

## The Review

# Bridging the gaps in cardiovascular care

*'If we don't create the future, the present extends itself'* (Toni Morrison, *Song of Solomon*).

It is rare for an international specialist society to provide a dedicated platform for primary care, but in September 2012, the International Society of Hypertension hosted a special satellite symposium on *Bridging the Gaps in Cardiovascular Care*. In the spectacular setting of the Sydney Convention Centre, the ISH President Stephen Harrap welcomed participants from 25 countries and speakers from five continents to discuss the challenge of delivering the best cardiovascular care to all who need it.

As a ubiquitous asymptomatic risk factor for fatal, disabling, yet preventable conditions, high blood pressure remains the quintessential challenge for universal health care, providing care according to need and not demand. A review of such care in South America, by Margarita Diaz from Uruguay, showed the wide range of health, social, and economic circumstances in which the challenge is being addressed and the difficulty of assessing system performance using the limited available routine and research data.

While universal coverage and the removal of financial barriers to care are essential, I argued that simple notions of access are insufficient. 'Measurement of omission' is needed to identify patients who have not been included, treated, or followed-up, resulting in gaps in coverage, quality, and continuity. Universal coverage does not in itself deliver needs-based care, or reverse the inverse care law.

Mark Harris from Sydney showed that people in poor parts of rich systems have particular difficulty in accessing the best care, yet this is where the best care is needed. Otherwise, inequalities in health will widen. Health care no longer simply responds to the social determinants of health. Its organisation and delivery have become social determinants of health.

Multimorbidity looms. Jane Gunn from Melbourne highlighted the consistent pattern in Australia and Scotland. Only one-fifth of patients with high blood pressure only have high blood pressure. Most have two or three other problems, with psychological distress the commonest comorbidity,

especially in middle-aged patients in poor areas.

While patients with multimorbidity dominate caseloads in primary care, they are virtually absent from the research literature, particularly from intervention studies. As patients and practitioners struggle to cope with different conditions, guidelines, specialists, and clinics, they do so largely without evidence or shared experience to guide them.

Focusing on single conditions for which there is research evidence has produced a new type of inequity: inequity by disease whereby, as in the UK Quality and Outcomes Framework, the care of some patient's problems is incentivised at the expense of others. Kavita Patel from the US and Jan De Maeseneer from Belgium struck independent but similar chords with the audience, describing older patients with complex lists of health problems struggling and failing to get the help they need from over-fragmented health systems.

In the 19th century, Sir William Osler advised, 'Listen to the patient, he is telling you the diagnosis'. In the future, we should 'listen to the patient, she is telling us her treatment goals', which may include clinical targets but are also likely to include functional status and social participation. In this way, patients provide the key for integrated, efficient, person-centred, goal-oriented care.<sup>1</sup>

There was a striking similarity between marginal groups in different health systems, be they aboriginal communities in Australia or deprived communities in post-industrial Scotland, in terms of premature mortality, reduced healthy life expectancy, under-resourcing of health care relative to need, and difficulties of engagement, not only with patients but also practitioners.

There was a broad consensus that vertical, disease-based approaches which dominate most medical research, education, health policy, and global health initiatives, are unable to deliver the unconditional, local, person-centred, humane, continuity of care required by patients with multimorbidity. The defaults of centralisation, specialisation, and privatisation all lead in the wrong direction.

The challenge facing most countries is to develop effective, affordable, and sustainable ways of delivering such care, avoiding the fragmentation that has

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become so common. Dorairaj Prabhakaran and Sunil Abraham from India and Karen Sliwa from South Africa described simple solutions: holding clinics in the community rather than hospitals to reduce travel costs and applying smart phone technology to fill gaps in communication. Justin Bielby from Adelaide and Terry Findlay from the Australian GP Network discussed 'Medicare Locals'; the new Australian policy to link general practices with local communities. Everywhere there is a need to spend serial time with patients to work through problems, applying simple audits to measure omission, linking more effectively with community resources.

Whether addressing the initial challenge of hypertension control in developing countries or the integrated management of multimorbidity in developed countries, primary care systems vary hugely in the infrastructure, staff, and skills available to deliver personal care on a population basis. Shifts in resources are undoubtedly required. However, what also emerged from the symposium were a common cause between practitioners from many different countries; the need for a common language and shared experience in developing 'horizontal care'; recognition of the need for generalists and specialists to work together; and a clearer vision of the types of care that patients want and need to live better and longer with multiple morbidity in the community.

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DOI: 10.3399/bjgp13X660904

### REFERENCE

1. De Maeseneer J. James Mackenzie Lecture 2011: multimorbidity, goal-oriented care, and equity. *Br J Gen Pract* 2012; DOI: 10.3399/bjgp12X652553.