Thank you for the invitation. I declare no conflicts of interest.
SLIDE 2
I’m speaking from Glasgow, in Scotland, still part of the UK, just, on the same latitude as Hudson Bay, on Scotland’s west coast, you can see the University, the River Clyde, town centre and the Duke of Wellington wearing a traffic cone as a hat.

Although there are many differences between Scotland and Canada, we have many challenges in common, which it is an honour and a pleasure to try to identify and share. I’ll be talking about more fundamental challenges than the troubled waters of the Covid pandemic.
ASPECTS OF HEALTH CARE

Dealing with emergencies, large and small

Access to specialist investigation and treatments

A good start in life

Dying in comfort with dignity

Living well with multimorbidity

SLIDE 3
Health care in the future will continue to deal with emergencies, large and small; provide specialist investigations and treatments; help families negotiate pregnancy, birth and childhood; die with dignity and comfort; and increasingly, to live well in later life with multiple diagnoses.
The majority of over-65s have 2 or more conditions, and the majority of over-75s have 3 or more conditions.

More people have 2 or more conditions than only have 1.

SLIDE 4
Multimorbidity increases with age, the older you are the more conditions you accrue.
but under 80 years of age, multimorbidity is always higher and begins 10-15 years earlier in poor areas, not so much as frailty but, rather, the number, severity and complexity of health and social problems within families and households.
1. Affirming the importance of unconditional personalised continuity of care

2. Imagining family medicine as a whole system

**SLIDE 6**

I have two main propositions

First, and no doubt familiar to you, clinical generalism needs to be affirmed, not as the poor relation of specialty medicine, but as its increasingly important partner, responding unconditionally to patients’ problems, without exclusions and as the antidote to health care fragmentation, inefficiency and inequity.

Second, and perhaps less familiar, the potential of general practice, or family medicine, working as a whole system to improve health and narrow health inequalities has been barely imagined let alone realised. And if it is not imagined, and agreed, how can we be heading in the same direction?
SLIDE 7
For her first birthday my granddaughter received this collection of pairs of wooden animal models
SLIDE 8
plus a boat, or ark, an old man with a beard and his family
SLIDE 9

All created by a man in his 91st year. When she is older, we shall tell her what a remarkable man he was.

Although Julian Tudor Hart was born in London, and lived most of his life in South Wales, his grandparents were half-Scottish, a quarter Polish and a quarter Canadian.
THE INVERSE CARE LAW

The availability of good medical care tends to vary inversely with the need for it in the population served.

The inverse care law operates more completely where medical care is most exposed to market forces, and less so where such exposure is reduced.

The market distribution of medical care is a primitive and historically outdated social form, and any return to it would further exaggerate the maldistribution of medical resources.

Julian Tudor Hart

SLIDE 10

On 27th February this year, The Lancet ran a series of articles marking 50 years since the first publication of his and its most cited article – Julian Tudor Hart’s paper on the Inverse Care Law – observing that the availability of good medical care tended to vary inversely with the need for it in the population served, especially when market forces hold sway.
With great effort any doctor can get to know all his patients, even in a city with a high migrant turnover. Only then can he learn to think of a responsibility, not only to the patient sitting in the surgery, but to the whole population for whose care he is paid and for whose health he is responsible. He can then see his role as the ultimate custodian of the public health on a defined section of a world front against misery and disease.

SLIDE 11
– not an anniversary he would have been keen to celebrate. It was his 5th publication, with over 150 papers and several books to follow, many of which he deemed more important. The big idea that fuelled his life’s work was that a general practitioner, working on a defined front on the war against misery and disease, could improve the health of a local population. Further, he believed that by working together, and with their communities, primary care teams could sow the seeds of a better society. His politics frightened conservatives but essentially were simple - anyone contributing a skill to society was an ally; people who lived by owning things were not.
The title was catchy, drawing on Isaac Newton’s Inverse Square Law, but while Newton’s law had precise and predictable properties, the gravitational pull between two objects varying inversely with the square of the distance between them, the Inverse Care Law was a loose amalgam of several things, none with mathematical properties.
Medical services are not the main determinant of mortality or morbidity
but that is no excuse for the failure to match the greatest need
with the highest standards of care.

