just can't. And sometimes you need to say, we'll just sort out your acute respiratory infection today and we'll get some blood and then come back next week and we'll look at your whatever else it is, your mental health issues or whatever, if they're not pressing. (Dr Martin McPherson, male, end of career, no Deep End involvement)*

Dr McPherson works in one of the 15 most deprived practices in Scotland, so it is potentially the large practice size (over 8 GPs) that enables him to bring patients back in for follow up. The follow up for additional problems, however, did not always necessitate an appointment.

Dr Rory MacGregor noted that telephone calls were often utilised for this purpose, particularly in the management of mental illness. This would typically involve phoning the patient up after a few weeks to see how they were doing.

In contrast, a minority of the GPs—from practices spanning the top 100—opted to try and address all the problems in one appointment. This was out of concern that the patient would not actually come back for a follow up appointment if asked to. However, the challenge with this approach was whether or not the patient felt their needs were adequately addressed. Thus, a ‘patient first’ mind-set was common amongst the majority of GPs, regardless of whether they chose to sort all the problems out or relied on follow-up appointments. This sentiment was strongly echoed amongst GPs with significant Deep End involvement and strong positive patient constructions, including Drs Anderson and Gallacher.

*And quite often it's very difficult for our patients to express what they want. And they are pretty chaotic in the consultation, and talk about the dog that died, and then their chest pain, and then, 'I've been coughing,' and, 'I'm losing urine.' So a lot of patients can't even hold a single line for a long time. And then, it's very difficult to listen, and filter out what is the most important for them, what is the most important medically, and what is my issue before they came in. (Dr Kenna Anderson, female, mid-career, significant Deep End involvement)*

*So if somebody has diabetes for example and everyone thinks diabetes is about your blood sugar and it's about your weight and it's about heart risk, so why are you not dealing with your diabetes? The patient might say, 'Well, that's not important because what is important is I can't look after my elderly mother because I don't have any support. My child's truanting from school and my son's an alcoholic and I've got to get up at four o'clock in the morning for my cleaning job. That's my priorities.' So rather than us shout at them to lose weight and eat more healthily we're trying to change the tack a little bit and say, 'If there's anything I can do to help you with any of those things, what of those things could we help you with so that you might be able to tackle your diabetes?' (Dr David Gallacher, male, end of career, significant Deep End involvement)*

Dr Anderson stated that she liked to go through the patient's records before they came in to have a few issues she would like to address. Ultimately, however, it was the patient agenda's first and she was tasked with distilling their priorities. This is because in the context of social issues stemming from high deprivation, these will often overshadow the medical issues seemingly most urgent from the GP's perspective, as highlighted by Dr Gallacher. Consequently, the ultimate objective expressed by many of the GPs was to engage in a partnership with the patient, wherein they are not only expressing their illness in consultations, but also sharing their treatment goals.

### **7.5.2 Identifying need from a proportionate universalism perspective**

As Chapter Four emphasised, GPs are positioned to identify those with greatest 'need' and as SLBs they have considerable discretion and autonomy to allocate resources accordingly. This is due to the specific skillset and generalist knowledge GPs have wherein they are able to discern major illness from minor medical problems; this skillset also provides the potential to work alongside patients in addressing their priorities. Dr Fleming echoed this sentiment that GPs do "know who the most disadvantaged patients are," and also, "who has very poor health and who has a great deal of problems"; the problem, however, is shifting from a reactive to a proactive approach. While the definition of 'need', as discussed in Chapter Three, is variable and imprecise, GPs working in deprived areas have the ability to distil patient priorities *and* identify patients who are not engaging with health services, which is perhaps more important than pre-established definitions of need. As this chapter has demonstrated, patient priorities do not always align with GP and practice priorities; however, a patient-focused practice provides a useful anchor from which to guide activities.

Whether or not they practise accordingly is significantly influenced by the context of strained resources, severe levels of multiple deprivation and premature multimorbidity. This research demonstrates that GPs do prioritise patient need and align practice structure to better address it, especially for GPs who have adopted a 17c contract. This better enabled GPs to organise practice strategies as opposed to simply trying to keep their 'head above water' in managing their existing caseload. Unlike traditional SLBs, GPs balance frontline worker and manager roles (Checkland, 2004), providing more scope to strategise and often side step bureaucratic structures to (potentially) better meet the needs of their patient populations. Under this

autonomy, GPs working in deprived areas certainly have the potential to practice from a proportionate universal perspective, wherein resources are proportioned to disadvantage and need. However, this necessitates that 1) GPs maintain considerable autonomy in order to be flexible and responsive to their patient populations and 2) GPs working in deprived areas have access to adequate resources. Accordingly, a proportionate universalist approach in practice might translate to: at an individual level, increased time during consultations for complex patients, as determined by the GP; at a practice level, preventative/promotion activities specifically geared towards the practice population and strategies aimed at identifying patients struggling to engage with services; and, at higher policy/political levels, a redistribution of resources that greater reflects need based on premature multimorbidity. This is perhaps easier to conceptualise than operationalise due to conflicting interests (e.g. who stands to lose in the redistribution of resources) but worthy of further exploration nonetheless.

## 7.6 Conclusions

GPs working in areas of high deprivation face a number of workload constraints in terms of time, complexity of caseload, and contractual obligations. Inadequate resources further exacerbate these challenges, proving Lipsky's SLB framework useful for understanding how GPs cope with restraints and negotiate dilemmas. The interviews revealed the underlying motivations for how GPs negotiate dilemmas stemming from this work environment—including autonomy versus bureaucratic control and responsiveness versus standardisation—to involve a patient-focused approach. Specifically, GPs choose to ignore bureaucratic guidelines if 1) it is viewed as in the best interest of the patient (based on the GP's clinical judgement) and 2) the financial risk is minimal. Similarly, GPs willingly increase workload by *following* bureaucratic guidelines if it is seen as in the best interest of the patient. This also adds an addendum to the narrative established in Chapter Six regarding how GPs' social constructions of patients relate to their conceptualisation of health inequalities (and what can be done to address them). Regardless of patient constructions, participants felt a responsibility to do what is best for the patient. Furthermore, the majority of the interviewees lauded the independent contractor status—and the autonomy it affords—because it allows GPs to determine patient and practice priorities (and practise accordingly).

Professional stress was not intrinsically tied to practice deprivation level, but did reveal patterning according to GPs' social constructions of patients, established in Chapter Six; specifically, GPs who positively constructed patients (and demonstrated greater patient empathy) in their interview discourse showed higher levels of perceived stress than those who negatively constructed patients. This might inherently be tied into how 'high' GPs set the bar in terms of what can be achieved during patient consultations; in other words, this suggests GPs demonstrating greater patient empathy have higher standards of what they are trying to achieve, and thus feel greater stress. These are preliminary findings at best, but are worthy of further exploration, involving GP motivations and ambitions, in terms of what can be achieved via patient consultations.

Coping strategies for working in a 'deep end' practice were not patterned according to deprivation levels, but instead were linked to the patient social constructions and practice size. Examples of the latter involve time-management strategies such as catch up slots (medium to large practices) and patient continuity (small practices), although continuity is arguably a coping strategy for all GPs regardless of practice size. Additional coping mechanisms employed by the majority of interviewees, regardless of practice size or patient social construction, included restricting clinical work to part-time and 'portfolio' work. Furthermore, a few of the GPs utilised practice structure, such as reducing GP income (via patient list size) or adopting 17c contracts, to better cope with workload and patient demand.

Prioritisation within the patient consultation involved balancing the GP's opinion, the patient's opinion, and the contract. For the majority of the GPs this involved negotiation and compromise with the patient. Thus, it was up to the GP to distil the patient's priorities, balancing these with the GP's opinion of what was medically important, as the two did not always align. This demonstrates a shift from Sir William Osler's 19<sup>th</sup> century biomedical advice of 'listen to the patient, he is telling you the diagnosis' to a more holistic focus of 'listen to the patient, she is telling us her treatment goals' (Watt, 2013, p.1). How this all translates into practising from a proportionate universalist approach includes GPs' maintaining considerable autonomy in their work and a redistribution of funding that better aligns with clinical need, the latter of which presents political barriers. However, this research found that GPs working in deprived areas are increasingly testing these political barriers through

advocacy work, explored in the next chapter. Consequently, this thesis finds that while Lipsky's framework is useful in understanding how GPs working in very deprived areas negotiate dilemmas and cope amidst strained resources, it falls short in adequately describing the advocacy work of GPs (at various levels) and how their role transcends the confines of the consultation room and practice boundaries.

## **CHAPTER 8 ‘Going the extra mile?’ Advocacy in Scotland’s Deep End**

### **8.1 Introduction**

Thus far, this thesis has argued that GPs’ perceptions of their role in tackling health inequalities is related both to how they conceptualise the problem of health inequalities and to how they socially construct their patients (Chapter Six). The latter also provides insight into perceptions of professional stress and, potentially, how ‘high’ GPs set the bar in working with patients. Additionally, Chapter Seven explored the utility of Lipsky’s SLB framework in understanding how GPs working in areas of severe deprivation cope, with inadequate resources, in order to meet the needs of their complex patient caseloads. Collectively, this serves as a foundation for this final findings chapter, which explores how GPs perceive themselves to be making a difference in the lives of their individual patients and patient populations through advocacy. The findings discussed thus far provide critical insight into how GPs conceptualise this advocacy role in addition to the contributory and limiting factors that support this. Exploring this role also builds on the literature reviewed in Chapter Three, which discussed the conventionally accepted GP responsibilities of ‘health system navigator’ and ‘gatekeeper’ for accessing secondary and specialist services. Specifically, this chapter adds to the discussion a better understanding of how GPs view themselves as ‘going the extra mile’, including an exploration of the discretionary boundaries within which advocacy operates. Consequently, this chapter attempts to tie the findings together, providing a holistic view of GPs’ work in deprived communities.

To accomplish this, the chapter first explores advocacy boundaries, which follow the ‘GP scope’ framework proposed in Chapter Six. These boundaries include: how GPs view their advocacy role in the context of individual clinical care and individual social determinants of health (SDH), as explored in Section 8.2; the extension of advocacy, in Section 6.3, to the communities in which they practice, such as taking on community roles and building links with local services; and, finally, whether or not they are involved in the politics of general practice and/or advocating for policy change, as discussed in Section 8.4. Following this

examination, Section 8.5 explores what the Deep End group offers in terms of advocacy, including contributions to the politics of working in deprived communities, policy change within general practice and concerning the SDH, and the result of new initiatives stemming from the group's advocacy efforts. To capture the range in which GP advocacy operates, Section 8.6 offers a theoretical framework exploring the boundaries of discretion. Pen portraits, providing examples of how advocacy operates across the spectrum, illustrate this framework. The findings in this research culminate in Section 8.7 by suggesting a reconceptualisation of GPs in the Deep End group that moves beyond fixed worker 'types' (e.g. SLBs). Based on the work of van Hulst et al. (2012) and Durose et al. (2015), the lens of 'exemplary practitioners' provides a re-imagination of GPs' work in deprived communities, one that moves beyond individual patient consultations to include "a mix of entrepreneurialism, strategic networking, and empathic engagement" (van Hulst et al., 2012, p.446). Thus, it shows how GPs might encourage community collaboration, organise community action, and/or project development to improve the communities in which they work (Durose et al., 2015).

## **8.2 Advocacy and the social responsibility of GPs**

There is a significant amount of literature devoted to exploring the social responsibility of GPs and, more broadly within the international literature, medical physicians. Inherent within the social responsibility model is the idea that medical physicians have a responsibility beyond individual patients to the communities (and potentially wider) in which they practice (Coulehan et al., 2003; Dharamsi et al., 2011). Thus, a GP's professional and civic duties can be seen as complementary through "ensuring, protecting, and contributing to the collective welfare of society" (Dharamsi et al., 2011, p.1110).

To better understand how social responsibility relates to medical physicians—and consequently GPs—Coulehan et al. (2003) describes two versions of this role: 1) a wider commitment to improving the health and welfare of a community as a whole; and, 2) the need to understand the economic, social, and cultural context individual patients live in. The first understanding of this role is in line with population medicine and the increasing focus of public health activities within general practice, while the second version of the role denotes

the need for social interventions beyond general practice. The literature on the social responsibility of physicians tends either to be focused on professionalism and ethics *or* advocacy; it is the latter in which this chapter is interested.

### **8.2.1 Natural advocates of the people**

*The social causes of illness are just as important as the physical ones. The ...practitioners of a distressed area are the natural advocates of the people. They well know the factors that paralyse all their efforts. They are not only scientists but also responsible citizens, and if they did not raise their voices, who else should? (Henry Sigerist, 1941, as quoted in Watt et al., 2012, p.14)*

This quote from Sigerist not only evokes the social responsibility role of medical practitioners, but also declares them to be “the natural advocates of the people.” Advocacy is an often ill-defined term, but from a general view simply means “public support or recommendation for a specific cause or policy” (Oxford English Dictionary, 2016, online). Further specifications depend on both the context and field; within the health and social care fields, advocacy has been frequently linked to both the nursing and social work professions in terms of promoting the health and wellbeing of patients and clients (Baldwin, 2003; Payne, 2014).

While there is a mass of literature on advocacy, including within health care, fully reviewing this is outwith the scope of this research. Instead, Table 8.1 provides a brief overview of the forms of advocacy related to health and social care. From the interviews, as will be seen, the data revealed that at times GP's advocacy took on a more explicit form, such as ‘patient advocacy’ or ‘physician advocacy’. However, rather than focusing on a narrow meaning, this chapter operates under the general definition of advocacy as ‘public support or recommendation for a specific cause,’ such as patients and/or patient populations. Finally, this chapter also avoids the normative assumption that GPs should have a social responsibility and/or act as advocates on behalf of their patients; rather, it explores GPs’ perception of advocacy both in and out of patient encounters.

