Editor's Briefing

HIGHLIGHTS

One of the challenges of reshaping primary care is the ever-present fear of unintended consequences — it brings to mind the analogy of rebuilding a jumbo jet full of people in mid-flight. Do we target specific groups? The editorial by Gina Agarwal *et al* highlights how we might do so for older adults in social housing. Or do we concentrate on the foundation-stone of practice, the consultation? Roger Jones' editorial offers much to consider as we define our future relationships in primary care.

Articles on multimorbidity, polypharmacy, and GP deployment in EDs underline the scope for development as well as the complexities. An Analysis article takes a long look at how we protect ethnic minority populations post lockdown. All of this reshaping has to be done in the glare of the media spotlight — who are not always kind to GPs — and research by Trish Greenhalgh's team in Oxford spotlights the changing depictions of remote consultations in the press.

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LEGISLATING FOR THE FUTURE: RESHAPING LAWS

Reshaping primary care has been an abrupt, if not brutal, process in 2020 and the debates on the future direction of primary care roil. Multimorbidity is the norm and we should be mindful of the challenges of treatment burden.[1] Living with a single chronic disease is hard enough and living with three or more can be all-consuming. Complexity may lie with the patient but shouldn't be designed into the system. When people struggle to access care or attend appointments we must guard against personal blame. There is a single principle we need to underpin any service redesign if we want to avoid unintentionally deepening inequalities: the more complex the patient, the simpler the healthcare pathways that are needed.

On the 27 February 2021 it will be the 50th anniversary of the publication of Tudor Hart's totemic article on the inverse care law.[2] Reshaping primary care has multiple competing priorities and Tudor Hart, who was largely railing against marketisation, was aware that the NHS has functioned quite well without the profit motive. He knew its limitations as well: *'Medical services are not the main determinant of mortality or morbidity; these depend most upon standards of nutrition, housing, working environment, and education, and the presence or absence of war.'*

We are reshaping our own systems. In 2021 the *BJGP* will be providing early access to accepted manuscripts so that research doesn't linger in a virtual drawer awaiting an issue. That should happen within a matter of days of acceptance. We have just accepted our first Registered Report and we hope to see more. And we are simplifying the pathway for our research to influence and shape primary care — in 2021 we will publish all research open access so it is available to everyone. We can all acknowledge the bruising experience of 2020 and the many challenges 2021 will offer us, but we should be optimistic about our capabilities.

Tudor Hart was plain in stating there was *'no excuse for failure to match the greatest need with the highest standards of care.'*[2] The focus in the *BJGP* in 2021 will be on action and translation into practice to help with that matching of need and standards. We already have the tools to reduce inequalities in healthcare delivery — it doesn't have to involve extra work and it is not a call for GPs to become public health doctors.

We will continue to publish research in all areas but we will be seeking articles that illuminate some neglected corners of practice. We have some ideas on these but, inevitably, because they are neglected we need your help to identify them.

Let us know, we want to hear from you!

Euan Lawson,
Acting Editor, *BJGP*

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