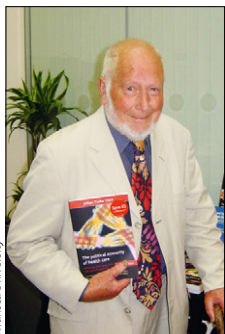


Offline: Face to face, side by side



Swansea University

I went to Trondheim last week to see Julian Tudor Hart. At least, to see Julian Tudor Hart on television. In Norway, he is listened to with attentive respect. Tudor Hart is admired by many in Britain too. But just when he is needed most in his own country, his ideas seem to have been forgotten. Thankfully, not by all.

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Tudor Hart was appearing in *Health Factory: Compassion on the Assembly Line*, which starred Steinar Westin, a specialist in general practice and Professor of Social Medicine at the Norwegian University of Science and Technology. Steinar is the Tudor Hart of Norway, a deeply inspirational figure, motivated by a belief in the power of medicine to deliver social change, as well as to improve patients' care. Along with colleagues, such as Magne Nylenna (who has just been appointed Director of the Norwegian Knowledge Centre for the Health Services in Oslo), Steinar is part of a slowly building movement to reassert the values of solidarity and universalism in Norwegian health care. His television programme exposed the poverty of the market approach to health. Magne, meanwhile, delivers a report to his government this week, in which he lays out solutions to some of Norway's chief health predicaments. He began this work 9 months ago. The first 3 months involved commissioning 31 discussion papers, reviewing the successes, problems, and future options for various dimensions of the health system, from emergency care to the management of chronic diseases. The next 3 months involved consulting online (with over 1600 responses) and holding regional meetings with citizens' groups, trades unions, and doctors' organisations. The final 3 months involved drawing these findings together, including negotiations with government departments about what could reasonably be done and what could not (on grounds of cost, for example). Compare this open, transparent, value-driven, data-rich, participatory approach to the kind of data-free, ideological health-policy making adopted by Andrew Lansley in England.

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Just as Tudor Hart looms troll-like over the Norwegian landscape, so another figure is applying the same powerful lessons in a different setting closer to home.

Graham Watt is a Professor of General Practice at the University of Glasgow. In a series of compelling essays currently appearing monthly in the *British Journal of General Practice*, Watt describes an initiative he and his colleagues call "GPs at the Deep End". 100 general practices serve the most deprived populations of Scotland—8% of the country. These individuals suffer almost three times the disease burden of the richest in Scotland, especially mental ill health and addiction disorders. Traditional efforts—writing reports, developing toolkits, and trying to redistribute resources—have failed. In a series of consultations, supported by the Scottish Government, Watt brought GPs together to work out how to optimise services to address these huge health challenges. He and his fellow GPs are not filled with despair. They have high morale and deliver high-quality care. Contrary to doctors in some health systems, such as the US, they also embrace the idea that GPs are the effector arms of public health. Here is the discipline of social medicine in action.

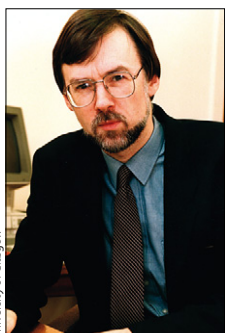
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What these GPs did regret was the gradual erosion of the doctor-patient consultation as the defining activity of general practice. Why was the consultation, and so the relationship that a doctor forms with a patient, being harmed? Because of financial incentives that have slowly crept into the NHS, financial incentives that will also damage "the heart of general practice" if market-based reforms are implemented in England. These are the same concerns diffusing through Norwegian health care. Such feelings are not romantic regrets for a time long past. They are genuine fears that the kind of "anticipatory care" pioneered by Tudor Hart will be impossible to recover. Watt explains Tudor Hart's philosophy of preventive medicine: he preferred routine contact (not screening or health checks) as the best means to expand health coverage in his population. By doing so, he created a sustainable and scalable model of health-care delivery that met the complex health and social needs of those he served—"initially face to face" with patients, but "eventually side by side".

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