SLIDE 13
He was very clear that while “Medical services are not the main determinant of mortality or morbidity ....that is no excuse for the failure to match the greatest need with the highest standards of care”.
This inverse care law operates more completely when medical care is most exposed to market forces and much less so where such exposure is reduced.

The market distribution of medical care is a primitive and historically outdated social form, and any return to it would further exaggerate the maldistribution of medical resources.

SLIDE 14
In 1971, just over 20 years into the NHS, he was concerned about the re-entry of the market into UK health care. As night follows day this is a prescription for inequity and inequality. Asked how long the NHS would last, Aneurin Bevan replied, “for as long as people are prepared to fight for it”, implying not one single effort such as the 1948 battle over the introduction of the NHS but a sustained defence campaign, more like maintaining a Dutch dyke, keeping the tides of market interest at bay. As NHS England, but not NHS Scotland, steadily succumbs to US corporates, to market encroachment and privatisation by stealth, Bevan’s advice has never been more relevant.
There was another important theme. Notwithstanding universal access free at the point of use (i.e. horizontal equity), for which the NHS is famous, if the distribution of health care resources is not commensurate with need (i.e. vertical inequity), widening inequalities in health will result, as some groups get the benefits of effective needs-based care while others don’t. Julian argued that that this wasn’t just about resource distribution. It was also about the preferences of the medical profession, as indicated by the content of medical education, the undervaluing (actually disparagement) of general practice and the career choices and geographical choices of doctors. The challenges were cultural as well as political.
Tudor Hart was unusual as a commentator on health inequalities in that, unlike most other writers on the subject, who have little or no connection with policy or practice, he could do something about it in his own small community.
Once upon a time, you could measure the blood pressure of all your patients, and publish the results in the Lancet.

**Lancet 1st August 1970**

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**SLIDE 17**

He had worked in the MRC Epidemiology Unit in South Wales whose community studies with very high response rates had demonstrated the usually asymptomatic nature of very high blood pressure. The VA trial of blood pressure lowering had shown that strokes could be prevented. Echoing Brecht’s dictum, “the figures compel us”, Julian became the first doctor in the world to measure the blood pressures of all his patients.
SLIDE 18
Famously, the last man to take part, Charlie Dixon, only agreed to take part if everyone else had taken part first. He had the highest blood pressure in the village, asymptomatic with a diastolic of 170. He would have been dead in 2 years but lived another 25. It is an important teaching case, showing that the work is not done until the last man or woman is on board.
THE MEASUREMENT OF OMISSION

1. Screen records, not patients
2. Review and priorities omitted tasks
3. Call and recall

SLIDE 19
The key to population blood pressure control was what Julian called the “measurement of omission”, highlighting not what he had done but what he hadn’t done, which required an information system with a denominator. He began by screening his records, not his patients, to identify what needed to be done. Of course, all that is a lot easier now.
MEASURING OMISSION

THE RULE OF HALVES

50% were diagnosed
50% were treated
50% were controlled

i.e. 12% get best care

THE IMPORTANCE OF GOOD INFORMATION

SLIDE 20
He could then address the rule of halves, the tendency in health care for things not to be done, or to be done poorly or incompletely.
SLIDE 21
Taking full advantage of the 1966 GP contract, he both employed and empowered his nursing and reception staff to help him provide high quality medicine and care for their local community.
HK, aged 42

Persistent disability from major compound fracture

Very high blood pressure, 200/120 mm Hg

Very high cholesterol, 9.5 mmol/l

High blood uric acid

High alcohol intake

Obesity

A New Kind of Doctor, p187

SLIDE 22
In his book *A New Kind of Doctor*, he described a 42 year old man, invalided out of the steel industry with a leg fracture, who was hypertensive, hypercholesterolaemic, diabetic, obese, with an alcohol problem.
Overall the story is a success …

For the staff at our health centre it was a steady unglamorous slog through a total of 310 consultations. For me it was about 41 hours of work with the patient, initially face to face, gradually shifting to side by side. Professionally, the most satisfying and exciting things have been the events that have not happened: no strokes, no coronary heart attacks, no complications of diabetes, no kidney failure with dialysis or transplant. This is the real stuff of primary medical care.