**Table 8.1 Definitions of ‘Advocacy’ within Health and Social Care**

<b>Advocacy (general)</b>	“Public support or recommendation for a specific cause or policy” (Oxford English Dictionary, 2016, online)
<b>Patient Advocacy</b>	An intervention “to help patients obtain services, rights, and benefits that would (likely) not otherwise be received by them and that would advance their well-being” (Jansson et al., 2015, p. 3).
<b>Policy Advocacy</b>	An intervention “to change dysfunctional policies in institutions, communities, and government that may create the need for patient advocacy in the first place” (Jansson et al., 2015, p.3); this includes changes in policies in hospitals, communities and legislatures that will improve the well-being of significant numbers of patients.
<b>Physician Advocacy</b>	Action by a physician to promote those social, economic, educational, and political changes that ameliorate the suffering and threats to human health and well-being that he or she identifies through his or her professional work and expertise. (Earnest et al., 2010)
<b>Health Advocacy</b>	Defined as “a combination of individual and social actions designed to gain political commitment, policy support, social acceptance and systems support for a particular health goal or programme” (WHO Europe, 2006, p. 21).

### 8.3 Advocacy at the individual level

Advocacy at the individual level can be examined through two separate perspectives, how GPs act as advocates in relation to clinical care and how they act as advocates in relation to tackling broader SDH. The distinction between the two is crucial, as the latter may not necessarily fall within a GP's clinical scope. Regardless of the perspective, advocacy at the individual level can take place during the patient consultation or outside of the consultation on behalf of the individual; interviewees provided examples of each.

### 8.3.1 Individual clinical care

Addressing individual patients' medical issues is an integral part of general practice. However, this research sought to understand how GPs viewed themselves going 'beyond the call of duty' with regards to individual care. While 'call of duty' implies professional norms, dictated by contracts, incentives, and moral imperatives, 'beyond the call of duty' introduces a discretionary element. This is not easily defined, but Chapter Three discussed key responsibilities generally considered within a GP's remit, including 'health system navigator' and gatekeeper to secondary and specialist services. This means that while writing a referral letter for a patient to access a specialist may be considered a standard GP duty, writing re-referral letters (e.g. due to patient non-attendance) and/or individually following up with specialists on the phone was considered by many of the GPs to be supplementary to their standard workload. Additionally, discretionary activities might relate to individual patient care or, as this chapter reveals, extend beyond the consultation room boundaries. Thus, the analysis in this chapter relies on GP's own perceptions of what is considered 'beyond the call of duty' to establish the potential ways in which they support patients in terms of individual clinical care, in line with the definition of 'patient advocacy' identified in Table 8.1.

The interviews revealed that all GPs perceived themselves as individual 'patient advocates' to some extent, as it pertains to clinical care. This advocacy was primarily discussed in the form of involvement in secondary/specialist care and through encouraging patient self-management. Regarding involvement in secondary/specialist care, many of the GPs described time consuming accounts of 'chasing up' specialists to discuss individual patient care. This was done either via emails to specialists or directly calling them on the phone, which Dr Clair Findlay stated she often did on her day off (coincidentally when the interview also took place) since there was otherwise no time during normal work hours. For others, writing re-referrals for patients who had missed hospital appointments took up a significant amount of their time.

*I think, as a GP in this area, you have to be a patient advocate...like this morning I saw one patient and I did two re-referrals [for hospital appointments he had missed] because he must follow up. And on discussion [in the letters], I noted that he's got these diseases, and nobody's looking after them...I quite often feel I'm becoming a secretary, because somebody else could just write a re-referral. I should be dealing*

*with other skills. Or somebody could help taking patients to appointments, instead of having this revolving door system. (Dr Kenna Anderson, female, mid-career, significant Deep End involvement)*

*[Responding to the question of how they advocate on behalf of patients] So things like patients who have maybe missed hospital appointments. And they might come in with the plastic bag full of different letters, all the different services they're involved with. And it might be, 'I've missed these appointments', and I'll pick up the phone and try and deal with that. Or they've been discharged from a clinic because they've missed it, [because] they turned up to a different hospital. (Dr Simon Alexander, male, early career, minimal Deep End involvement)*

Drs Anderson and Alexander highlighted an important issue of working in deprived areas, the fact that many of their patients suffer from multimorbidities and are thus being seen by a variety of specialists. This creates an understanding by the GP of the complex, and often siloed, health care system many of their patients deal with, as specialist services often treat patients on a single-disease basis rather than taking a holistic approach to the patient. Understanding the complexity their patients face, often combined with additional social issues related to deprivation, encouraged many of the GPs (and particularly those who positively constructed their patients) to be sympathetic towards missed appointments and willing to either write re-referrals and/or phone the providers directly for follow up. However, as Dr Anderson noted this is not always done without objection, as she felt additional support was needed to address the “revolving door system” problem with patients in deprived areas, i.e. the issue of patients in deprived areas going in and out of medical *and* social services without actually having their needs addressed. Consequently, she expressed that her GP skills were not always utilised to the ‘top of her license’ (i.e. what she was clinically qualified to do) due to the large amount of secretarial duties she performed in chasing up missed appointments. This was not discussed as a worry of de-professionalisation, or “reduction in occupational privileges” (Larkin, 1995, p.48), but rather from the SLB perspective described in Chapter Seven of re-referrals placing an additional pressure on already limited time.

In line with this, many of the interviewees suggested individual patient advocacy necessitated the traditional GP role of health system navigators, wherein GPs described guiding their

patients through their medical journey. Again, this acknowledged the complex system many of their patients were required to navigate and the additional support patients in deprived areas often require in sorting out the patient journey, as Dr Duncan Macleod explained:

*I spend hours on the phone trying to sort out, trying to make sense of [the patient's] journey and then trying to sort out where they're going, what's supposed to happen, what investigations they're supposed to get, what you're supposed to do, what should they have done. Well, that's what we do all day. So this advocacy thing, we are advocates in that sense because we just sort everything out for people. (Dr Duncan Macleod, male, end of career, minimal Deep End involvement)*

In addition to re-referrals, phoning specialists, and navigating the patient journey, some of the GPs discussed patient advocacy *during* patient appointments in terms of encouragement to attend secondary services, as Dr Alison Kelly noted:

*You encourage them to go to appointments. You encourage them to go to hospital for investigations that they might be very frightened of. It's more this, kind of, advocacy and holding their hand a wee bit sometimes. Not everyone, some people are very enabled here and they're fine but for the ones that have been avoiding coming down until the last minute and then they're frightened to go to hospital, I think, that we do a lot of hand holding and encouragement and things like that. (Dr Alison Kelly, female, end of career, significant Deep End involvement)*

“Holding their hand” was perceived to be a form of advocacy because it was supporting the patient to access services they might not otherwise receive. As Dr Kelly noted not all patients required this extra encouragement; rather this support was provided to patients who had previously been disengaged from health care services. Individuals or communities considered ‘in need’ of health services but not accessing them have frequently been referred to as ‘hard to reach’ by academics and professionals alike. However, the use of the term has been criticised for its lack of conceptual, political and practical clarity, with Mackenzie et al. (2012) suggesting ‘candidacy’ as a more appropriate framework. Describing how individual’s eligibility for healthcare is a process of negotiation between themselves and health services (Dixon-Woods et al., 2006), candidacy is useful in understanding how access operates as a

social construct. This denotes a more complex process of recognising health care need and navigating access to services (Mackenzie et al., 2012), rather than the simplified narrative of patients failing to engage with health services. Thus, GPs are crucial in this negotiation process, which Dr Kelly recognises as a significant element to her work.

For some GPs, individual patient advocacy was tied to “taking responsibility for the full thing” (Dr Cecilia McCullough), wherein they would leave notes for themselves to personally follow up on a patient’s blood results rather than letting the responsibility fall elsewhere. This was largely linked to the encouragement of continuity, which is generally seen as one of the strengths of general practice (Chapter Three), as Dr Lucy Carroll iterated:

*If I see someone in particular trouble or with an interesting problem, I will keep booking them in to see me. So there's a guy who I know really well with a drug problem, who was doing really well, then completely relapsed. So I'm now seeing him every week as an extra patient, like, extra to my general workload, to try and get him back to where he was before. (Dr Lucy Carroll, female, early career, no Deep End involvement)*

As Chapter Seven discussed, how high GPs ‘set the bar’ is up to individual discretion. Working in a large practice with over 10 GPs, Dr Carroll might have tried to unload more complex or ‘problem’ patients onto one of her partners. Unlike the Lipskian view of a SLB trying to reduce workload, Dr Carroll continued to book the patient in to her appointment list. Willingness to increase workload via individual patient advocacy—particularly if it was seen as in the best interest of the patient’s clinical care—was common across all participants. This is in line with Chapter Seven’s emphasis that GPs frequently prioritise patient needs above contract requirements, further demonstrating GP advocacy in individual clinical care.

### **8.3.2 Social determinants tackled at an individual level**

*Your role is advocate. Your role is advocate with the hospital; your role is advocate with the benefits agency. (Dr Fergus Lindsay, male, end of career, some Deep End involvement)*

Individual advocacy was not constrained to clinical care, as the majority of GPs acknowledged the importance of dealing with the “non-medical side of practising in a deprived area” (Dr James Henderson). One of the primary ways in which GPs acknowledged supporting individual patients, beyond clinical care, was in the form of writing benefit letters for their patients (e.g. ‘fit-for-work’ letters and housing support letters that aim to make special pleas for individual patients against policy decisions detrimental to the social determinants of health). Since GPs are contractually obligated only to provide medical information for welfare benefit applications but not to write benefit letters (e.g. providing supplementary information for appeals, for which they typically receive no compensation unless they specifically charge patients), it is entirely up to individual GP discretion whether or not they perform this role. For those that did (including the majority of GPs interviewed) the reasons were varied. One GP stated that if they were in the patient’s shoes, they would want their GP to do the same (Dr Carroll). Others said it was difficult to say no if the patient’s benefits were at risk. This prompted a feeling of obligation to try and help the patient, especially those with limited resources because, “You’re the only person that they can ask for support” (Dr Kelly) and, “If we don’t do it, who will actually put their case forward?” (Dr Macleod). Regardless of whether the letters actually had an impact on the patient’s benefits, a few of the GPs wrote them so that the patient knew they ‘bothered’.

*Indeed we [write] numerous letters, as every GP in deprived areas do; numerous letters for all kinds of purposes to do with the justice system, em, to do with housing, to do with benefits, grants...[Patients in deprived areas] are—on the whole—very sick people with lots of health problems and with little money, so they are, they need help applying for lots of benefits, either state benefits, for other organisations or help with housing, etc...They need a GP to help and to decide if the case has merits for achieving whatever benefit or whatever help they can offer to the patient. (Dr James Henderson, male, late career, minimal Deep End involvement)*

Dr Henderson felt that writing benefit-related letters on behalf of patients was very much within his remit as a GP working in one of Scotland’s most deprived areas. This is in accordance with the findings presented in Chapter Six, wherein the majority of GPs felt they played some role in tackling health inequalities, particularly at the individual level. Moreover,

writing letters is seen as a tangible way of doing this. While improving patient's access to benefits would not likely prevent health inequalities from occurring, it could potentially mitigate existing inequalities from widening, depending on the benefit levels.

Although he was one of the GPs who tended to negatively construct his patients, Dr Stuart Booth felt responsible to do “more than what's written in [the GP] contract” (Section 7.3.1). This is in line with the ‘doing what's best for the patient’ attitude, regardless of patient construction, demonstrated in Chapter Seven. His account revealed an enlightened self-interest in explaining why he writes benefit-related letters:

*Yeah, absolutely, you're a social worker, you're phoning housing associations, you're writing letters of support for housing which they can't afford to pay for. But you think, right, this person gets chucked out of their house, their mental health is gonna deteriorate, their physical health is gonna deteriorate, and I'm gonna have a bigger problem on my hands and I'll have a more sick patient, so, it makes an interest for me to actually write that letter for free to give them a help. (Dr Stuart Booth, male, mid-career, some Deep End involvement)*

Other GPs were not quite as willing to write letters of support on behalf of patients but instead chose to direct patients to where they might get additional support. For example, Dr Martin McPherson recognised that recent changes to the benefits system had caused “a huge amount of stress and anxiety for patients” and, “You could end up just writing letters for everything.” Thus, he encouraged his patients to go to the charity organisation Citizens Advice in the event that they were appealing against a benefits assessment decision. Similarly, Dr Carroll explained that financial problems were often the underlying source of her patient's stress or depression and she frequently referred patients to the financial advice service Money Matters or the co-located welfare officer in the health centre. Co-location of social services was one of the advantages of working in a practice situated within a health centre. However, some of the stand-alone practices noted they often had representatives from a variety of services visiting their practices during the month to meet with patients. While having a welfare rights officer in house would certainly make it easier for GP referrals, it is unclear from the data whether this lessens the need for GP advocacy (and potentially reduces professional stress) and is an area worthy of further exploration.

Out of all the interviews only two GPs explicitly stated they do not write letters of support (although, as Chapter Seven noted, Dr Anderson had been looking at curbing benefit-related letters in an attempt to harness her unsustainable workload). The reasoning given was that the letters were seen as unhelpful in determining whether or not a patient kept their benefits, in addition to falling outwith the scope of the GP's work. More specifically, Dr Elizabeth Duggan felt that GPs were erroneously placed into the frontline as a gatekeeper for patient's benefits.

