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EDITORIALS

Looking beyond "the house of care" for long term conditions

Some patients are at risk of being left outside

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Spike Milligan once described the invention of a machine that did the work of two men. Unfortunately, it took three men to work it.[1] As populations age, multimorbidity accrues, budgets tighten, and inequalities in health widen; patients, practitioners, and health systems cannot afford multiple services that provide fragmented care. We shall need machines that do the work of two people but need only one person to work them.

With its intrinsic features of contact, coverage, continuity, flexibility, cumulative knowledge, and trust, general practice has the potential to deal with this challenge. It is the natural hub of local health systems, providing unconditional personalised continuity of care for all patients, whatever combinations of problems they have. But practices cannot do this on their own; they need a host of effective partnerships—with patients, other services, NHS managers, and community resources.[2]

In England, the "house of care" has been adopted as a central metaphor in plans for improving care for people with long term conditions.[3] The house of care is based on substantial pilot work in the care of people with diabetes and is summarised in a recent King's Fund review. The system involves personalised care planning at the centre of a model of care that includes engaged and informed patients, healthcare professionals who are committed to partnership working, supportive organisational systems, and local commissioning plans.[3] Everyone is being challenged to think and act differently.

The ubiquitous challenge is multimorbidity. In only 14% of patients with diabetes is diabetes the only health problem. In the most deprived 10th of the population, 24% of patients with diabetes also have coronary heart disease, 28% take prescription analgesics for chronic pain, and 21% take regular antidepressants.[4] Yet, because of the flat distribution of GPs,[5] steep social gradients in ill health, and the inverse care law that ensues,[6] patients with mental health problems in deprived areas have shorter consultation times and report less enablement as a result of seeing their GP.[7] Universal coverage is essential but not sufficient; practitioners also need to be able to respond proportionately to the problems that patients present.

Effective healthcare reduces the severity of health problems and delays their progression, while enabling patients to live well and independently.[8] Although the origins of health inequalities lie outside the health service, the inverse care law exacerbates them. If "tackling health inequalities is a central aim of the house of care,"[3] it will have to be more specific on this problem.

Self management by patients involves a spectrum of activity. Many patients already self manage, leading long lives without needing extra help from health professionals. For many others—especially in deprived areas—self management is a distant aspiration, rather than a starting point. This is because patients may lack the knowledge, motivation, and agency to behave in this way. They may also have a more complex task—accessing multiple professions and services for different health and social problems. Will longer appointment times for all, to support self management in articulate well informed patients, use up NHS resources that could be better deployed?

The house of care is currently an aspiration,[3] with few examples of all its components in action. However, in another King's Fund report, the active ingredients of coordinated care have been described, including schemes for palliative care at home, mental health services, home care for people with dementia, care for older and frail people, and complex case management to reduce unnecessary hospital admissions.[9]

The report questions the need for defined care packages, arguing that protocol driven approaches lack the flexibility that patients with complex needs require. Such schemes are weaker without GP engagement, knowledge, and leadership. Bottom-up approaches are needed to develop "the building blocks of effective partnership working," rather than "top-down approaches, no matter how well they may have worked elsewhere."[9] Most of the projects took six to seven years to achieve the desired changes.

Key elements in building the house of care will be professional and organisational relationships. Co-production, or partnership working,[10] to achieve long term aims is not just a prescription for patients and practitioners. It is also needed, and is often less evident in terms of mutuality and trust, in the relationships between professional groups, services, and leaders at the top and bottom of health systems. At every level we need to conserve, build, monitor, and apply social capital.

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Whereas previously doctors used to "listen to the patient, he is telling you the diagnosis," increasingly they will "listen to the patient, she is telling you her treatment goals."[11] In general, what matters to patients with multiple problems is functional status and social participation, rather than clinical or health service targets,[12] so the goals of care—how success and failure are judged, and by whom—are changing.

Whatever national and local arrangements are established to tackle these challenges, the product will be a compendium of individual narratives that reflect patients' knowledge and confidence in living with their conditions and using services. In each of the four countries of the United Kingdom, random samples of patient experience will be needed to assess what is being achieved, and for whom.

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