A New Kind of Doctor, p187

SLIDE 23
25 years later, he could write

Overall the story is a success … For the staff at our health centre it was a steady unglamorous slog through a total of 310 consultations. For me it was about 41 hours of work with the patient, initially face to face, gradually shifting to side by side. Professionally, the most satisfying and exciting things have been the events that have not happened: no strokes, no coronary heart attacks, no complications of diabetes, no kidney failure with dialysis or transplant. This is the real stuff of primary medical care.
TWENTY FIVE YEARS OF CASE FINDING AND AUDIT IN A SOCIALLY DEPRIVED COMMUNITY

28% reduction in premature mortality over 25 years, compared with conventional care in a neighbouring village

Julian Tudor Hart et al
British Medical Journal 1991 302 1509-13

SLIDE 24
After 25 years, he could report in the BMJ that premature mortality was 30% lower in his village than in a neighbouring village, the only evidence we have of what a GP working in, with and for a community, can achieve in a lifetime of practice.
NOT ONLY

Evidence-based medicine (QOF, SIGN, NICE)

BUT ALSO

Unconditional, personalised, continuity of care, provided for all patients, whatever problems they present.

SLIDE 25

... partly by delivering evidence-based medicine (less available then than it is now) but also by the delivery of unconditional, personalised continuity of care, whatever problem or combination of problems a patient might have.

He had put his big idea into effect, reversing the inverse care law in one of the most deprived communities in South Wales. The story is one of the foundation stones of general practice and must not be forgotten.
SLIDE 26
Fast forward 20 years, this slide divides the Scottish population into ten groups of just over half a million people, most affluent on the left, most deprived on the right. Premature mortality in blue and multimorbidity in red increase over two and half fold across the spectrum. But funding, in black, is broadly flat, especially in the more deprived half of the population.

Consultation rates in green rise a little, about 20%, but with no extra resource, this is only achieved by GPs in deprived areas, in the bottom right hand corner, having shorter consultations, or working a longer day.
CONSULTATIONS IN DEPRIVED AREAS

Multiple morbidity and social complexity
Shortage of time
Reduced expectations
Lower enablement (especially for mental health problems)
Poorer outcomes after 12 months
Health literacy
Practitioner stress

Mercer SM, Watt GCM: Clinical primary care encounters in deprived and affluent areas of Scotland

SLIDE 27
In a study of 3000 GP consultations, my colleague Stewart Mercer showed that consultations in deprived areas were shorter, dealt with more multimorbidity and social complexity, had lower expectations and poorer outcomes, especially for patients with mental health problems, and were associated with higher GP stress. The daily reality of the inverse care law for patients and doctors.
SLIDE 28
Turn the slide upside down and you see where we got the idea of the deep end of a swimming pool, and from this, the Deep End logo.
SLIDE 29
With the deep end of a pool, the steep slope of need, the flat line of resource, a sunrise or a sunset (depending on your disposition); a thistle for Scotland, top left; a spurtle down the side (that’s a traditional kitchen instrument for stirring porridge); the whole thing is a flag for rallying under.
And now there are similar flags for Deep End Projects in Ireland, Australia and six English areas, plus possible projects in Canada, Denmark, the US and Belgium. It’s catching.
SLIDE 31
There have now been four Deep End International Bulletins, each with 40 pages of news and views from the various Deep End Projects. The 5th will be ready shortly.

The projects have given identity, voice, shared activity, shared learning and policy impact to a previously neglected group of general practitioners and, by proxy, the patients they serve.
SLIDE 32
What can Deep End GPs do and what can be done to help them? The first step was to listen to what they had to say - at a conference in 2009 involving GPs from practices serving the 100 most deprived communities in Scotland. That’s about 10% of all practices. Two thirds of practices were represented. It was the first time they had ever been convened or consulted. The seating plan was a circle, with everyone in the front row. The conference report captured their experience and views,
SLIDE 33

.... and set the agenda for a series of roundtable discussions on specific topics, all with short and long reports on the Deep End website, the latest addressing general practice in the time of COVID.
One report listed the educational needs of GP working in deprived areas, which were partly to do with issues specific to such areas, but there were also generic issues: how to engage with patients who are difficult to engage; how to deal with multimorbidity in high volume; how to apply evidence when so little of it is based on the types of patients you see.
SLIDE 35
Some reports have been about austerity, welfare benefits, alcohol pricing - using the experience and voice of general practitioners to highlight social issues as they affect patients.
ADVOCACY

The social causes of illness are just as important as the physical ones.