*I think deprived practices, in particular, have been sold down the road on the benefits issue here because we've been sort of put into the frontline as if we are potentially gatekeepers for patients' benefits. And that's wrong, 'cause we shouldn't be. (Dr Elizabeth Duggan, female, end of career, significant Deep End involvement)*

This is in line with the findings discussed in Chapter Six, wherein Dr Duggan described tackling health inequalities as a 'social issue' and that GPs could do little to help sort out patients' social problems. Interestingly, while Dr Duggan claimed she was unable to 'sort out' her patients' issues stemming from socioeconomic deprivation, she described doing just that at another point in the interview.

*I remember when I first started going up to somebody in [very deprived neighbourhood] and she's sitting in the dark and wrapped in newspapers, with nothing in the fridge, because she hadn't got the money to put the light on! And I just got social work to come round to sort her out. I mean she wasn't claiming [any benefits]. (Dr Elizabeth Duggan, female, end of career, significant Deep End involvement)*

Dr Calum Fraser, the other GP against writing benefits-related letters, did not perceive writing the letter to be beneficial, but also placed an element of responsibility on his patients, thus discouraging them from seeking letters of support. Dr Fraser was also one of the GPs who tended to negatively construct his patients in Chapter Six, suggesting that they "like to abuse drugs."

*They tend not to ask for them. Even if they did ask for them I probably wouldn't do it...I think if they ask for it it's because they've been told to ask for it. I usually say, 'Well, ask the person who asked you to ask for it to contact me' and they never, ever,*

*ever do. Now that might be because they've not gone back and said to the person, 'You've to contact Dr Fraser.' Probably that's what's happened, but usually the person they're dealing with doesn't know how to deal with it and they just say go and get something from your doctor, which isn't needed. (Dr Calum Fraser, male, end of career, some Deep End involvement)*

Unlike Dr Duggan, who recognised the role of wider structural inequalities negatively impacting on the health of deprived areas, Dr Fraser conceptualised the problem as largely related to individual lifestyle and health behaviour. While it is not clear whether involvement in the Deep End group accounts for this discrepancy in understanding, there is a distinct connection between Dr Fraser's reluctance to write benefit-related letters, how he negatively constructed patients, and his understanding of the problem of health inequalities in deprived areas.

Whether or not the GP wrote benefit letters on behalf of a patient, it was clear most of the GPs felt the need to acknowledge and attempt to address their patients' social problems. This was because they felt practising medicine in a very deprived area had a significant social component that could not be ignored, and thus required familiarity with available services in the community.

## **8.4 Community advocacy—building linkages with services**

### **8.4.1 Community roles**

In comparison with advocacy at an individual patient level, advocacy at a community level was not as strongly prioritised amongst the GPs. Rather than working as an advocate for the communities in which they practised, there was a greater focus on using discretionary space to build knowledge of the community and create linkages with local services as a way of improving the integration between general practice and social care services. That being said, a few of the GPs reported taking on a role within the community via organisations outside of the practice, including a mental health support organisation and a local charity aimed at improving the delivery of social services within the community.

*I was on the board of what's now CareSupport, the counselling service, for about, um, 15 years? But I stopped that about 5 years ago. And I mean the organisation just got steadily bigger and bigger, became CareSupport and I just felt that I didn't have the time to, um...yes, to really keep on top of, you know, what I thought a board member should do. But I had that involvement for a long time, which is one reason that CareSupport came into our building, because [of] my link with it. And so we still have workers from them coming in. And so we always knew what resource was there and [I] was able to refer folk on with knowledge of the services that were there. (Dr Helen Reilly, female, end of career, significant Deep End involvement)*

*I'm actually a trustee of [local charity aimed at improving the delivery of local social services]...It involves, once a year, I go to a meeting, and we look at, you know, as a charity, what we're going to do in order to help, to hopefully continue [local charity] in the future. So, I feel I'm putting something back there...I'm not being particularly active, but you know, I was asked to go on it, so I felt, it was at least putting something back... Yeah, I feel I'm part of the community...And that's another, I mean, that's just another layer of how we can make a difference, you know, there's all different layers, and we should integrate. (Dr Fergus Lindsay, male, end of career, some Deep End involvement)*

While Dr Reilly was no longer on the CareSupport board, her involvement had a clear benefit to her practice population through connecting the service to her patients. Unfortunately, the increasing workload demand facing GPs in deprived areas, defined in Chapter Seven as shortage of time and complex patient caseloads, meant that she could no longer uphold the time commitment. For Dr Lindsay, the time commitment to the local charity was minimal—with an annual meeting at most—but helped him feel both connected to the community and that he was contributing to its development. This sheds light on potential motivations for community involvement and is similar to the motivations for writing benefit-related letters; in other words, if a small act such as writing a letter or going to a meeting might have a positive impact, without sacrificing workload, then it is justifiable.

### 8.4.2 Developing community links

In contrast to taking on a community role outside of the practice, the majority of the GPs felt that linking their practice to local community services was seen as a substantial part of working in a deprived area. For example, Dr Anderson emphasised that all social services in deprived areas, including general practice, needed a greater focus and that GPs could contribute to their development through improved community linkages.

*I wouldn't say [just] general practice, I would say primary care in deprived areas, education and social work need to be adequately resourced. I think, in [very deprived area] it's quite interesting, because there's more and more happening in the communities – housing projects, support, third sector organisations. I think we [as GPs] could do much more if we had a bit of time, better linking us up, and working together. For example, when I mentioned earlier on, the kids who don't go to school – we should be working much closer together, match them up, see how they can be supported [to attend school]. (Dr Kenna Anderson, female, mid-career, significant Deep End involvement)*

Similar to Dr Reilly, time was a significant constraint to developing community linkages—such as working with local schools to improve attendance—and she had felt better connected to her practice community in past years, when she had more time. While she still found time to speak with the schools every once in a while, developing links with third sector organisations was much more difficult.

Improving practice links with local services was a main objective for all of the GPs, regardless of how long they had practised in the area. However, this objective brought about several challenges. For example, ten of the GPs specifically mentioned the difficulty of knowing what local services were available. Even if the GP had some knowledge of local services, they noted specific frustration with third sector services and how its ‘transient nature’ made it difficult to stay up to date because “they change, it’s like quicksand, it moves all the time, and you think you find something like the Stress Centre, that’s no longer available, and things move around—funding gets moved and councils change the contract for the provider” (Dr Booth). So the desire to connect the practice with local services, and thus help the patient

journey around the city, was impaired by a lack of local knowledge. To compensate, Dr McCullough admitted to frequently ‘googling’ services with the patient during the consultation, if they knew the patient did not have computer access. Others, such as Dr Katie Stewart, relied on members of the practice team for knowledge of local services.

*I saw a relatively young patient, a female, eh, who has 3 children, who—I think I’ve been seeing her for a while with depression—and she sort of disclosed that she can’t read? And I just didn’t know where to send her, you know? She said, ‘I would like to learn to read,’ and I thought I have no idea what there is available to [her]. Eh, so I had to speak to the practice manager who did know, luckily, somewhere that I could [refer her to]. (Dr Katie Stewart, female, early career, no Deep End involvement)*

Helping patients navigate clinical services within the health system is certainly within a GP's remit, and this navigator role extends further, due to the context of social issues stemming from high deprivation. However, it was not limited to simply connecting individual patients with social services. Across interviewees there was an overall desire to be more connected to the community in which they practised but, as Drs Reilly and Anderson noted, this was largely inhibited due to overwhelming workloads. According to Dr Janet Campbell, “Apart from doing lots of home visits I find it very difficult to know exactly what is going on [within the community].” To compensate, several of the GPs, including Dr Reilly, who constructed health inequalities from an Analytical/Structural approach, in Chapter Six, explained that their patients actually enabled them to feel greater connectivity within the community.

*I suppose I’ve got an understanding about a lot of things that go on, you know, particularly through patients who have been very active. So, patients who’ve been involved in housing associations or patients who are involved in local disability project. (Dr Helen Reilly, female, end of career, significant Deep End involvement)*

Working in a larger practice with over eight GPs, Dr McPherson described how one of his colleagues organised a meeting with local service representatives to improve community linkages through the sharing of resource and service knowledge.

*[One of the associate doctors] organised one big sort of open meeting where she invited representatives from all the local resources across all sorts of health and social care needs, to come and along, and we went and we all split ourselves up and sat on tables and mapped out the resources and shared information and contact details, and that was hugely successful. And then as part of that process as well—we get some protected learning time occasionally and close the building for an afternoon—she arranged for us [to do a] local walkabout...going round about half a dozen of the local projects...[including] a couple of children’s centres [and a] local gym where they run youth groups.* (Dr Martin McPherson, male, end of career, no Deep End involvement)

As Dr McPherson noted, protected learning time was one of the factors that enabled his practice to make connections with the local community.

In line with this, several of the GPs working in health centres explained the importance of co-located general practice, social work, and third sector services as a way of “finding new ways of working and dealing with the problems that our population faces, and addressing negative community outcomes” (Dr Hamish Mackay). Dr Mackay noted this required a ‘partnership approach’ to improving health and social outcomes, not just within the health centre, but also across schools and wider community. Again, shortage of time and demanding workloads meant that GPs had “their face buried in on the coalface seeing patients” (Dr Macleod) and little time to take a partnership approach within the community. In addition to this barrier was the lack of capacity, at a practice level, to link to their communities. This did not seem to vary by health board locality and was affirmed by Dr Alistair Fleming in the sense that:

*Although from an NHS standpoint we’re community based, in reality we’re not, especially in deprived communities. Perhaps in affluent communities we might live in the area and have a kind of citizenship role, because we live there, but deprived communities, none of us live there.* (Dr Alistair Fleming, male, mid-career, significant Deep End involvement)

The fact that ‘none’ of the GPs live in the areas they practice was indeed confirmed, with only one of the GPs stating that they used to live near their practice (but no longer did).

Thus it can be questioned how GPs working, but not living, in a deprived area can be connected to the community. First off, they spend significant amounts of time in these areas (both within the practice and outwith doing house calls); second, they arguably have considerable knowledge related to their patients and patients' families, which affords an element of continuity within the community. As Dr David Gallacher put it:

*We're meant to be leaders in the community. I think we're trusted. We're here. We're available. It's not difficult to come and speak to me and we're intelligent. We have a view. We're going to be here for 40 years like me, may as well make it better for me as well.* (Dr David Gallacher, male, end of career, significant Deep End involvement)

Given this, several of the GPs acknowledged feeling personal responsibility to not only become more involved in the community through improving linkages between general practice and local services, but also higher up to a political and policy level.

## **8.5 Policy and political advocacy**

### **8.5.1 The politics of general practice**

The majority of GPs aimed to improve practice and community linkages; equally, almost all felt it was important for GPs to have a frontline voice in politics. However, this expansion of discretionary boundaries was reserved for interested 'political GPs', as only a small portion of the participants acknowledged a desire to be personally involved in challenging and shaping policy. There was also a difference between interests in changing the politics of the profession and seeking to address wider SDH. The latter of which was due to the perceived disconnect between those who make the policies that generate the SDH and what is actually going on in Scotland's most deprived communities, and is thoroughly discussed in Section 8.5. Further to the concerns GPs had with challenging politics and policy beyond general practice, professional scope shifts from simply advocating on behalf of individual patients to advocating on behalf of a patient population. Specifically, GPs subscribing to this belief felt they had clout to provide evidence of the impact of social inequalities on health and was not limited to GPs involved in the Deep End group. As Dr Henderson, who works in one of the ten most deprived practices in Scotland, put it:

*I mean, we know what's happening. We are at the front line or the 'deep end', whatever you want to call it. And we know what's happening here, and there is a role for us. I mean we can't fix everything, we're doctors. We don't have the resources to give people jobs or give people better housing, or more money, or deal with child poverty. That's a political issue and a social issue and we can only advise [on] what we see and what the effects of that is on patients health...But we should be part of the solution and part of the group of people who are designing strategy to help with all these problems. (Dr James Henderson, male, end of career, minimal Deep End involvement)*

This acknowledges that while directly tackling health inequalities may not entirely be within the remit of general practice, GPs working in deprived areas have a responsibility to advocate politically on behalf of their patient populations for the improvement of health outcomes. Dr Kelly was particularly clear in her argument that the “general practice of health is very political” and thus requires GPs providing a “frontline voice to what’s actually happening [in deprived communities] without it sounding like we just want more money, because that’s how it’s portrayed in the press.” As she noted, the debate was not simply about allocating more resources to deprived practices; rather, many of the GPs clarified the issue as the need to address premature multimorbidity, which disproportionately affects deprived areas. As Section 8.5 emphasises, the Deep End group has been one of the primary means of joining the political debate.

### **8.5.2 Advocating for policy change**

Several of the GPs mentioned specific ways in which they influenced the policy, rather than the politics, of general practice, including involvement in their Local Medical Committee (LMC) and the Scottish GP Committee. Dr Gallacher provided a specific example of policy change:

*I'm on the Scottish GP committee who deal with all sorts of things...that affect GPs...I helped set up the out-of-hours doctors' service, the GEMS [Glasgow Evidence-Based Medicine Society] [Out-of-Hours] Service which took a lot of the stress off GPs. So, it was at that point we didn't have to do nights on call. We didn't have to do Saturday*

*mornings...That was a huge success not just I think for patients, because they get a better service from less tired doctors, but also the doctors were very much in it together.* (Dr David Gallacher, male, end of career, significant Deep End involvement)

As Dr Gallacher's example reveals, involvement in professional groups is not confined to advocating on behalf of the profession, but also has knock-on effects for their patient populations.

