Editor's Briefing

Euan Lawson

COMPLEX SYSTEMS HARM PEOPLE WITH COMPLEX NEEDS

Complex systems harm people with complex needs. It is a principle to keep in mind as we scramble to cope in a pressurised system with too few doctors. Any appointment booking system or clinic, across primary and secondary care, re-jigged to manage access, at a time of savage demand and pitiful resources, needs very few hurdles to become inaccessible to the most vulnerable. Whether you are a migrant, older and frail, a person who uses drugs, or just carrying the burden of multiple conditions, then the complexity of the system matters. Not in an obscure academic chin-stroking way. Life or death kind of matters.

Any complexity in the system tends to push people away. Away from seeking the right help at the right time, away from the best care, away from the timely diagnosis and early treatment. It is often an unintended consequence of elaborate workarounds trying to compensate for lack of provision, but it morphs into an invisible rationing by exclusion. It could be argued that continuity of care offers one mechanism to pushback against this complexity. Perhaps it is even one of the key attributes that makes continuity effective in improving health outcomes, an antidote to Byzantine booking systems and multiple layers of triage. When it comes to navigating complex systems what could be simpler than already knowing the name of the doctor who will look after you?

Poverty offers complexity in itself but the cognitive load of poverty can also reduce the ability of people to negotiate complex systems. The daily stress of living is not to be underestimated and the cost of living crisis will drag more people into lives where they will, in former Prime Minister Gordon Brown's words: *'starve and shiver'*. Fuel poverty may feel like an unreachable challenge for GPs to contend with but, as Khan reports this month in *Life & Times*, we can have an influence. Similarly, food insecurity demands our attention. Worryingly, we have moved towards a situation where we have normalised food banks in the UK. In 2020/21, Trussell Trust foodbanks gave out 2.5 million 3-day emergency food supplies to people in crisis. Why are we not more scandalised by this?

There are people fighting, not least the Deep End movement, to structure primary care to look after our most needy populations and support those already doing so. As Mercer and colleagues point out: *'disadvantage is not a given to be endured but a challenge that can be overcome'*. Supine acceptance of the status quo is a failure. Yet, every time we change the practice system, change how we consult or develop primary care networks, we need to pause and squint at it. If it adds complexity, it will probably add to the injustice of health inequalities.

Euan Lawson,
Editor, *BJGP*

Issue highlights

The WHO has registered over half a billion cases of COVID-19 and puts global deaths at over 6.3 million. It continues to infect people around the world, many living with long-term consequences, and it stresses healthcare systems. We publish high-quality evidence that colchicine can't be recommended for COVID-19 in the community as well as research on its impact on prescribing, children and young people, people experiencing homelessness, and colorectal cancer. There are fine editorials on migrant health and Brexit, global primary care and ethics, and some expert commentary on how we can improve detection of ovarian cancer in primary care.

Further notes from the editors and other *BJGP* news can be found at https://bjgplife.com/bjgp

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