The medical officer of health and the practitioners of a distressed area are the natural advocates of 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, John Hopkins University

SLIDE 36
As Sigerist put it, “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 scientist but also responsible citizens and if they did not raise their voices, who else should?”
But Deep End advocacy has been mainly about health care. If health care is not at its best where it is needed most, inequalities in health will widen. As health care has become more effective, the implications of inequity have become more important.
SIX ESSENTIAL COMPONENTS

1. Extra TIME for consultations (INVERSE CARE LAW)
2. Best use of serial ENCOUNTERS (PATIENT STORIES)
3. General practices as the NATURAL HUBS of local health systems (LINKING WITH OTHERS)
4. Better CONNECTIONS across the front line (SHARED LEARNING)
5. Better SUPPORT for the front line (INFRASTRUCTURE)
6. LEADERSHIP at different levels (AT EVERY LEVEL)

SLIDE 38
All this gave rise to the six point Deep End Manifesto:

• more time for consultations, addressing the inverse care law
• better use of serial encounters, staying long enough to make a difference
• building local health systems, with general practice as the natural hub
• better sharing of experience and learning
• better support from the centre
• stronger leadership at every level, especially ground level

.... the last point emphasised by Julian Tudor Hart who commented, “Everything depends on leaders at practice level, demanding media attention, gaining public support, and insisting on material resourcing from governments, in return for which they can guarantee immensely greater efficiency of care generated by people who know each other”. He knew that to achieve change, new alliances would be needed, with politicians and the public, putting pressure on the establishment.
Not every GP signs up to this. My colleague Breannon Babbel interviewed GPs working in deprived areas in Glasgow. All saw their role in clinical consultations. Some saw no further than that, while others tuned in to patient’s social situations, viewed the local community as a resource, saw the social and political determinants of poor health being played out in front of them, and wanted to do something about it.
Engagement and listening were first steps but only a start. Keeping the initiative going required central coordination, documentation and continuity, provided by colleagues based in an academic department of general practice, but a role that could be carried out by anyone known and trusted by practitioners. With a network of interested practices, we were also ready to take on projects, showing what could be done.
He who would do good to another must do it in minute particulars.

General good is the plea of the scoundrel, hypocrite and flatterer.

William Blake
Advocacy isn’t only what you say; it is also what you do. I’ll very briefly describe 5 Scottish Deep End projects. Further details are available on the Scottish Deep End Project website. (www.gla.ac.uk/deepend)
**THE CARE PLUS STUDY**

- RCT of longer consultations for selected complex patients
- CARE Plus prevents decline in QOL
- Cost-effective (< £13,000 per QALY; NICE threshold is £20,000)

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**SLIDE 43**

In a randomised clinical trial, the Care Plus Study showed that extended consultations for selected patients with complex problems is cost-effective, not only improving patient’s quality of life, on the left, but also preventing its further decline, as observed on the right, in the control group.
GOVAN SHIP

Social Health Integration Partnership
4 general practices in one health centre
Added clinical capacity (long term GP locums)
Protected time for host GPs
Monthly Multidisciplinary Team (MDT) Meetings
Attached social care workers
Administrative support
Reduced practice workload by 8%

SLIDE 44
The Govan SHIP Project, had nothing to do with ships, although Govan is where some famous ships were built. GP locums made it possible to give every GP in the health centre one protected session per week to use as they saw fit. Most used their knowledge to select patients who needed more consultation time, sorting out and prioritising their problems, re-coordinating their care, driving integrated care from the bottom up, via enhanced multidisciplinary team meetings, with attached social care workers and community link workers. Focusing in this way on about 8% of practice patients reduced GP workload for the practices as a whole.
SLIDE 45
The community link worker programme provided an extra person in the practice team, acting not only as a signpost to community resources (sometimes called “social prescribing”), but also working one to one with patients, especially those struggling to cope with a complicated and fragmented health and social care system. The scheme is now being rolled out nationally.
THE PARKHEAD FINANCIAL ADVICE PROJECT