As with the other forms of advocacy, involvement in policy conflicted with GP workload. For example, Dr Anderson had previously been involved in the Glasgow LMC, but noted the time conflict between becoming a "better clinician" and being a "politically interested person," stressing that it was near impossible to be both. Dr Reilly also noted the difficulty of knowing how to be involved in policy, as she did not view "spending lots of time sitting in meetings" as particularly helpful. One avenue for change Dr Fleming had particular hope for was through the GP contract, which is currently in negotiation talks for a 2017 start. For him, this would be "a different type of contract that valued community-based support and linkages to the community." How this would look in practice was not explicitly stated as the interviews were not focussed on the reimagining of a new GP contract, but it did reinforce a desire for a more holistic general practice, integrated within the community.

## **8.6 What does the Deep End offer in terms of advocacy?**

Beyond exploring how GPs working in deprived areas view their role as potential advocates, this research sought to understand what the Deep End group offers GPs in terms of advocacy. Through the GP interviews and informal attendance (by the researcher) at various Deep End events—including steering group meetings, the third national Deep End conference, and various meetings engaging with government and third sector organisations—the advocacy benefits afforded by the Deep End group were evident. While many of the GPs interviewed noted the need to provide a voice for the deprived communities in which they work, the Deep End group has provided an opportunity not only to pursue this common agenda, but also a clear platform for the organisation and mobilisation of this advocacy. This primarily has been in the form of political advocacy, policy work and new initiatives involving general practice in

deprived communities. The activities detailed below are not meant to be an exhaustive list of all Deep End activity, but rather an overview of advocacy-related efforts. Additionally, evaluation of the programmes is outwith the scope of this research.

Table 8.2 is an overview of participants' Deep End group activity, categorised according to the breakdown of Deep End involvement offered in Chapter Five. As previously reported, in Chapter Five, the sample was selected for variability in participant's Deep End group involvement. This ranged from no involvement to extensive involvement in the steering group and either project or political experience. Steering group meetings are entirely voluntary and held roughly every 6 weeks on a weekday evening from 7pm-9pm. Daytime meetings and conferences have always provided locum funding<sup>30</sup> for clinical backfill, but, as several GPs noted, locums are increasingly hard to come by, especially for deprived practices. Additionally, political activity and projects stemming from Deep End initiatives have all been based on collated material, typically from daytime meetings, giving individuals authority in speaking for the whole group.

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<sup>30</sup> Funding for locum payments has been provided for by the Scottish Government, RCGP Scotland, and the Glasgow Centre for Population Health

Table 8.2 Participant involvement in Deep End group activities

Deep End Involvement Group 1	Deep End Involvement Group 2		Deep End Involvement Group 3		Deep End Involvement Group 4
<i>Extensive participation in steering group meetings (17 or more) and project or political experience</i>	<i>Steering group participation only</i>	<i>Moderate participation in non-steering group meetings (7 meetings) and involvement in a project</i>	<i>Participation in non-steering group meetings (4-6 meetings)</i>	<i>Participation in 1 non-steering group meeting</i>	<i>No Deep End participation</i>
Clair Findlay	Cecilia McCullough	Stuart Booth	Calum Fraser	Simon Alexander	Lucy Carroll
Helen Reilly		Agnes Gillies	Fergus Lindsay	James Henderson	Rory MacGregor
Kenna Anderson				Neil Ferguson	Hamish Mackay
Elizabeth Duggan				Duncan Macleod	Janet Campbell
David Gallacher					Katie Stewart
Robbie Bannigan					Martin McPherson
Chris Wallace					
Alison Kelly					
Alistair Fleming					

The work described below primarily involves the nine Deep End group members listed in the first column who have had both extensive participation in Deep End meetings *and* have been involved with projects or political activity stemming from the group.

### **8.6.1 The Deep End's contribution to the politics of working in deprived communities**

Several of the GPs viewed the Deep End group as particularly successful in “[getting] the ear of the government” (Dr Bannigan), and Dr Kelly offered her explanation for why she thought this was the case:

*The Deep End's been very clever in the sense that it's very much guided by frontline GPs and their working experiences but you've got this academic framework to it that really gives it a gravitas, I think, so, we're not just a moaning shop and so, I think, that's been really important and it's just managed to raise issues that, I think, otherwise would have been very difficult. They had only been raised in academic journals and things like that. It's managed to give it a much more popular dimension that even politicians can get their teeth into and understand it and in a way that's not criticising politicians and, I think, that's the thing about the Deep End it's not there to beat people up and say you're not doing your job properly and this is why we're in this situation. It's more about, how can we progress? What can we do? (Dr Alison Kelly, female, end of career, significant Deep End involvement)*

For her, the Deep End had been more than just a support group in which to lament the difficulties of practising in a very deprived context; its strengths lay in the combination of frontline experience with academic support. Not only had it helped articulate the challenges GPs working in deprived areas face, but also brought clarity to the scale of the problem. Recognising these challenges meant a “collective feeling of relief” for Dr McCullough that she was not inefficient in her practice, but that very deprived areas demand additional focus to meet the needs of their complex patient populations.

Part of this political voice has included presenting evidence of the damaging effects the SDH have on their patient populations to several Scottish Parliament committees including the

Public Audit Committee and Health and Sport Committee. In particular, one of the GPs expressed feeling ‘empowered’ by presenting evidence to the Scottish Parliament, which echoes the views of several other participants who lauded the Deep End group as providing a voice to GPs—in addition to patients—working in very deprived practices. According to Dr Bannigan, the real role of the Deep End group has been engaging with government in changing the SDH, since GPs come from a relative position of power and have potential to address the politics of health.

Through this the Deep End group has made it clear inequalities in the SDH result in shortened healthy life expectancy and increase the period of ill health that predates premature mortality. This lobbying on behalf of deprived communities has recently garnered the attention of MSPs, including a Parliamentary Question at the end of October 2015 discussing the current funding distribution in general practice and calling on the Scottish Government to address this in the funding formula (Scottish Parliament, 2015a). This question stemmed from a Possilpark GP, involved in the Deep End group but not a research participant, contacting their local MSPs. In December 2015, Scotland’s First Minister, Nicola Sturgeon, responded similarly during the First Minister’s Questions on what the Scottish Government is doing to reduce health inequalities. She stated that the GP contract needs to reduce bureaucracy and “give GPs more time to devote to the complex problems their patients can face, particularly in areas where patients can face the greatest inequalities and health issues” (Scottish Parliament, 2015b, p.21-22). She concluded that a review of the Scottish Allocation Formula is needed to ensure GP surgery funding is proportionate to need. Garnering the attention of the First Minister is notable, considering Dr Gallacher’s belief stating, “there’s no point in talking to the health board [about Deep End ideas] you may as well go and speak to the First Minister...this is about politics.”

In a similar vein, McLean et al. (2015) utilised 2011/2012 data from the Information Services Division (ISD) of NHS Scotland to highlight the mismatch of GP practice funding in Scotland. Specifically, this found that practices in areas of high deprivation have an increase in consultation rates per patient, but no increase in funding as a result. This British Journal of General Practice paper was produced in collaboration with the academic, non-GP members of the Deep End group and subsequently garnered a significant amount of media coverage

including over ten articles across local and national newspapers and spots on both BBC radio and STV (a Scottish regional news service).

At the time of this research, British Medical Association (BMA) Scotland had not included measures to address the funding allocation to GP surgeries in Scotland in its inputs to the development of the new Scottish GP contract in 2017. However, the Deep End group's message has gained traction with the Scottish Government as the National Clinical Strategy report released in February 2016 highlighted the mismatch of GP funding to need and suggested that there is scope in the new 2017 GMS contract to address the issue “by redistributing existing resources, or ensuring that any additional resources improve the match with need” (Scottish Government, 2016, p.52). Dr Anderson commented on the Deep End's success in providing evidence of the inverse care law (Chapter Two and Three), but also suggested that the Deep End is a “fringe group political organisations [and] non-political professional bodies,” which potentially proves to be a barrier in the group's ability to gain traction in effecting system change.

### **8.6.2 Policy and the Deep End**

Adding to this, some of the GPs felt that they were unlikely to ‘change politics’, with a few citing involvement in the Deep End group as a way of “chip[ping] away through policy” (Dr Duggan) instead, both in and out of general practice. While this has resulted in the introduction of several project pilots, which are subsequently discussed below, it has also offered GPs an avenue to advocate for policy change both within the profession and as it relates to wider SDH.

Considering that over half of the GPs interviewed—including those involved in the Deep End group—described health protection, prevention, and promotion as ways in which they might positively impact on health inequalities (Chapter Six), it is not surprising that Minimum Alcohol Pricing is a policy supported by the group. The group has taken a definitive stance to address alcohol misuse problems (an issue especially prevalent in deprived areas) through Deep End Report 11 (2010), calling on the government to introduce measures, including minimum pricing, which inhibit people from regularly consuming excessive amounts of alcohol.

However, not all Deep End policy support has been directed at public health and lifestyle measures. In addition to advocating on health care reform, the Deep End group has taken a socio-political stance and highlighted the welfare benefits system as a key area for reform. This includes two Deep End reports collating 1) GPs' experience and views regarding the impact of austerity<sup>31</sup> on patients and GP surgeries in deprived areas (Deep End Report 16, 2012) and 2) GPs' experience of welfare reform in very deprived areas (Deep End Report 21, 2013). In addition to describing the consequences (both direct and indirect) of austerity policies on patient health, Deep End Report 16 (2012) explains the disproportionate effect benefit and services cuts have on the most vulnerable individuals. This subsequently places an increased demand on practices in very deprived areas through 'endless cycles' of appeals. The follow up report, 21 (2013), criticises the current welfare reform programme (including the Personal Independence Payment (PIP)<sup>32</sup> and the "Bedroom Tax"<sup>33</sup>) as being damaging to the lives and well-being of individuals in deprived areas. It also describes the difficulty many patients have in understanding and engaging with changes to the welfare benefits system and how they operate, including the long and complicated Employment and Support Allowance (ESA) application process. To support this, Dr Anderson highlighted the damaging impact sanctions (the reduction in payment due to perceived non-compliance with system guidelines) have on the mental health of patients in deprived areas. Identifying this challenge has resulted in the creation of a Benefits Toolkit, through the support of the Deep End group, to simplify the ESA application process for GPs.

Deep End Reports 16 and 21 garnered media coverage and political attention, but more importantly resulted in multidisciplinary meetings with the Glasgow Financial Inclusion Network and Glasgow Centre for Population Health to improve joint working in supporting

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<sup>31</sup> The establishment of the 2010 Coalition government resulted in a variety of austerity measures and spending cuts as the primary solution to the 2008 recession (Levitas, 2012; Wade, 2012). Deprived areas have been arguably the hardest hit, with proportionately higher levels of spending cuts compared to the least deprived areas (Hastings et al., 2015).

<sup>32</sup> The Personal Independence Payment (PIP) is a replacement for the Disability Living Allowance (DLA) and is available for working age individuals who are disabled or are living with long-term health conditions. Individuals receive payments associated with mobility and daily living.

<sup>33</sup> "Bedroom Tax" refers to the changes to housing benefit rules, as of 1 April 2013, for working-age adults renting in the social sector which reduces their housing benefit if 'under-occupied' (reduction of 14% for one extra room and 25% for two or more extra bedrooms).

people having problems with welfare benefits. Deep End Report 25 (2014) is an overview of the first multidisciplinary meeting involving GPs, organisations, services, advice centres and groups in Glasgow who provide either information, advice or support to individuals dealing with the benefits system. This meeting acknowledged that while GPs are regularly asked to provide supporting medical information for benefit applications and appeals, they are not always informed regarding changes to the benefits system or support services available (Deep End Report 25, 2014). Thus, it is crucial to recognise the role general practice teams play in identifying patients with financial problems and signposting or referring them to advice centres for support. A programme of initiatives to assist the interaction between GP practices in deprived areas and the benefits system is currently under development. Collectively, this depicts an important advocacy role in terms of the SDH beyond the health care system.

### **8.6.3 New initiatives resulting from Deep End work**

In addition to political and policy measures, advocacy efforts on the part of the Deep End group have resulted in several new initiatives. This includes one aimed at improving linkages between community resources and health care, known as the Links Worker Programme (Cawston, 2013), and a similar programme in the Govan Health Centre in Glasgow, known as Govan Social & Health Integrated Partnership (SHIP), focused on integrated care between general practice and social work via attached social workers. This Scottish Government funded Links Worker Programme commenced piloting within seven Deep End practices in 2014 and is the latest in a series of activities including Deep End Report 8 on Social Prescribing, the Links Project<sup>34</sup> and the Bridge Project<sup>35</sup>. The Links Workers Programme explores the primary care team's use of a practice attached links worker, helping to link a practice's patient knowledge to available community resources, an important component of

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<sup>34</sup> Established in October 2010, this six-month project provided General Practice teams time and practical support to 'explore the nature of their connections with the communities they serve'. It was established on the premise that improved knowledge in primary care staff about community resources could support social prescribing to encourage self-care and self-management in patients in deprived areas.

<sup>35</sup> The Bridge Project, funded by the Scottish Collaboration for Public Health Research and Policy between January 2012 and February 2013, aimed to build relationships between practices working in deprived areas and community resources to benefit older patients access to services and/or activities that might improve their wellbeing.

overall integrated care. The links worker aims to provide support to patients by strengthening connections between the practice and community resources, in addition to helping the patient identify issues to be addressed and any barriers that may prevent this.

