**RE-IMAGINING PRIMARY CARE**

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**SLIDE 1**

My main premise is that the future of general practice and primary care, and by implication, the role of academic general practice and primary care, have been insufficiently imagined.

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If we do not change direction (perhaps we are to busy to consider such a thing), we shall arrive where we are heading.

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Actually, we’re already there, our direction of travel involving increasing inequality, increasing fragmentation of care and institutions, past their sell-by date, which are increasingly dysfunctional. I’ll describe each of these trends in turn.

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The ball is in our court. As Jerry Garcia put it, somebody has to do something, and it’s just incredibly pathetic that it has to be us.

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We do have strengths. Together these three Deep End GPs have over 60 year’s knowledge and experience of the health problems of the people of Govan.

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The Deep End reports have captured that experience, determined a common view and given voice to a group of practitioners, who had previously never been convened or consulted in the history of the NHS.

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The differences in life expectancy between top and bottom tenths of the Scottish population are stark. The differences in healthy life expectancy are even starker – 19 years for men, 17 years for women.

It’s not enough to have Early Years policies to prevent inequalities in the future. We should be doing what we can to narrow exiting inequalities, and prevent them getting wider.

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While the social gradient in need is steep, the distribution of general practitioners is flat, or at least it was in 2003, the last time that data on GP WTE were collected. Turn this slide upside down and you get

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the swimming pool analogy, which gave the Deep End project its name.

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The consequences of this mismatch of manpower to need are well documented. GP consultations in very deprived areas have more multimorbidity and social complexity, less time, reduced expectations, less enablement, lower health literacy and greater practitioner stress.

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There is a view of the NHS that we are all in the same boat, that all practices should be treated equally, for being busy, but that is a primitive view, like the old fashioned view that the world was flat. The truth is that the NHS is built on a slope. We shouldn’t pretend and behave as though it were built on a level.

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Insofar as we provide universal coverage, the front line is thinnest where the needs are greatest.

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I’m not going to labour this. It is not the purpose of my talk. But if you think you’re not involved in this, think again. The bottom slope shows where we are. If we do nothing, perhaps everyone’s health will improve, the social gradient remaining. If we target the most deprived areas, we simply produce an upturn at the bottom of the slope. The challenge is to level the slope, providing resources proportionately to need – the policy of proportionate universalism. I’ll come back to this later.

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The problem that everyone can see is the problem of fragmentation

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where coverage is incomplete, consultations are dysfunctional, continuity is interrupted and care is poorly coordinated.

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It doesn’t affect everyone, certainly not the patients who don’t consult (unless perhaps they have elderly relatives), or people like ourselves who consult occasionally, but it certainly affects the 16% of patients accounting for 50% of all face to face encounters, as shown by these PTI data.

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We know that non-communicable diseases are on the rise, and that public health measures are needed to address the fundamental causes – cigarette smoking, salt, alcohol, obesity – but there are also implications for primary care

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As Jan De Maeseneer and colleagues said, in their letter to the Lancet, the voice of primary care has not been heard, at the UN summit in 2011, or in the many subsequent papers in The Lancet.

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By now, this audience well knows these Scottish data, showing that multimorbidity occurs 10-15 years earlier in very deprived areas, that the commonest co-morbidity is a mental heath problem, that for all the common chronic conditions, patients with only that condition are a small minority, and that most people with multimorbidity are under 65.

Applying these data to Scottish GP lists, the prevalence of multimorbidity, defined simply as two or more conditions, was a third higher in the most deprived fifth of practices, compared to the most affluent fifth –the effect of deprivation trumping old age, at least with this particular definition of multimorbidity.

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It’s hard work for patients with multimorbidity; it can be dangerous, because of polypharmacy; there is generally little guidance on what to do

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Randomised controlled trials, and almost the whole world of evidence-based medicine, is systematically biased, and of limited relevance, because of its wholesale exclusion of patients with multiple problems. In marked contrast, the approach of general practice is unconditional, excluding no one, attempting to provide personalised continuity of care for all patients whatever their problems or combinations of problems are.

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Most other parts of the NHS provide partial care, with lots of different cooks concentrating on their particular part of the recipe.

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Switching analogies, the NHS has too many hubs, seeing themselves as centres around which everything else revolves

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Expert witness Spike Milligan, who wrote, “I’ve just invented a machine that does the work of two men. Unfortunately, it takes three men to work it”. The NHS in a nutshell.

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Last year, I had the good fortune to be given a budget of about $70,000, to hold a satellite meeting, as part of the International Society of Hypertension scientific conference in Sydney, with the instruction - “organise a conference you would like to go to”.

The plan was to add the primary care voice to current discussions and debates about how to address non-communicable disease. The Sydney harbour bridge provided our them – Bridging the Gaps.

The Sydney harbour bridge was designed by a Scotsman, the Paisley architect Thomas Tait, who also designed St Andrew’s House in Edinburgh. He didn’t design the whole of the bridge – just the granite towers at either end. They contribute nothing to the structural strength or function of the bridge and were added simply to reassure the public, with the impression of solidity.