- Engagement of practices
- Increase in new referrals, made mostly by GPs
- 65% uptake
  - Median financial benefit per claimant of £7,000 per annum
- 68% of people engaging with the service stated they had a mental health condition
- About a half of people were referred to additional forms of community support
- More time for GPs to address clinical problems
- Now being rolled out to 7 other local practices

SLIDE 46
At Parkhead Health Centre, in the shadow of the Celtic football stadium, financial advice workers who were embedded in the practice, and not simply working nearby, increased the number of new referrals for welfare benefits, with an average financial benefit per referred patient of over £7000 per annum.
THE DEEP END GP PIONEER SCHEME

Additional capacity via GP fellows
Protected time for host GPs
GP lead for service development
Day release scheme for GP fellows
Recording of shared activity via website

SLIDE 47
The Deep End GP Pioneer Scheme puts young GPs in deprived practices, partly to add to practice clinical capacity, but also to release the time of experienced GPs so that they can apply their knowledge and experience to service developments. The GP fellows are also engaged in service developments and have a fortnightly day release scheme to meet their educational needs, filling the gaps not covered by conventional GP training. Learning from all these activities is shared between fellows, GPs and practices on a website.
WORKED EXAMPLES OF MAKING A DIFFERENCE IN THE DEEP END

Leadership at a local level
GP protected sessions (SHIP, PIONEER)
Extended consultations for selected patients (CARE PLUS, SHIP)
Bottom-up integrated care via multidisciplinary team meetings (SHIP)
Embedded community link practitioners acting as generalists (LINK WORKERS)
Embedded financial advisors
Attached alcohol nurses
Associated evaluation and research
Shared learning between practices (PIONEER)
Advocacy
Involvement of the next generation of GPs (SHIP, PIONEER)

SLIDE 48
In summary, over ten years, the Scottish Deep End Project has developed worked examples of extended consultations for selected patients; GP protected time; attached or embedded co-workers, including link practitioners, social care workers, financial advisors and alcohol nurses; enhanced multidisciplinary teams; a pioneer scheme for young GPs.

Only link workers and financial advisors have so far been rolled out by the Scottish Government to all Deep End practices, in both cases after almost ten years of pioneering work. We have learned that advocacy isn’t a short sprint but a marathon, requiring persistence and perseverance, and not being deterred when the establishment (by which I mean the existing order of power and resource) says No, as it often has. There is still unfinished business.
In 2019 we held a conference in Glasgow to celebrate the life and work of Julian Tudor Hart, the progress of the Deep End Projects and the publication of a book, *The Exceptional Potential of General Practice*, with 55 contributors from 11 countries, 44 of them general practitioners.
The idea of the book is that medical students and young and not so young GPs would say, “Yes, that describes what I do”, “Yes, that’s what I want to be part of” and “Yes, that’s the direction I want my career to go”
SLIDE 51
The primary motivation of most Deep End general practitioners is not to address the abstraction of inequalities in health, but rather, to improve patient care, closing the gap between what they are able to do and what they could do with more time and resource. This is partly about evidence, but it is also about values.

I shadowed a GP in Scotland’s most deprived general practice, observing her day from 7 in the morning to 7 in the evening, and wrote it up in the BJGP. I saw multimorbidity in large measure (not the simple counting of conditions but rather, the number, severity, complexity and continuing nature of health and social problems in families and households), presenting as a succession of complicated stories. I saw the importance of prior knowledge, allowing consultations to start at a higher level and without which much less could be achieved in a short consultation. I saw the importance of empathy and the trust patients placed in a doctor who knew them well and cared what happened to them. I saw no worried well patients but I saw a “worried doctor”, using her better knowledge to anticipate and try to prevent complications. She was ambitious for what might be achieved, not immediately but over time. Every patient mattered.
In *Tales of the 1001 Nights*, Sheherazade had to invent a new story every day. Her life depended on it. That’s also the task of primary care, helping to create strong patient stories. Every practice is a compendium of such stories, but what kind of stories? Who knows?
An important part of story building is boosting patients’ knowledge, confidence and agency.
RELATIONSHIPS WITH PATIENTS