Under way since April 2015, the Govan SHIP project utilises attached social workers, and also involves the added benefits of: additional clinical capacity (two extra salaried GPs per four practices); multidisciplinary team (MDTs) meetings for case reviews; and additional GP time for patient consultations, home visits, and conference attendance. Another key element of the SHIP project has been the addition of protected learning time for GPs, which is perceived to have been critical in providing experienced GPs capacity for practice planning and development. The SHIP project has reported that one of the main outcomes has been the discussion of 742 complex patient cases at the multidisciplinary teams between April and September of 2015. While this only involves four practices at present, they suggest it would cost £4.5 million per year to roll out to the 100 most deprived practices in Scotland (Deep End 3<sup>rd</sup> National Meeting, 2015). In terms of preliminary outcomes of the project, one of the GPs felt that additional capacity and support meant, “we now meet [patient] demand.”

Beyond strategic practice planning, several of the GPs described the importance of involving those working in the community in partnership development. Examples of this collaborative working includes a project between the Deep End group and Glasgow Alcohol and Drug Programme, which has resulted in the embedding of alcohol nurses in six general practices in north west Glasgow. In describing her work with the attached alcohol nurse initiative, Dr Helen Reilly noted:

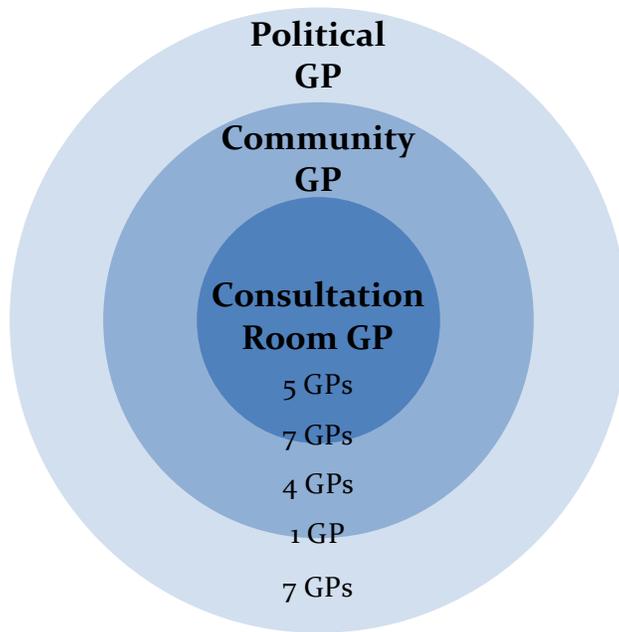
*I've learned much more about the alcohol services [through] meetings with folk from the community addiction team, as far as alcohol is concerned. So it's increased awareness actually of other services and how they can link in in our sort of area. (Dr Helen Reilly, female, end of career, significant Deep End involvement)*

In addition to increasing awareness of other services in the community, Dr Reilly's involvement in the Deep End group has also provided her practice the support of a chaplain in providing pastoral services to patients.

Additional collaborative projects not yet started include working with the Scottish Association for Mental Health to establish a new programme linking its local resources and activities with Deep End practices and collaboration with the Wheatley Group, a major housing, community regeneration and care group in Scotland.

## **8.7 Boundaries of discretionary space**

To better understand the extent of GP advocacy, this chapter has framed the analysis in terms of boundaries of discretion; in other words, exploring to what extent individual GPs exercise discretion to benefit either individual patients and/or their patient populations. This can be understood as a continuum, with discretionary space widening when moving from the ‘consultation room GP’ (at the centre), where discretion is primarily limited to individual clinical concerns, to the ‘political GP’, who exercises their discretion as a way to advocate on behalf of their patient population to policymakers and parliament. In between the two is the ‘community GP’. They exercise their discretion beyond individual clinical care, but primarily within the scope of a local, community level. As with the categorisation of GP discourse in Chapter Six, based on Raphael (2011) and Brassoloto et al.’s (2013) work, not all participants fit distinctly within one category, often overlapping across boundaries, as displayed in Figure 8.1. Consequently, the following pen portraits do not attempt to fully describe the work of the GPs, but rather give broad generalisations of each category in understanding how participants perceive themselves as making a difference through their work.



**Figure 8.1 Depiction of expanding ‘discretionary boundaries’ moving from ‘Consultation Room GP’ to ‘Political GP’ and distribution of GPs across categories**

### 8.7.1 Consultation room GP

Under this framework, the ‘consultation room’ GP exercises discretion primarily within the scope of the patient consultation. While they are committed to addressing individual patient’s clinical concerns, they may not exercise discretion much wider than this. These GPs, as discussed in Chapter Six, had a tendency to negatively construct their patients as ‘undeserving’, largely in the form of victim blaming, and also perceived the problem of health inequalities to be primarily rooted in individual lifestyle and behavioural issues, akin to the Functional approach described in Chapter Six. For example, what Dr Calum Fraser thought he could do to tackle the problem was to try and address ‘inbred attitudes’ surrounding alcohol use and to focus on health promotion amongst his patients. However, the demanding workload common amongst GPs working in very deprived areas proved to be a barrier to achieving this. He also felt that a barrier to patients accessing needed services was that they failed to follow GP advice. In terms of advocacy, Dr Fraser’s discretion was confined to the practice, noting that he declined to write benefits-related letters on behalf of his patients.

Mid-career Dr Stuart Booth was another GP who had a propensity to negatively construct his patients and describe the problem of health inequalities from a Functional approach. In Section 6.4.2, he suggested acting as a ‘healthy role model’ as a way in which he might contribute to tackling health inequalities. Dr Booth also portrayed himself as a fairly confident GP, proudly recounting his tight prescribing with the suggestion that his patients were trained to behave according to the rules of his practice. Unlike Dr Fraser, Dr Booth was committed to writing benefits-related letters on behalf of his patients, but noted it was self-interested, so that his patient’s health would not worsen and create more problems. Dr Booth noted attending a few Deep End meetings, but was not actively involved in the group and described members of the group as ‘activists’. While Dr Booth did have involvement in the LMC, shifting closer on the continuum towards the ‘community GP’, he admitted to never actively putting himself forward. His involvement was primarily driven from a “selfish way...so that I know I can deal with things (within the surgery) better,” rather than trying to “change the system.”

### **8.7.2 Community GP**

The boundaries of discretion widen when considering the ‘community GP’, as their discretionary space extends beyond the confines of the consultation room and practice. This GP understands their role to go beyond clinical and social care as it relates to the individual and includes looking for ways in which to engage with the wider community. Dr Rory MacGregor’s social construction of his patients was largely positive, portraying them as ‘deserving’, in Chapter Six. He was a self-proclaimed friendly GP who “enjoyed a good chat” with his patients, noting that he would have done well practicing 30-40 years ago when the ‘family doctor’ was a more prominent figurehead in the community and had less bureaucratic management. To him, health inequalities were a multi-factorial issue, including housing and financial problems, but he also attributed part of the problem to broader structural forces such as the decline of the shipping industry. In terms of what could be done to address the problem, he felt a focus was needed on health and education in early years, and felt that his promotion of education to younger patients might help. Dr MacGregor wrote benefits-related letters on behalf of patients, but was also involved in a local drug clinic as a way in which to connect to the community. With no involvement in the Deep End group, Dr MacGregor felt there was a need to advocate for policy and system change, but did not see himself as a ‘fighter’.

In contrast to Dr MacGregor, Dr Fergus Lindsay was very vocal about his progressive political views but was careful to distinguish himself from ‘political GPs’ who lobby on behalf of the profession or their patient populations. His progressive views included reducing income inequalities as one of the primary suggestions to tackle health inequalities. The self-reported “advocate with the hospital...[and] benefits agency” was particularly empathetic in his patient discourse in Chapter Six. He noted writing benefits-related letters, but maintaining “boundaries” to avoid getting “swamped” with paperwork and frequently phoning up secondary and hospital services on behalf of patients, particularly if he felt they were “getting a raw deal.” This is because to him, the essence of general practice lies in individual patient consultations; thus, nurturing patient relationships is an integral part of his work. This discretion, however, is not confined to the consultation room. Dr Lindsay is a trustee on the board of a local charity and has collectivist aspirations; he feels like a part of the community in which he practices, and likened this unto the ‘market town GP.’ To him, social support in the community is the crux of addressing individual health and wellbeing since life “can be very difficult” if you do not have a support network. Consequently, improving social support within the community is “just another layer of how we [as GPs] can make a difference.” Dr Lindsay has had some involvement with the Deep End group, but this is confined to attending only four meetings and conferences.

### **8.7.3 Political GP**

Exercising discretion across the entire continuum, the ‘political GP’ expands this space to advocate on behalf of their patient populations directly to policymakers. Common amongst the majority of the political GPs in the research frame is commitment to social justice and their understanding of health inequalities linked to wider structural issues. The Deep End group provides a vehicle in which to carry out political efforts, as most of the political GPs included in this research have been involved in one (or more) of the various Deep End projects and/or presented evidence at Holyrood on the devastating effects socioeconomic deprivation has on the practice populations they work with.

Dr Kenna Anderson had previous involvement with the LMC but took a break to focus on improving her clinical skillset. In the last several years she has returned to political work through her involvement in the Deep End group. While she mentioned she never gives up on

her patients, she voiced concern around her ability to practice safe medicine as a result of increasing time and workload demands in Section 7.2.1. To compensate, she switched to 15-minute consultations and her practice adopted a 17c contract as a way to better align practice strategies with the needs of their population. While Dr Anderson noted looking at curbing benefits-related letters in order to cope with increasing demands, she does find time, when possible, to talk to local schools about health-related education. Ideally her practice would be better connected with services in the community, including housing projects and third sector organisations, but this is a challenge for the immediate future. Dr Anderson felt her connection to the community had diminished over the last several years, but noted the practice has kept close working ties with a local children's charity. Rather than simply accepting the consequence of austerity's effect on her patients, she has used the Deep End group to become politically active, meeting with politicians and presenting on behalf of the group to bear witness to austerity's effects. Involvement in the Deep End group has not drastically changed her views on any of the issues, but has articulated the collective experience of GPs working in deprived areas, making it easier to justify to her partners switching to 15-minute consultations. For a limited time, it also afforded her the help of a medical student, who collectively developed a toolkit to simplify the ESA application process. She acknowledged that the Deep End group has provided a platform for GPs working in deprived communities, but "the main issue is now delivery." She worries about GP recruitment across Scotland, but particularly in deprived areas "because, why should you work in a very busy area if you can have an easier job somewhere else?" As a mid-career GP she also worries about professional burnout and for the time being remains committed to "political stuff," but so far as it does not come at the expense of her clinical skills.

According to Dr Allison Kelly, general practice is political and demands the contribution of GPs working in deprived areas in providing a frontline voice. In Section 6.3.3 she attributed the decline of social mobility for individuals in deprived areas as a key contribution to health inequalities, in addition to wider structural determinants. Similarly to Dr Lindsay, she noted the importance of building up relationships with patients and described practising patient advocacy through encouraging individuals— particularly ones who "blur lots of different kind of service boundaries"—to attend appointments. Dr Kelly writes letters of support for patient benefits and housing because she feels GP letters "carry some weight" and are often the only

ones available to offer this support; however, she does not feel inundated with letter requests. In addition to the Deep End group, Dr Kelly was politically involved with the Yes campaign during the 2014 Scottish Independence Referendum and is a member of her area GP committee, which works with implementing policy passed down through the community health partnership (CHP) via the health board. As far as involvement in the Deep End group, this has changed the way her health centre—including the practices and services within—work together, which ultimately can be attributed to her involvement in the Govan SHIP project. This is not only because of the attached social worker, but also from the additional clinical time the project enables for practice planning and development. Dr Kelly views the Deep End group as more effectively engaging with the government directly, rather than the health board, to change the politics of general practice and working in a deprived community.

### **8.8 GPs in the Deep End as ‘exemplary practitioners’**

Chapter Seven established the value of Lipsky’s SLB framework in understanding the constraints and coping mechanisms of GPs working in Scotland’s most socioeconomically deprived practices. It also revealed that GPs have more scope than traditional SLBs to strategically align their practice structure to meet the needs of their patients, and 17c contracts proved one of the preferred ways of doing so. This chapter has added to this discussion an examination of GP discretionary space, showing how it extends well beyond the consultation room and practice boundaries. Additionally, this chapter has argued that the Deep End group provides a platform for political advocacy and innovation. As a result, there is a need to explore alternative classifications, reimagining the conventional frontline worker framework. Rather than reclassifying GPs into a narrow fixed type, this thesis instead shows the value of examining GPs working in deprived areas from a broad conceptualisation as ‘exemplary practitioners’ through characteristics based on the previous work of van Hulst et al. (2012) and Durose et al. (2015).

Discussed in Chapter Four, ‘exemplary practitioners’ work in urban neighbourhoods and are perceived as making a difference, by catalysing social change in some form (van Hulst et al., 2012), including mobilising different organisations within communities to work together, organising community action, and/or project development to improve a neighbourhood

(Durose et al., 2015). These practitioners do political work and have a large degree of autonomy that allows them to use their personal and professional knowledge to facilitate between people, the community, and policy. This is done through interpersonal networks and the use of local knowledge. As van Hulst et al. (2012) propose, the work of exemplary practitioners in deprived neighbourhoods involves “a mix of entrepreneurialism, strategic networking, and empathic engagement that differ from standard bureaucracy” (p.446). Entrepreneurialism refers to innovative strategies for specific problems, rather than the managerial use of the word, while strategic networking and empathic engagement refers to organising groups using a holistic approach in deprived neighbourhoods (van Hulst et al., 2012).