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There were speakers from five continents and participants from 26 countries., including Jane Gunn from Melbourne, Jan De Maeseneeer from Belgium and Terry Findlay, former Director of Primary Care in Glasgow.

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Superficially, the gaps to bridge were straightforward -

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* the gaps in coverage, quality and continuity

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That are ubiquitous as a result of the rule of halves, and the tendency of most health care systems to leak patients like sieves.

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The conference was summarised in January’s BJGP.

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A striking aspect of the meeting was when presenters from Washington in the US and Ghent in Belgium described almost exactly the same type of patient, an elderly, multiply morbid women, failing to get high quality of care from a multiplicity of services. Everyone recognised these patients, and could have provided many similar patients of their own. Not a patient who is well represented in the research literature, but a familiar patient in everyday general practice.

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In the century before last, Osler taught “Listen to the patient, he is telling you the diagnosis”. Jan De Maeseneer, developed this idea in a recent RCGP Mackenzie Lecture. Today we should, “Listen to the patient, she is telling you her treatment goals”. That is the key to integrated, non-fragmented care. It isn’t the only outcome measure, but it is the most important one, putting the others in perspective.

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At a deeper level, however, the conference identified a more fundamental gap Without political direction, health care invariably centralises, specialises, privatises. That’s where professional, managerial and market interests take it.

This is also the world of disease-based approaches, as embodied in hospital departments, specialities, policies, services, guidelines, the world of evidence-base medicine, based on randomised controlled trials.

All these institutions are on one side of the gap. Patients and primary care practitioners are on the other. One side is driven by knowledge; the other by wisdom based on experience.

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*Knowledge and Wisdom, far from being one,*

*have oftimes no connexion.. Knowledge dwells*

*In heads replete with thoughts of other men;*

*Wisdom in minds attentive to their own.*

 *Knowledge is proud that he has learned so much,*

*Wisdom is humble that he knows no more.*

Of course, general practitioners have to be knowledgeable, about many things, but the skill of the generalist is in how to use that knowledge, or not to use it, in the circumstances of the individual patient.

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It’s not that the dominant institutions of medicine are inappropriate, but many of them have hypertrophied, consolidating their existence rather than their original purpose, and putting the system out of balance. The Olympic celebration of the NHS reflected that hospital bias.

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Expert witness, Arthur Miller. Famous not only as a brilliant playwright, and husband of Marilyn Monroe, but also as the father of a son with Down Syndrome, whom he put away in an institution and never saw again. That seems shocking to us now, from a leader of progressive opinion, but it was normal at the time.

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Here is Lennox Castle. It wasn’t a prison, like Colditiz, but it was where people with learning disabilities were put away. It no longer exists. The building was demolished and the resources it contained have been re-distributed throughout the community, with a whole new set of relationships. There’s a metaphor for our time. What other centralised resources should be broken down and re-distributed?

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Somebody has to do something, and it’s just incredibly pathetic that it has to be us. These proposals come from General Practitioners at the Deep End.

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Of course, universal coverage is still essential -

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giving expression to Bevan’s call, that illness is neither an indulgence for which people have to pay, nor an offence for which they should be penalised, but a misfortune, the cost of which should be shared by the community.

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That clarion call is no longer sufficient, because as health care now makes such a difference - not only via the 12% of consultations involving a QOF condition, but also the other 88% of consultations, involving unconditional, personalised, continuity of care for everyone - if we deliver such care inequitably, health care itself will widen inequality.

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The modern challenge of universal coverage is that the health service should be at its best where it is needed most. There’s no point in saying it if we don’t mean it, and there’s a price tag that almost everyone would have to pay, based on where we are on the slope.

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The Deep End proposals, which have been widely circulated and await a political response, are summarised in this recent report, available at [www.gla.ac.uk/deepend](http://www.gla.ac.uk/deepend).

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There are six essential components. None of them is exclusive to Deep End practices, and most are relevant to most practices, on a pro rata basis.

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Consultations provide a continual series of starting points. As Stewart Mercer has shown, you can get empathy without enablement, but never enablement without empathy. Relationships are important.

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First, foremost and not to be glossed over, the inverse care law must be addressed, providing time where it is most needed. It’s amazing how mainstream policies and initiatives ignore this, as though it was not their business.

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In life as in the film, very little happens in brief encounters. Our principal delivery mechanism is the serial encounter.

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Single encounters are only the beginning. Tudor Hart famously described 310 encounters with one patient over 25 years, “initially face to face, eventually side by side”.

The challenge is to help patients become more knowledgeable and confident, not only to live with their conditions, but also to make good use of a network of advisors and other resources. This should prolong independent living, reduce or postpone the use of emergency care and increase life expectancy. Matching resources to needs, this approach would also reduce inequality.