Initially face to face, eventually side by side

Julian Tudor Hart
A NEW KIND OF DOCTOR

SLIDE 54
Without which, self-help and self-management are destinations not starting points. It’s a shared journey, at an appropriate pace, in Julian Tudor Hart’s words, “initially face to face, shifting slowly to side by side”.
10% of patients with 4 or more conditions accounted for

34% of patients with unplanned admissions to hospital and

47% of patients with potentially preventable unplanned admissions.

Payne R, Abel G, Guthrie B, Mercer SW.
The impact of physical multimorbidity, mental health conditions and socioeconomic deprivation on unplanned admissions to hospital: a retrospective cohort study.

SLIDE 55
Not every patient needs this but in Scotland, the 10% of patients with 4 or more conditions, who account for a third of unplanned admissions to hospital and a half of potentially preventable unplanned admissions, certainly do.
Applying the CARE measure and Patient Enablement Instrument (PEI) after general practice consultations

YOU CAN GET EMPATHY WITHOUT ENABLEMENT BUT YOU NEVER GET ENABLEMENT WITHOUT EMPATHY

Mercer SW Jani BD Maxwell M Wong SYS Watt GCM
Patient enablement requires physician empathy: a cross-sectional study of general practice consultations in areas of high and low socio-economic deprivation in Scotland
BMC Family Practice 2012, 13:6

SLIDE 56
Patients with multimorbidity are all different (there is no simple case definition), but their needs are the same – unconditional, personalised continuity of care from a small team of providers whom they know and trust.

In a study of 3000 GP consultations, patients could report practitioner empathy (“Did the doctor listen, care etc?”) without being enabled (to cope better with their conditions), but they never reported enablement without practitioner empathy.
RELATIONSHIPS ARE THE SILVER BULLETS OF GENERAL PRACTICE AND PRIMARY CARE

SLIDE 57
Relationships are the silver bullets of general practice and primary care. But not just relationships with patients.
The intrinsic strengths of general practice are first contact, continuity, population coverage, coordination, flexibility, long term relationships and trust. These features are not exclusive to general practice but very few public services have them in such large degree. They make general practice the natural hub of local health systems.
INVENTING THE WHEEL

HUB
- Contact
- Coverage
- Continuity
- Comprehensive
- Coordinated
- Flexibility
- Relationships
- Trust
- Leadership

SPOKES + RIMS
- Keep Well
- Child Health
- Elderly
- Mental Health
- Addictions
- Community Care
- Secondary Care
- Voluntary sector
- Local Communities

INTEGRATED CARE DEPENDS ON MULTIPLE RELATIONSHIPS

SLIDE 59
But hubs go nowhere unless connected via spokes to other services and community resources, each spoke a relationship that needs to be built up and looked after.
SLIDE 60
It follows that realising the exceptional potential of general practice requires competence not only in clinical consultations but also in two practice-based building programmes, neither based on bricks and mortar or fancy architecture, but on relationships: the first, building a compendium of patient narratives; the second building strong local health systems based on general practice hubs.
Systems can be resource poor but people rich, or resource rich and people poor. Think of the United States. Think of Cuba. The social capital of a health system is made up of all the relationships it contains.
THE COLLABORATION LADDER

Involving joint working between two potential partners

0  Never heard of each other
1  Have heard but have had no contact
2  Contact but no relationship
3  Relationship between named individuals
4  Joint review and planning

SLIDE 62
We have learned from this collaboration ladder, developed in Quebec. Potential colleagues and partners can work in the same community but not know of each other (Level 0); know of each other but have never met (Level 1); have met but do not work together (Level 2); work together haphazardly (Level 3); or meet regularly to review and plan their joint work (Level 4). It takes time and effort to climb the ladder.
The opening ceremony of the 2012 Olympics in London celebrated not only the NHS but also, seen here in their top hats, as they were mostly men, the pioneers of the industrial revolution. In the main they weren’t investors, scientists or inventors. They were people who knew how to blend new discoveries, raw materials, information, local people and capital into productive local systems. We need such enterprise now to produce not goods for market but vibrant productive local health systems.
ACCOUNTABILITY

UPWARDS to funders

DOWNWARDS to patients and communities

SIDEWAYS to colleagues

SLIDE 64

In this regard, the independence of individual general practices is both an asset, providing huge scope for local initiative, enterprise and leadership, and a liability as a prescription for variation, inefficiency, inequity and a weak collective voice.