Under this description, GPs involved in the Deep End group can be reconceptualised to fit within the scope of ‘exemplary practitioners’ via three primary ways: 1) acting as advocates, both during and outside of individual consultations; 2) seeking to improve connections with local services, which is important considering that most of the SDH lie outside of the NHS; and finally 3) their potential role in influencing top-down policy, an example of which might be directing more resources to deprived areas. Fitting within the ‘exemplary practitioner’ description, common attributes (summarised in Table 8.3 and originally listed in Table 4.1) that GPs working in the Deep End group share are: their commitment to social change; empathy towards their patient populations, demonstrated through their proclivity to positively construct them as ‘deserving’ versus ‘undeserving’; an understanding of the need to tackle wider structural inequalities; and finally a partnership approach to working with individual patients *and* organisations within the community. This chapter has described various examples of GP work through the Deep End group, including both the Links Worker Programme, and Govan SHIP project, which are focussed on integration with community services and social work services, respectively.

**Table 8.3 Key attributes of GPs significantly involved in the Deep End group (Adapted from Durose et al., 2015 and van Hulst et al., 2012)**

<b>Key Attributes of GPs Working in Very Deprived Communities</b>	
<i>GPs who practise:</i>	<i>GPs focused on:</i>
Strategic networking	Connecting people and organisations within the community (and beyond)
Empathetic engagement	A commitment to social justice
Entrepreneurialism	Mobilisation within communities to bring about social change
	Finding innovative, practical solutions to the community's needs

It is important to note what facilitates individual GP's ability to 'make a difference' in the communities they work in. Thus far the Deep End group has been valuable in organising 'political GPs' and providing a platform for patient advocacy, knowledge exchange, and collaboration with other organisations and services. It is also important to note the elite position of GPs compared to many traditional frontline workers, as this no doubt has an impact on their ability to garner attention from the government. An additional facilitating factor that is increasingly under pressure is time. This refers to time available for patient consultations, time for strategic practice planning, and time for community engagement. Whether this is achieved through a 17c contract—identified in Chapter Seven as a strategy to align practice structure with patient needs—or one of the Deep End pilot projects, it is a vital component to GPs' potential ability to influence social change in deprived communities in Scotland.

## 8.9 Conclusions

The interviews revealed that all GPs perceived themselves as advocates, in some form, for individual patients; additionally, many of the participants perceived this role extending far beyond the confines of the consultation room. By collating their experiences, this study has demonstrated the broad spectrum in which GPs perceive themselves going 'beyond the call of duty' to make a difference in the lives of their patients and patient populations. This is partly based on individual discretion and the extent to which GPs perceive advocacy efforts as being within their remit; it is also based on the capacity and support GPs have to carry out such efforts.

This chapter has described how advocacy efforts operate at the individual level through improving patient care and attempts to address patients' social problems, the latter of which participants emphasised as a significant part of working in a very deprived area. Advocacy within the community ranged from taking on community roles, outside of the practice, to building links with local services and organisations. While only a handful of the participants were politically active in advocating on behalf of the GP profession and/or their patient populations, the majority of GPs felt this was a necessary duty to uphold, regardless of their individual desire to participate. Advocacy for their patient populations, including influencing policy related to the SDH, was seen as particularly critical since GPs can 'bear witness' to the damaging effects that political decisions such as benefits system changes have on their patients' health. GP workload, and the subsequent time constraints, proved to be the primary barrier to effecting advocacy efforts across all levels. However, this chapter has offered evidence to suggest that the Deep End group provides a platform for GP advocacy, in addition to articulating the experience of working in deprived areas and giving voice to a common cause. Given the professional clout GPs command (and the independence to speak out on social and political issues), the Deep End group has become an audible voice in Scottish politics. Whether this results in change remains to be seen, demonstrating the need for continued research.

Not all GPs, however, were interested in effecting policy change, as the 'boundaries of discretion' framework demonstrated. Just as GPs' conceptualisation of health inequalities varied and intersected in Chapter Six, so too did the extent to which they advocated on behalf of patients and/or patient populations. For those 'political GPs' who choose to exercise discretion in their communities and beyond, this thesis suggests the use of 'exemplary practitioners' as a way in which to characterise their work and understand how they might catalyse social change.

This thesis set out to obtain a better understanding of how GPs conceptualise health inequalities; how they cope in the context of severe deprivation and inadequate resources; how they view their role as advocates; and, ultimately, what general practice can contribute to tackling health inequalities. Each of the three findings chapters has explored distinct aspects of these issues. The final Conclusion chapter refines the findings from all three of these chapters

and, drawing on the evidence presented, demonstrates a vital role for general practice in tackling health inequalities. This concluding chapter will illuminate that the way in which GPs conceptualise the ‘problem’ is critical to offering ‘solutions’. It will also further explore how the Deep End group works as a primary mechanism for enabling change.

## **CHAPTER 9 Final conclusions**

### **9.1 Introduction**

The previous three chapters explored a range of issues in relation to how GPs view their work in very deprived areas. These included an exploration of GPs' perceptions of their patients and what they think they can achieve, both in and out of consultations, in order that their activities can best contribute to addressing health inequalities. The chapters also provided a critical analysis of the idea that GPs can be understood as classic 'street-level bureaucrats' in terms of understanding how GPs cope and negotiate dilemmas in their work. The analysis proposed that it was necessary to look beyond Lipsky's (2010) SLB framework in order to capture and explain the implications for tackling health inequalities via the advocacy that GPs engage in for individual patients and their patient populations.

This final, concluding chapter draws together and reflects on these findings to provide a comprehensive overview of what GPs—particularly those working in areas of severe deprivation—can achieve in terms of tackling health inequalities. To accomplish this, the chapter will first provide a brief reprise of key findings and the specific contributions this study makes to both theory and the existing evidence base on health inequalities and primary care. Building on this, the chapter then offers implications for policy and practice of the rich evidence base developed via this study. The final parts of the chapter set out limitations of the study, reflect on the Deep End group as an example of the importance of supportive structures for GPs, and suggest areas for further research.

### **9.2 Contributions**

Chapter Eight provided a synthesis of the study's findings, effectively tying them together with the literature reviewed in Chapters Two, Three and Four. Faced with the constraints of inadequate resources, complexity of caseload, and contractual obligations, GPs working in deprived areas in some ways exemplify the typical Lipskian SLB. This research, however, found limitations in the SLB framework's applicability to a subset of the participants, namely

those who not only acknowledge the need to tackle wider structural inequalities, but who are also involved in advocacy outside of the practice, including working to improve connectivity across community services. Thus, the idea of ‘exemplary practitioners’ was proposed in Chapter Eight as a way of reconceptualising the ‘GP as SLB’ in order to capture the work of GPs as they aimed to make a difference beyond individual patient consultations. This reconceptualisation pulls together the primary research threads of street-level bureaucracy and health inequalities, helping to explore the extent to which GPs perceived themselves as ‘going the extra mile’ in their work, in the service of their practice populations.

The overarching focus for this research was exploring the role of primary care—and more specifically that of GPs—in tackling health inequalities. Further to this, the study set out to address several gaps in the literature including how GPs working in deprived areas negotiate the ‘dilemmas’ which arise in their frontline work and how they view their role in tackling health inequalities. While tackling the latter gap is a contribution to the evidence base on primary care and health inequalities, the former primarily relates to the contribution of this thesis to theory on street level bureaucracy and is described first.

### **9.2.1 Contributions to SLB theory**

A central feature of this study is the degree of insight offered into the challenges faced by GPs working in very deprived areas. Previous researchers have examined the role of the GP through the lens of SLB theory, but none have exclusively looked at it from the context of GPs working in areas of severe deprivation. While all GPs can be considered SLBs who are struggling to cope with demanding workloads, the effects of high levels of concentrated deprivation within their practice population present particular and significant challenges. Not only do individuals in deprived areas face poorer health outcomes than those in affluent areas, they are also more likely to suffer from multiple illnesses at a much earlier age, with the rate of mental illness almost twice as high in the most deprived areas (Barnett et al., 2012; Jani et al., 2012; O’Brien et al., 2011). These challenges are further aggravated by problems related to social deprivation such as, higher levels of unemployment, fewer financial and other material resources, and higher rates of addiction. This results in increased complexity so that in the context of a 10-minute GP consultation, GPs working in deprived areas face a major challenge in adequately addressing all the problems their patients present with. The use of Lipsky’s

framework sheds light on how GPs working in deprived areas try to manage complex workloads and negotiate constraints in ways that do not further exacerbate existing health inequalities.

The evidence from the interviews suggests that a ‘patient first’ mentality not only anchors GPs’ work, but also describes how they negotiate dilemmas and multiple identities, which has not been fully explored in previous SLB/GP research (Checkland, 2004; Dunham et al., 2008). For example, the most frequently discussed dilemma—autonomy versus bureaucratic control—was negotiated through a ‘patient first’ approach. In particular, participants described ignoring bureaucratic guidelines if 1) it was seen to be in the best interest of the patient (according to the GP’s view) and 2) the financial risk of ignoring the guideline was minimal. Furthermore, participants expressed willingness to increase their workload for patient advocacy efforts, which conflicts with the notion that SLBs are always trying expeditiously to minimise workload (Lipsky, 2010). The ‘patient first’ mentality further explained how GPs prioritised within the practice. Competing interests such as the GP contract, GPs’ and patients’ opinions were prioritised based on what was perceived to be in the best interest of the patient. This was even more evident for GPs who constructed their patients in positive, rather than blameworthy terms (as evidenced in Chapter 6), demonstrating the importance of empathy in delivering a patient-led practise.

Given the ‘patient first’ mentality and GPs’ dual role as front-line worker and manager, the term ‘street-level professional’—presented in Chapter Four as an amalgamation of SLB and professionalism (Evans, 2011)—is perhaps more suitable in describing the work of GPs in very deprived areas. The term street level professional has been suggested through this research in order to capture the multiple identities that GPs inhabit: front-line workers who interact face-to-face with patients; managers – of businesses, staff, resources; and advocates for individuals, communities and on the political stage. It also helps to explain how GPs’ elite status positions them to engage in political and policy advocacy. Specifically, this research suggests that GPs’ social position as elite professionals partially explains the Deep End group’s political clout and indeed success in lobbying directly to the government (a subject further discussed in Section 9.3 on policy and practical implications).

A further distinction of the ‘street-level professional’ explicitly relates to GPs significantly involved in advocacy outside of the practice. The term ‘exemplary practitioner’, based on the work of Durose et al. (2015) and van Hulst et al. (2012), describes GPs who are actively working to make a difference in the communities they work in through: 1) acting as advocates, both within and outside of the practice; 2) seeking to improve connections with local services, and finally 3) their potential role in influencing top-down policy. This study has identified these GPs as specifically engaged in strategic networking with other health and social services and involved in entrepreneurial activities—including the Links Worker and Govan SHIP projects—that offer innovative, practical solutions to the community’s needs.

### **9.2.2 Contributions to primary care and health inequalities literature**

One of the significant findings emerging from this research relates to the variation, and indeed patterning, in how GPs think of—and discuss—their patients. This was because social constructions of patients were linked not only to GPs’ conceptualisations of the causes of health inequalities, but also to how they viewed their role in tackling them. While GPs’ perceptions of patients could not be entirely simplified as positive or negative constructions, there were tendencies for participants to either take a more empathetic view of patients (via positive constructions) or to engage in victim blaming discourse (via negative constructions). GPs taking the latter approach were more focused on individual patient’s failure to adopt healthy lifestyles rather than recognise how the issues patients face, stem from social deprivation, and make health behaviour change difficult. As a result, GPs who positively constructed their patients were more likely to acknowledge and discuss how the SDH negatively affect their patient population.

Further to this, social constructions were linked to patients’ ‘deservingness’ of the discretionary services which GPs are not necessarily required to provide, such as writing benefit letters or doing re-referrals to secondary services. This link/pattern provides evidence that GPs who construct their patients more positively may be more willing to take on such discretionary activities. A consequence of this, as revealed in Chapter Seven, is that these GPs may be more likely to suffer from professional stress than their counterparts who limit discretionary patient activity. This, then, reveals a potential tension in general practice regarding the extent to which GPs should engage in discretionary activities if it increases

professional stress, especially considering the existing risk of professional burnout in deprived practices (and across the whole of general practice in Scotland) (Deep End Report 28, 2016).

Participants' social constructions of patients were also linked to how GPs understood the causes of health inequalities and proposed solutions for tackling them. Raphael's (2011) SDH discourse levels framework was particularly helpful in unpicking the various ways in which GPs think about health inequalities and their social determinants. Participants who negatively constructed their patients were more likely to focus on lifestyle and health behaviours as explanations for what causes inequalities in health outcomes, which is indicative of Raphael's lower SDH discourse levels. Conversely, GPs who positively constructed their patients were more likely to identify policy and structural conditions as explanations for health inequalities (in line with the higher discourse levels). There were limits, however, in participants' discussion and understanding of health inequalities. Like previous research by Brassoloto et al. (2013) and Mackenzie et al. (2015), participant discourse was confined in its application to the distribution of SDH as a consequence of structural inequalities, suggesting that there are continual barriers to understanding how power distributions affect health.