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Serial consultations are often insufficient. Other resources are needed. The intrinsic strengths of general practice – contact, coverage, continuity, comprehensiveness, coordination, flexibility and trust – make general practices the natural hubs around which local system should develop, but they need to be better connected, better connected to almost everybody.

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Health professionals need to ask themselves not only “What is it that I do?” but also “What am I part of?”.

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We are only at the beginning of building the social capital, that is the sum of human relationships, not only between patients and practitioners, but also between practitioners in different services, on which the future of integrated health care will depend. Social capital is the only major unexploited resource we have and we need to make much better use of it

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The hub and wheel analogy is important, because it implies a journey, the technology may be simple, it needs pioneers and it needs everyone to stick together.

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A word of warning ...

I once spent an Easter weekend with friends on the island of Eigg. The island is known for its quartz beach, called the “singing sands”, on account of the squeaking noise it makes if walked on when dry.

We tried walking on the singing sands, without effect. Possibly it wasn’t dry enough, but maybe it was how we were walking. We tried running, jumping, stamping, doing all these things together, with no effect. There was a simple explanation. We were on the wrong beach.

My point is this. Even though general practitioners have serial contact with their patients, get to know them well, and say lots of right things, it’s possible that nothing will happen. Co-production is certainly more than can be achieved by single encounters, but what is that patients and practitioners are doing when they “co-produce”, and what do we understand of the process? Even though the serial encounter is our main delivery mechanism, we know rather little about it. The null hypothesis is that serial encounters do not matter. Can we show that this is not the case? If they do matter, what is that makes the difference?

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I have mentioned the vertical approach, its dominance in the virtual worlds of policies and guidelines, its strengths and limitations, and implied the horizontal alternative, in which the vertical components are important, but have to be incorporated in the overall, integrated care of the patient.

The vertical/horizontal dichotomy is not new – articles were written on the topic over 60 years ago. The dominant paradigm in policy, in research and in education, is the vertical, because by definition it deals with the definable, the measurable, the manageable, the trainable. It is easier to carry out research on the vertical.

Of course it is not a question of “either/or”. Both approaches are needed and need to be in balance. Our institutions are out of balance.

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Which creates a challenge for academics in general practice and primary care. John Bain, former head of the Dundee department, used to say that academic GPs in universities were situated on the outside of a doughnut. If they focused their attention inwards, on respectability and reward within their university, where the vertical paradigm is dominant, they risk irrelevance and alienation from ordinary GPs. If they focus their attention outward on everyday general practice, they risk marginalisation, lack of influence and perhaps exclusion from their universities.

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As universities have become knowledge factories, churning out information in the best scientific journals, one can reflect, with TS Eliot, *“Where is the wisdom we have lost in knowledge; where is the knowledge we have lost in information?”*

Possibly the REF will help, with its new requirement that research should have impact. It won’t be quick, but the requirement for research to address society’s problems may come to our aid.

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In the Bridge Project, which Sally Wyke will present in more detail here tomorrow, we have recently learned a salient and salutary lesson. Our idea was to link the knowledge of older people that exists in general practices to local community resources for social and physical activity. What was new wasn’t the idea of realising community assets, it was the linkage with existing practice knowledge and relationships. We spent a lot of time developing a blueprint of how the system would work, a very logical, clear blueprint, but in the study itself, we had to put the blueprint aside.

The system we described wasn’t something that could simply be switched on, to process large numbers of people quickly. Progress was made, but it was made by trial and error, patient by patient, building up a compendium of individual narratives, learning from experience. Using this approach, local systems emerge, grounded on local knowledge, experience, relationships and trust. They cannot be imposed.

This is probably true for most integrated care arrangements. It’s not easy for researchers, when funding bodies want to know exactly what you are going to do before you do it, but is where we have to go.

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If we don’t have the institutions we need, we shall have to invent them.

At one of the Deep End meetings, a social entrepreneur said that if he was setting up a new university, he wouldn’t start with a building. Neither should we.

First, there is the sharing of experience, and ideas. Then there is energy, then movement, with joint activity, involving colleagues and friends with common purpose. Eventually, for sustainability, some formal arrangements are required.

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Whatever form that takes must incorporate some principles. I suggest three.

First, the unit of currency is the individual patient experience, or story. The average general practice in Scotland comprises over 4000 such stories. Whether the currency is strong or weak can only be determined by random samples of patient experience.

Second, local health systems are the sum of the relationships of which they comprise. Co-production is not just for patients and practitioners, it is also for professional colleagues. Social capital is an asset we should value, promote, invest in and study.

Third our system of general practice is only as strong as its weakest link.

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General practice has enormous strengths, but they will never be fully realised by 1000 practices doing their own thing. They need, not only to be singing from the same hymn sheet, but to stop singing the hymn that everybody sings.

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Robert Louis Stevenson wrote, *“It is better to travel hopefully than to arrive, and the true success is to labour”.*

Being busy isn’t enough. Industry must have purpose and direction. I suggest it is a good time, possibly the best of times, to be imagining the future of primary care.

**GCMW**

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