The exceptional potential of general practice as a coherent system depends, therefore, on three types of accountability: upwards to funders, providing quality and value for money; downwards to patients and local communities, addressing their needs; and sideways to other practices, ironing out inefficiencies and inequity.
So, a third building programme is needed, based on the collegiality and solidarity of practices, and requiring a variety of connecting infrastructure.
POLITICAL AND CENTRAL SUPPORT NEEDED FOR ..... 

- **Resources** commensurate with need
- **Information systems** to measure omissions and monitor progress
- **Educational opportunities** to share learning
- **Research and Evaluation** to establish what works
- **Career opportunities** to attract, sustain and retain practitioners

**SLIDE 66**

- resources commensurate with need;
- information systems to measure omission and monitor progress (e.g. the balance between routine and emergency care, the quality of patient experience, the amount of social capital in local systems);
- educational opportunities to share experience and learning;
- research and evaluation to establish what works;
- career opportunities to attract and retain committed practitioners.
The building programmes I have described are needed everywhere, pro rata based on need, but if the NHS is not at its best where it is needed most, inequalities in health will widen.

Health care is not a level playing field. It is built on a slope. There are four cogent reasons for beginning at the bottom of the slope.

First, by improving outcomes for individual patients and delivering such care for all patients, population health can be improved and inequalities in health narrowed. Addressing health inequalities is a consequence of such care rather than its starting point.
SLIDE 68
Second, for health service managers, stronger care in the community can prevent, postpone or lessen crises requiring emergency A&E attendance or hospital admission. Patients can pass through the gateway to emergency services at any time, but when they have access to a primary care team they know and trust, when they are confident in their care arrangements, when the complications of their conditions have been prevented, they choose not to. The elegance and sophistication of this type of gatekeeping is that there is no gate.
SLIDE 69
Third, for an increasing group of Deep End practitioners, from newcomers to old hands, this is what they aspire to do, it is the direction they want their careers to take and it is the collegiate culture they want to be part of. Here is the Scottish Deep End steering group, meeting recently, lots of young GPs, mostly women. They are the future. The beating heart of the Project, energised, not drained, by the career path they are taking.
WHAT MAKES PEOPLE ENJOY THEIR WORK?

AUTONOMY  
MASTERY  
PURPOSE

but only after basic needs are met

SLIDE 70
With the three essential ingredients for enjoying your work: autonomy, mastery (knowing you are doing a difficult job well) and purpose.
...in the dark age in which we are living
and the new world order,
the sharing of pain is one of the essential preconditions
for a re-finding of dignity and hope.

Much pain is unshareable.
but the will to share pain is shareable
and from that inevitably inadequate sharing
comes a resistance.

John Berger

SLIDE 71
But finally, and perhaps most important, it is what publicly-funded doctors can contribute
to the healing of society.

The late John Berger wrote a seminal book about general practice called *The Fortunate Man* but, reviewing the work of the artist Frida Kahlo, he also wrote,

*In the dark age in which we are living and the new world order* (I don’t need to tell you what that is), *the sharing of pain is one of the essential preconditions for a re-finding of dignity and hope. Much pain is unshareable. But the will to share pain is shareable. And from that inevitably inadequate sharing comes a resistance.*
“By excluding exclusions, 
keeping everyone on board, 
and building three types of relationship, 
inclusive health care can be a civilizing force 
in this increasingly dangerous, fragmented and uncertain world.”

The Exceptional and Equitable Potential of General Practice

SLIDE 72
Health care can be part of that resistance.

“By excluding exclusions, 
keeping everyone on board, 
and building three types of relationship, 
inclusive health care can be a civilizing force 
in this increasingly dangerous, fragmented and uncertain world”

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28th May 2021