Discussions surrounding the role of primary care—and more specifically that of GPs—in actually tackling health inequalities were not as varied as the ways in which patients were constructed. Specifically, the majority of GPs envisioned some type of role they could play as part of the solution to addressing health inequalities in very deprived areas. This was discussed in terms of health improvement strategies, continuity of patient care, and advocacy efforts. Where there was divergence, however, was the extent to which GPs perceived their professional role extending beyond individual care. Represented in Chapter Six's diagram of GP 'scope' (Figure 6.2), this framework captured the various levels GPs might envision their role in tackling health inequalities. Furthermore, this divergence reflects discrepancies between how GPs view advocacy. The individual levels of GP scope, including both clinical care and social issues, represent a narrow definition of advocacy specific to individual patient encounters. Within this definition of 'doing what is best for the patient', all participants perceived themselves as patient advocates. This is important when considered alongside patient social constructions as it implies that, regardless of how GPs think of their patients, the majority perceive themselves as 'going the extra mile' during individual clinical encounters.

Again, what is considered ‘above and beyond’ varied considerably across GPs, ranging from encouraging patient self-management during consultations to ‘chasing up’ specialists on behalf of patients on the GP's day off. In fact it was clear that all GPs perceived themselves to be providing the best individual care within their professional scope. Positive patient social constructions, however, were much more indicative of GPs’ involvement in the higher levels of GP ‘scope’ including community, policy, and politics levels.

Thus, unlike previous research exploring physician advocacy during individual patient encounters (Dunham et al., 2008), this study builds further on the proposed social responsibility in medicine, wherein GPs have obligations not only to individual patients, but also to the communities in which they practise. Participants positively constructing their patients were much more likely to broaden what is meant by ‘advocacy’. This suggests there is a subset of GPs who feel responsible, in the words of Sigerist (1941), to be “natural advocates of the people” (as quoted in Watt, 2012, p.14), perceiving their role not only as ‘scientists’, but also as ‘citizens’ responsible for bearing witness to the adverse effects the inequalities in the SDH have on their patient populations. In particular, this subset of GPs saw themselves as part of the solution to addressing health inequalities in deprived areas not just through the aforementioned health improvement strategies, but also through strengthening links between community services and policy/political advocacy on behalf of their patient populations. This signified recognition that treating medical illness is only part of the solution to improving health outcomes—and potentially tackling health inequalities—for patients in deprived areas. It is critical, however, to emphasise that while all participants expressed a desire to have stronger connections between their practice and community services, not all GPs felt personally responsible for developing the local health system. Thus, it can be questioned who should be responsible for strengthening links between primary care and community services? If, as suggested in the literature, general practice is to be a ‘hub’ around which other services within the community operate (Gillies et al., 2009; Norbury et al., 2011; RCGP, 2010; Watt, 2012), then an increasing number of GPs working in deprived areas must take a leadership role towards achieving this. Through strengthening local health systems, there is scope for general practices’ role in mitigating health inequalities in deprived areas to be realised.

An even smaller portion of GPs felt responsible for policy/political advocacy, including presenting evidence of the damaging effects the SDH have on their patient populations to several Scottish Parliament committees. Consequently, the Deep End group emerged in this research as an example of how supportive structures can capture and accumulate the experience of frontline workers who wish to make a difference by ‘catalysing’ social change in some form (van Hulst et al., 2012). While it is unclear whether the voice of GPs working in deprived communities would be heard without the support of the Deep End group, there is no doubt that the support of the group has been crucial to organising a collective identity and platform for GPs’ political voice to be heard. Furthermore, it has enabled knowledge exchange and collaboration not only between deprived practices but also with other organisations and services. Consequently, this research demonstrates the value of a practitioner-led, academic supported group for the organisation and support of GP professionals.

Fundamentally, this research suggests that there are significant differences in terms of what GPs working in deprived think they can—and aspire to—achieve. While this research is unable to distinguish whether empathetic, ‘political’ GPs are more likely to be involved in the Deep End group or if the Deep End group encourages empathy and political involvement, it is an important point nonetheless. In terms of the former, this is because previous research has shown physician empathy to be a prerequisite to patient enablement (Mercer et al., 2012c) in addition to improved outcomes when patients perceived empathetic consultations (Mercer et al., 2016; Mercer & Watt, 2007). This inextricably links the importance of empathy not only to helping patients, but also to what GPs felt they could accomplish beyond individual consultations, including advocacy on behalf of their patient populations in order to tackle health inequalities.

### **9.3 Implications**

Drawing on the evidence across the three findings chapters, there are significant policy and practical implications. These help to explore further the role of general practice in tackling Scotland’s pernicious health inequalities, how the Deep End group supports this role, and the implications for policy development more generally.

### 9.3.1 Policy implications

The implications from this study, which affect the immediate policy agenda, can be summarised under two main points, general practice and public health policy.

#### *General practice*

As Chapter Eight highlighted, current GP practice funding fails to match deprivation levels (McLean et al., 2015). This is an area demanding attention because communities with high deprivation are also most affected by premature multimorbidity. For general practice to mitigate, rather than exacerbate, existing health inequalities, it is imperative that funding reflects need. As previously identified, this opens the potential for the NHS to be a positive factor in addressing the health gradient. Given that the NHS is universally accessible, funding proportionate to need—as indicated by premature multimorbidity and social disadvantage—would contribute to a proportionately universal approach. Given that this term has yet to be fully operationalised in practise in Scotland, a provision in the 2017 GP contract for both premature multimorbidity and socioeconomic deprivation presents a unique opportunity to test the theory in practise and allow fully for general practice to be a contributing force to tackling Scotland’s health inequalities. In order for proportionate universalism to be operationalised at the practice level, practices need sufficient resources and flexibility to cater to their populations’ needs. Thus, there is scope to address this through the contract, looking at how to provide practices additional time, outwith patient contacts, to deal with individual patients, population health strategies, and improving links within the community. A caveat to this, however, is in terms of how GPs used additional time, as the research suggests not all GPs are interested in strengthening local health systems. Furthermore, whether GPs used additional time during consultations to practise holistic patient care or to criticise ‘unhealthy’ lifestyles is unclear and worth taking into consideration.

#### *Public health policy*

Chapter Two brought attention to the divergence in government rhetoric and public health policy regarding the causes of health inequalities and the theoretical approaches for tackling them. Adding to this, GPs have been increasingly involved in delivering public health interventions. This research does not dilute the importance of tackling wider structural

inequalities. Instead it highlights the need for coordinated effort across all sectors and the inclusion of GPs in planning strategies. GPs arguably know a considerable amount about their patient populations; since they are in a discretionary role regarding the delivery of services it is important that GPs are able to do so based on need. Inviting GPs into the public health narrative suggests that population-based interventions will be more effectively delivered at the ground level and reach those with most need.

### **9.3.2 Practical implications**

The evidence relating to how GPs view their role in tackling health inequalities and advocacy has implications for GPs working in deprived communities and organisations—including the Deep End group, which supports and collaborates with GPs working in these areas. These practical implications are garnered from the interview data as well as informal attendance in Deep End group steering group meetings, conferences, and ancillary meetings with social services over the past three years.

As evidenced in Chapter Eight, not all GPs personally will want to be involved in politics. For GPs aligning with an ‘exemplary practitioner’ model, who feel responsibility to speak on behalf of their patient populations, a support structure like the Deep End group has been shown to be a valuable forum for enabling GPs’ involvement in policy and politics. This includes providing a platform for advocacy and supporting collaboration between health and social services. As one of the GPs noted, the Deep End group had been particularly successful in “[getting] the ear of the government” through lobbying directly to Scottish Parliament, and government funding for Deep End projects is evidence of this. While the success of the group is partly due to academic support from the University of Glasgow, its GP-led format is also fundamental. The group is driven by frontline experience and GPs are the ones setting the agenda regarding the needs of their practice population. Regardless of changes in the 2017 GP contract, this research found that GPs working in deprived areas see themselves going ‘beyond the call of duty’ to make a difference in the lives of their patients and patient populations. GPs working in deprived areas should be encouraged to use their professional status and political clout not only to strengthen local communities, but also to advocate for policy change—health, social, and beyond—that might potentially affect the degree of disadvantage of their patients, and levels of social and health inequalities more generally.

## 9.4 Further considerations

### 9.4.1 Limitations

Limitations are an inevitable aspect of research, and within this study they can be categorised under research design, theoretical limitations, and practical issues.

Research design: The most significant limitations of this research are related to the sample, including size and representation. The targeted number of participants was 30 GPs, but, due to non-responses, ended up at 24. While this presents limitations in terms of the generalisability of results, the strong narrative threads both within and across interviews demonstrated a meaningful sample within the scope of this research. Furthermore, the use of a gatekeeper (who also served as a supervisor to this research) provided great and unprecedented access to a group of Deep End GPs previously not available for academic exploration of this scope. However, this privileged research position had inherent limitations as well. The non-response to interview requests primarily came from GPs not actively involved in the group. This suggests a potential bias in the sample towards GPs actively involved in the group. While it is unclear whether the Deep End group strengthens GP's commitment to social justice or if GPs already committed to social justice are more likely to be involved in the group, this point is worth noting. Given that eight (33%) of the participants were actively involved in the Deep End group, results are interpreted cautiously and under this caveat.

Another fallout of this limitation is the over-representation of end of career GPs. As noted in the implications, the Deep End group has strong participation from mid and late career GPs, but is limited in their involvement with early career GPs. Given the large number of participants actively involved in the Deep End, the sample is biased towards end of career GPs. However, this limitation was not easily remedied through the sampling strategy as ISD's list of GPs and their practices in Scotland, used for recruitment, does not provide years of clinical experience.

Further to the use of a gatekeeper, my close proximity to the Deep End group brought potential drawbacks as well. This primarily relates to objectivity in the research and avoiding potential bias. To overcome this, the study was purposefully not an evaluation of the Deep

End group but rather aimed to present evidence of the Deep End group's activities, what it offers GPs in terms of advocacy, and how GPs themselves viewed the group's efforts. Furthermore, two additional supervisors, neither of whom were affiliated with the Deep End group, oversaw this research. This helped to maintain objectivity in the analysis and write up of the data.

A final limitation regarding research design relates to the methods. While in-depth interviews provided meaningful data related to GPs' perceptions of their work, analysis is limited to this scope. Thus, observational data would be valuable to assess how perceptions align with practise. For example, do GPs who positively constructed their patients actually demonstrate more empathy during patient consultations? And do GPs' perceptions of their coping mechanisms fully represent the coping strategies they employ in practise?

Theoretical: Limitations surrounding patient constructions also presents a theoretical challenge. Since analysis of GPs' description of patients was based on interview data, this study is unable to measure how constructions impact on practise. Specifically, analysis is limited to how patient constructions impact on discourse related to health inequalities and how GPs view their role in tackling them. Consequently, there is a potential gap between GPs' perceptions and the reality of their practise.

While this research considered the role of primary care in addressing health inequalities, participant interviews concentrated more explicitly on the role of GPs and general practice, thus narrowing the study's overall scope. This research is also only able to comment on GPs working in deprived areas. It is likely that GPs in areas which are more mixed in terms of deprivation and affluence may also perceive themselves as under high stress as they attempt to negotiate competing needs and demands. While this study cannot directly speak to this, it is worth noting that general practice as a whole is under increasing constraints and further research should explore the perceptions of GPs working in other kinds of areas and practices.

Practical: Given the increasing time constraints GPs face as SLBs, interview time was largely limited to one hour. As discussed in Chapter Five, this necessitated the need to quickly establish rapport in order to delve into deeper conversations with the GPs. Interviews were consequently limited in scope to specific, pre-identified themes for exploration. This limitation

was addressed through a semi-structured format wherein the interview guide provided a systematic and flexible format to follow.

Notwithstanding these limitations, this research achieved its overall aims and objectives. However, knowledge created from this study poses significant areas for future research.

#### **9.4.2 Areas for further research**

Areas for further research can be categorised under three main themes: linking data to outcomes, the relationship between health boards and general practice, and patients' perceptions. The first area is related to the increasing demand for evidence-based activities in health care. Specifically, further research is needed to explore what the impact of GP advocacy is on patients' health outcomes. For example, how does political advocacy improve population health? Given the complexity of health factors, measurable outcomes might be operationalised in terms of improved access to both health and social services and the availability of resources allocated to deprived communities.

While this study presents significant insight into the work of GPs in very deprived areas, it is limited in its one-sided perspective from general practice. Therefore, an area for further research would be to explore the relationship between general practice and health boards. This is topical given the increasingly overlapping boundaries between primary care and public health and how the two can work together to improve population health.

A final area demanding further exploration relates to the patient populations GPs represent. Unlike emancipatory research involving vulnerable populations, the subjects of this study represent an elite population. There is evidence that GPs play an important advocacy role by 'bearing witness' to the damaging effects social deprivation has on their patient populations, but further research should explore how patients in deprived areas view the role of general practice in their lives. Many of the participants self-acknowledged the important role they play in areas of high deprivation; however, this should be sufficiently explored from the perspective of patients who live in these areas.

## 9.5 Final thoughts

This study set out to address a gap in the literature relating to the role of general practice in tackling health inequalities. It details evidence that GPs acknowledge this role, in addition to that of advocate. Furthermore, this research has emphasised the importance of the practitioner-led groups—such as the Deep End group—through their organisation of GPs’ efforts and by providing a platform for their advocacy.

SLB theory draws attention to the dilemmas (such as autonomy versus bureaucratic control) and constraints GPs face in their work in addition to subsequent coping mechanisms, adopted to manage demanding workloads. However, it does not sufficiently explain GPs’ roles as advocate and manager, thus presenting the need to open the scope to ‘street-level professionals’ and, for GPs actively involved in advocacy efforts beyond the consultation room, ‘exemplary practitioners’.

