

The Review

A social institution based on mutuality and trust

In 1948 when the NHS was born, the challenge of universal coverage was to include everyone, regardless of ability to pay. This remains an important objective, but it is no longer sufficient. Now that health care can improve public health, via the mass delivery of effective care, the test of universal coverage is that health systems should be seen at their best where they are needed most. Otherwise health care will widen rather than narrow inequalities in health. This cannot be achieved by pandering to the loudest voices, whether these come from the worried well, local interests, or corporate health care.

After 2 years of activity, the Deep End Project has only reached the end of its beginning, but we hope that two important objectives have been achieved: that it will no longer be acceptable to address the 'social determinants of health' or inequalities in health without mentioning the inverse care law, and that GPs will no longer be exhorted to address health inequalities without reference to the circumstances and constraints under which they work.

In capturing the experience and views of GPs at the Deep End, this series has highlighted not only the substantial social capital that exists in general practices serving very deprived areas, in terms of knowledge, commitment, contact, coverage, and relationships, but also the frustration of not being able to use these resources to full effect.

General practice in the Deep End should be centre stage in NHS efforts to reduce the health effects of socioeconomic disadvantage, not only as part of the new and important focus on early years (which won't impact on inequality statistics for decades) but also in addressing the health problems and shortened life expectancy of adults.

The 100 most deprived general practices in Scotland, serving as many patients in very deprived areas as the 700 next most deprived practices combined, are where the NHS needs to show it can make a difference. The cost of not doing so can be counted in human lives, which are shorter and harder than they need to be.

This series has made frequent reference to the work of Julian Tudor Hart, not as a model to be slavishly followed, but as an illustration of core principles and active ingredients. First and foremost was his acceptance of responsibility for the health of

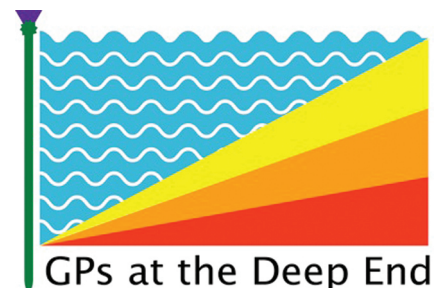
all his patients, using epidemiology to measure not only what he had done but also what he hadn't done and showing concern for patients who had fallen out of the system. We have tried to correct the misunderstanding that he lowered premature mortality by screening, health checks and an exclusive focus on cardiovascular risk. Instead, he used case-finding and routine consultations for most of what he did, and while evidence-based medicine was important and used whenever it was available, his main intervention was unconditional, personalised, continuity of care, 'initially face to face, eventually side by side', for whatever problem or combination of problems his patients presented. The Quality and Outcomes Framework has devalued this important aspect of care.

The Tudor Hart example illustrates that the NHS is neither a commercial business to make profits, nor a public utility providing services for choosy consumers, but a social institution based on mutuality and trust. This type of care is not needed by everyone, but it is certainly needed by the substantial numbers of patients with multiple morbidity who account for the majority of encounters in general practice.

Mutuality and trust mean relationships based on personal recognition, joint work, effective communication, understanding and respect of each others' roles, positive experiences and confidence in the future. All this is enshrined in policies, guidelines and practice concerning relationships with patients, but these are not the only relationships in the NHS requiring mutuality and trust.

The same features need to characterise relationships between general practices working together as a whole system (as begun by the Deep End Project), between general practices and other local professions and services (tackling the ubiquitous problem of health care fragmentation) and between GPs and others concerned with the health of local communities (bridging the gulf between list-based and areas-based approaches). On each trajectory, there is a dearth of information, infrastructure, and will, with too much resource locked up in central institutions.

If the NHS is to be seen at its best where it is needed most, Deep End practices need help, not only to address the inverse care



law with additional time and attached workers, but also to play a full part in the continuing development of the NHS, building mutuality and trust. As the Deep End Project enters its next phase, we seek opportunities and partners to show what general practice can do.

Graham Watt,

On behalf of the Deep End Steering Group. This is the 12th and last in a series of articles from GPs at the Deep End. The steering group comprises Georgina Brown, John Budd, Peter Cawston, Margaret Craig, Robert Jamieson, Susan Langridge, Andrew Lyon, Alan McDevitt, Stewart Mercer, Catriona Morton, Anne Mullin, Jim O'Neil, Euan Paterson, Petra Sambale, Graham Watt and Andrea Williamson.

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Articles in the Deep End series:

GPs at the Deep End — DOI: 10.3399/bjgp11X549090

Patient encounters — DOI: 10.3399/bjgp11X556380

Anticipatory care — DOI: 10.3399/bjgp11X561401

Working with vulnerable families —

DOI: 10.3399/bjgp11X567306

Social prescribing — DOI: 10.3399/bjgp11X572517

Alcohol problems — DOI: 10.3399/bjgp11X578089

The Keppoch Medical Practice —

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Learning journeys: where to, who with and how? —

DOI: 10.3399/bjgp11X588529

Time to make a difference —

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The tortoise and the hare —

DOI: 10.3399/bjgp11X601415

Inventing the wheel in general practice —

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