The evidence in this study also highlights the importance of the social construction of patients and how the problem of health inequalities is conceptualised. Generally speaking, GPs who framed their patients positively were more ambitious in terms of what they could achieve both in and out of patient consultations. There was also evidence that these GPs may be more at risk of professional stress. Furthermore, how GPs socially constructed their patients also signifies the importance of empathy in general practice. This helps to reposition the GP-patient relationship, in line with that described by Julian Tudor Hart (1988), wherein “patients are not consumers, but joint producers (with professionals) of solutions to their problems” (p.121). However, in order to do this, it is imperative that GPs not only have time to cope with clinical work, but also, as Hart (1988) emphasises, time to care:

*Above all, health workers at all levels must have the time to talk to people and listen to them—in fact, have time to do their work as they were trained to do it; not only cope, but to care (p.294).*

This thesis proposes that there is scope for general practice to contribute to addressing health inequalities. Further research, however, is needed to understand how links between general practice and social services within the community might collectively strengthen local health

systems. Moreover, the solution will not be in applying a blanket approach to practices in deprived communities across Scotland, but providing flexibility and sufficient resources; enabling practices to develop innovative solutions that meet the needs of their practice population. The importance of addressing wider structural inequalities, however, must be first and foremost. GPs are simply one part of the puzzle of tackling health inequalities. Action must be comprehensive—mitigating existing health inequalities while also tackling their fundamental social determinants.

# Appendix A — Ethics approval form

CSS Oct 2013



## Ethics Committee for Non-Clinical Research Involving Human Subjects

Staff Research Ethics Application   
Application

Postgraduate Student Research Ethics

### Application Details

Application Number: 400130172

Applicant's Name Breannon Babbel

Project Title Tackling health inequalities in primary care: An exploration of GPs experience at the frontline

Application Status **Approved**

Start Date of Approval (d.m.yr) 15/04/14

(blank if Changes Required/ Rejected)

End Date of Approval of Research Project (d.m.yr) 01/07/16

Only if the applicant has been given approval can they proceed with their data collection with effect from the date of approval.

### Recommendations (where Changes are Required)

- **Where changes are required all applicants must respond** in the relevant boxes to the recommendations of the Committee and upload this as the **Resubmission Document** online to explain the changes you have made to the application. All resubmitted application documents should then be uploaded.
- **(If application is Rejected a full new application must be submitted via the online system. Where recommendations are provided, they should be responded to and this document uploaded as part of the new application. A new reference number will be generated.**

(Shaded areas will expand as text is added)

MAJOR RECOMMENDATION OF THE COMMITTEE

APPLICANT RESPONSE TO MAJOR RECOMMENDATIONS

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MINOR RECOMMENDATION OF THE COMMITTEE

APPLICANT RESPONSE TO MINOR RECOMMENDATIONS

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Page 1 of 2

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Tel: 0141-330-3007  
E-mail: Terri.Hume@glasgow.ac.uk

**REVIEWER COMMENTS****APPLICANT RESPONSE TO REVIEWER COMMENTS***(OTHER THAN SPECIFIC RECOMMENDATIONS)*

You may wish to improve the formatting of the PLS by moving heading 3 down to the top of the second page.	
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Please retain this notification for future reference. If you have any queries please do not hesitate to contact Terri Hume, Ethics Administrator.

End of Notification.

## Appendix B — Information sheet



### Information Sheet

#### ***Tackling Health Inequalities in Primary Care: An Exploration of GPs Experience at the Frontline***

*Researcher:*

Ms Breannon Babel, PhD Student, School of Social & Political Sciences/Institute of Health & Wellbeing

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You are being invited to take part in a research study as part of individual PhD research at the University of Glasgow. Before you decide to participate it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

Thank you for reading this.

#### **1. What is the purpose of the study?**

The purpose of this study is to explore the role of primary care in tackling health inequalities which arise from social and spatial forms of inequality. Specifically, this research will be focusing on the experience, constraints, and attitudes of GPs who work in the most disadvantaged areas within Scotland. This includes exploring not just how GPs view their role in tackling health inequalities (and to what extent health inequalities can be tackled within primary care), but how this factors into their day-to-day practice and work within the overall

healthcare system. This information will inform and contribute to the write-up of my PhD thesis.

## **2. Who is conducting the study?**

As a PhD student at the University of Glasgow, I am the sole researcher carrying out this project.

## **3. Why have I been chosen?**

This PhD research involves interviewing 30-40 GPs working in the most deprived practices within Scotland.

You have been selected because you are working as a GP:

- 1) Whose practice falls within the 100 most deprived practices of Scotland (known as the 'Deep End') or 2) whose practice population constitutes 40-43% of individuals living in datazones defined as the 15% most deprived according to the Scottish Index of Multiple Deprivation (SIMD)

And

- Your practice is located within either 1) the Greater Glasgow and Clyde health board or 2) the Lothian health board.

## **4. Do I have to take part?**

Your participation is entirely voluntary. If you do decide to take part, you may withdraw consent at any time and also withdraw any data previously supplied without giving a reason.

## **6. What will happen to me if I take part?**

If you agree to participate, we will arrange a time and place for the interview to take place. This would either be at a designated spot at the University or at your practice (if there is an empty room available); whichever is most convenient for you. Again, participation before and during the interview is entirely voluntary and may be stopped at any time. Should you give your consent, the interview will be audio-recorded and is likely to last around 45 minutes to an hour.

## **7. Will my taking part in this study be kept confidential?**

The information obtained during this research will remain completely confidential. Your name and any identifying information will be changed to maintain anonymity. This involves either using a pseudonym (which you may choose for yourself) for any direct quotations or an ID number. These identifiers will not link you to a specific practice. As the sole researcher, only I will know the actual identity of participants.

## **8. What will happen to the results of the research study?**

The results of this research will be written up for completion of my PhD thesis. This research may also culminate in published work and/or academic conference presentations. However,

the data will remain strictly confidential at all points throughout (and following completion of) my PhD.

#### **10. Who has reviewed the study?**

This project has been reviewed by the University of Glasgow College of Social Sciences Research Ethics Committee.

#### **11. Contact for Further Information**

If you need any additional information regarding this research, please contact Ms Breannon Babbel at [b.babbel.1@research.gla.ac.uk](mailto:b.babbel.1@research.gla.ac.uk)

If you have any concerns regarding the ethical conduct of the research project please contact the College of Social Sciences Ethics Officer by contacting Dr. Muir Houston at [Muir.Houston@glasgow.ac.uk](mailto:Muir.Houston@glasgow.ac.uk)

## Appendix C — Consent form



### Consent Form

**Title of Project:** *Tackling health inequalities in primary care: An exploration of GPs experience at the frontline*

**Name of Researcher:** Breannon Babbel

1. I confirm that I have read and understand the Information Sheet for the above study and have had the opportunity to ask questions.
2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason.
3. I consent to my interview being audio-taped.
4. I understand that I will not be referred to by name in any publications arising from the research and that quotations will not be attributable.
5. I agree to take part in the above study.

\_\_\_\_\_  
Name of Participant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Researcher

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

## Appendix D — Interview schedule

### Interview Schedule

#### *Tackling Health Inequalities in Primary Care: An Exploration of GPs Experience at the Frontline*

#### 1. Participant's background

- To start, I'd like you to tell me a bit about your background as a GP. This is the Nth most deprived general practice in Scotland. Could you describe how you came to be working here?
  - [How long have you worked in this practice? First impressions working here? Other practices? Motivations, opportunities? Career plans?]

#### 2. Common Issues in Deep End

I want to understand a bit more about your practice, your caseload, and the common issues you may face in your practice. [Hand them A4 list of Common DE Problems] Here is a list, compiled based on existing literature and Deep End reports, of common issues that GPs who work in the most disadvantaged areas within Scotland face.

- Is there anything on this list that you disagree with and/or you don't face working in your practice?
  - [Can you help me to understand how some of these issues (either on their own or in combination) make your practice difficult and stressful? Can you think of a recent example of one of these issues and talk me through how that made you feel and how you tried to cope with it?]
  - [Do you think these challenges are well understood by other practices? NHS/RCGP/BMA?]
- It's often said that patients in very deprived areas have low expectations, lack knowledge and are more concerned with coping day to day than changing their lifestyles? How is that for you?
  - How realistic do you think it is to try to improve long-term outcomes with patients with low expectations, lower health literacy, and complicated combinations of problems? Barriers?
- How do you select the problems to deal with? Is there a tension between what patients want and what you as their GP thinks is best for their health? How is that resolved?

#### 3. Coping Mechanisms and Stress (SLB view)

- Do you feel you need different attributes working in a very deprived versus GPs working in other practices?
  - [How do GPs acquire the knowledge and skills needed to do this (e.g. training, CPD, experience?]
  - [Barriers they face?]
  - [Research suggests that GPs working in very deprived areas are more stressed than their counterparts in more affluent areas. Is this your experience? How do you cope with this? Can you describe how you prioritise problems between patients?]

- To what extent do you think others understand and support the work you do? Who?
  - [Within the NHS, what could improve GP support in addressing patient’s problems? Effects? How would this enable you to do more?]
    - [Is the independent contractor status of GPs as part of the problem or part of the solution for improving general practice and primary care in deprived areas?]
    - [Do you find conflicting interests between meeting patient needs and practice goals related to contract?]
  - [Outwith the NHS, what could improve GP support in addressing patient’s problems? Effects? How would this enable you to do more?]
    - [In what ways could your practice be ‘better connected’ w/ services/resources that would help patients? Has the practice become more/less connected with the surrounding community/resources? Why--what’s helped/hindered this?]

You’ve just described some of your experience within the practice—now I’m interested in looking at how your role as a GP might extend beyond individual patient encounters.

#### **4. Patient Advocacy & GP Roles**

- Have you ever lived in this kind of community (growing up, currently)? From your work you must know a great deal about patients and their families, but how connected do you feel you are to the local community and, is this important?
  - [Probe for specifics, do they get out in the community outside of the practice?]
- To what extent are you able to make use of other resources in the local community to help patients cope with their problems?
  - How do you support patients for improved patient outcomes at the practice level? Outside of the practice? [Prompts- health board, within the community, to policy makers]
- What would make the biggest difference to improving what you can achieve as a GP working in a very deprived area?
  - Barriers to achieving this and whether they might be overcome?
- Have you heard of the Deep End project? If yes, are there any ways in which it has been helpful to you?
  - [Changed your views/understandings of the problems GPs working in deprived communities face? Changed how you practice, either individual/practice level?]

Thinking a bit more broadly on your role as a GP, I’m interested in some of your views on health inequalities and how these relate to your practice.

#### **5. Attitudes surrounding health inequalities and the role of GPs**

- Do you think general practice can make any contribution to reducing health inequalities in Scotland? If so, how? (GP, Health Care Team)
  - [What do you think you can achieve by working with individual patients in consultations?]
  - [In what ways can teamwork and practice organisation help to improve outcomes for patients, and as a result narrow health inequalities?]

## Appendix E — Interview prompt sheet

### Commonly known issues in practices serving the most deprived populations in Scotland

*(Based on existing literature and Deep End reports)*

- Shortage of **time**
- **Multimorbidity**
  - Often of a complex social type
- **Mental health** co-morbidity
- Alcohol and **addiction** problems
- Lower **health literacy**
- Professional **stress**
- Less willing **patient engagement**
  - Especially for self-help, self-management
- Frustrations in dealing with **hospitals** and other **services**
- Causes of **health inequalities**

## Appendix F — NvVivo coding nodes

▼ Advocacy	24	▶ Descriptive	24	▼ Prioritisation	
▼ Community Level	24	▼ Health Inequalities	23	▼ Consultation	
Community Resourc...	20	Inverse Care Law	6	Follow up	
GP Role	12	Keep Well	5	Negotiation	
LINKS	11	PCT	11	Partnership vs Pa...	
▼ Individual Level	23	▼ Role of Primary Care	14	Patient first	
▼ Benefit Letters	19	'Healthy' Role Models	3	Sort all out	
Do Write	15	Continuity & Serial E...	17	Practice	
Don't Write	2	▶ Health Prevention	14	▶ Skills	
▼ Beyond Consultation	17	Structural Change	5	▼ Social Construction- P...	
Chasing up issues	6	Voice for Deprived A...	7	'Soldier on'	
Non clinical	11	▼ Underlying Causes	19	▶ Avoiding stereotypes	
Phone Calls to sp...	8	Cultural	9	▶ Lack of Life Skills	
▼ Policy Level	14	DownstreamLifestyle	9	▶ Victim Blaming	
'Expert' Knowledge	3	UpstreamStructural	13	▼ Sources of stress	
'Shed light'	4	▶ Other	24	Contract & QOF	
Change	9	▼ SLB	24	GP partners	
▼ Deep End	2	▼ Conflicting Roles	3	Incapacity to help	
▶ Change from involvem...	14	Advocate vs manager	8	Staff	
Chapter 8	3	Bureaucracy vs prof...	18	Time	
▼ DE Benefits	21	Demand vs supply	8	Workload	
Articulation of 'probl...	11	Frontline worker vs...	8	▼ Workload	
Avenue for change	15	Practice manageabil...	7	'Planning' Time	
Intellectual discussi...	2	Public health vs pri...	2	Admin work	
Solidarity	10	QOF vs patient dem...	22	Patient consultations	
Strategy sharing	4	Responsiveness vs s...	7		
▼ No Involvement	11	▼ Coping strategies	0		
'Academic'	2	▶ Personal	21		
'Glasgow'	1	▼ Practice	23		
'Moaning & grumping'	1	Personal strategies	21		
'Political'	3	Practice-level str...	19		
		Structure Flexibility	8		

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