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**Strategic Review of Health Inequalities in England Post 2010 (Marmot Review):
An RCGP paper on the role of primary care in the reduction of health
inequalities**

1. The RCGP welcomes this opportunity to contribute to the Marmot review on a future strategy to address health inequalities.
2. The Royal College of General Practitioners is the largest membership organisation in the United Kingdom solely for GPs. It aims to encourage and maintain the highest standards of general medical practice and to act as the 'voice' of GPs on issues concerned with education, training, research, and clinical standards. Founded in 1952, the RCGP has over 37,000 members who are committed to improving patient care, developing their own skills and promoting general practice as a discipline.
3. Universally-available primary care is a mechanism for reducing health inequalities by providing **comprehensive, coordinated and longitudinal care** to people from their first point of contact with health services. The development of a good primary care system is recognised as a key action in reducing health inequalities in countries where it is not available.
4. General practitioners, alongside their teams, are the main providers of primary care in the UK. Every person who is resident in the UK is entitled to register with a general practitioner in order to obtain primary care.
5. Geographically, every community in the UK is covered by one or more general practices. As a result, primary care has a unique level of contact with the population of the country.
6. People in the UK identify their GP as their first port of call for and main source of health care. Registration with a general practice is key to accessing the comprehensive range of care available in the NHS.
7. Primary care in the UK is traditionally placed at the interface between the population and specialist health care services, acting as a gatekeeper, in a model that is understood internationally to be cost-effective, in comparison with systems with direct access to secondary care. Furthermore, recent health reforms have aimed to move more services from secondary to primary care, in order to bring care closer to patients and also to maximise cost-effectiveness.

8. Primary care has been involved in the commissioning function via GP fundholding in the early 1990s and subsequently via practice based commissioning.
9. Primary care is at the heart of health care in the UK, performing a complex range of roles, from provider of community and preventive health care to the management of long term conditions which used to occur in hospital outpatient departments, and in many areas retaining the urgent care function, in addition to a commissioning function.
10. Embedded as they are within communities, general practices act as a natural hub for person-centred services. People seeking help in a range of domains often come to their GP first and need to be redirected to other agencies. For people with complex and multiple needs, it usually falls to the GP or primary care team member to perform the signposting and coordinating function, particularly within the health system but often beyond.
11. Another consequence of this embeddedness is that practices are affected by the same social determinants of health inequalities that affect their patients. A poor built environment, substandard housing, failing education, unemployment, high levels of mental illness, increased levels of violence and social exclusion will impact negatively on the practice team caring for the population, as well as on the population itself, unless specific measures are undertaken to prevent this from occurring. It is no surprise that areas of high deprivation are also those in which it is unpopular to work as a GP. Higher rates of staff turnover, low morale and burnout result in lack of continuity in these 'underdoctored' areas, a term which disguises the true level of understaffing by not acknowledging the concomitant under-provision in other members of the primary care team.
12. Pioneering GPs and teams have developed innovative services for, excluded groups, within the NHS. Many of these teams now face the challenge of having to tender for their services as Primary Care Trusts (PCTs) shed their provider responsibilities. These tendering processes are time-consuming, disruptive and stressful and are subject to a range of unintended consequences.
13. Marmot observed in the World Health Organisation (WHO) Commission on Social Determinants of Health (CSDH) paper that the effects of primary care are frequently taken for granted and fail to attract much attention when it comes to policy and research. This has the unfortunate result that the potential for additional refinement or reform of primary care in order to address health inequalities is not recognised. Additionally, the ways in which the current primary care system fails to address health inequality are not uncovered and rectified.
14. **This submission to the Review will attempt to highlight the role of primary care in the reduction of health inequalities and to outline how developing structures and capabilities for inclusive practice within primary care can help to address the social determinants of health inequalities, thus reducing inequities in the lives and health of their communities.**

How does primary care address health inequalities?

15. As observed by the Review, primary care does much to address health inequalities, through providing universal access to a range of health promotion and disease prevention activities.
 - GPs undertake population-based screening and immunisation programmes on behalf of the NHS.

- GPs provide sickness certification and as such participate in the issue of employment.
- GPs are often the first port of call when a patient runs into problems with the benefit system, usually with a request for advocacy of some kind, usually in the form of a letter.
- GPs see children and young people as part of their overall remit as family physicians and can be involved in the child health screening and in the education system, especially when there are special needs or a child has a physical or psychological problems. Some GPs also participate more formally in school health and adolescent health schemes in their areas.
- Sexual health, preconceptual and antenatal care and health visiting are based in and involve primary care, thus putting the GP and practice staff in the frontline of addressing early years and maternal health care.
- Long term conditions are increasingly managed in primary care. Although this trend has been developing over the last 30 years, the Quality and Outcomes Framework (QOF) has resulted in unprecedented systemisation of practice based and external monitoring of this care. It has also led to improvements in some parameters of long term condition management which have been more marked in deprived areas than in more affluent areas i.e. an element of catch up has occurred.
- Primary care is responsible for much of the prescribing of medications within the NHS. As such, there is an increasing awareness of the issue of difficulty of affording prescriptions for people with long term conditions that do not attract exemption from prescription charges. The RCGP supports the introduction of free prescriptions in the NHS, which would have the effect of reducing inequality in affordability of treatment.
- Primary care is in contact with and manages the vast majority of mental ill health within the community. Poor mental health lies behind most behaviourally related disease, and affects many people with long term conditions. Much of this poor mental health is socially determined and improving the understanding of this issue within the health system as well as enhancing the resources available to address the social determinants of poor mental health could have enormous potential to address health inequalities.
- It is known that many people with mental illness do not attend secondary mental health services, and that a large factor behind this is stigma¹. Closer working between psychiatric services and primary care and bringing care closer to the patient, has helped to overcome this issue in areas where it has occurred, and has the potential to simultaneously overcome the great problem of untreated physical illness in people with mental illness.
- GPs and primary care teams would benefit greatly from the provision of resources to work more positively with issues around mental health, and from training in 'psychological mindedness' in order to protect their own wellbeing.
- Excellent work has been undertaken by members of the joint forum established between the RCGP and the Royal College of Psychiatrists (RCPsych). Examples such as the Mental Health Promotion Toolkit² and the Mental Health Toolkit for Offenders³ highlight the huge potential for

¹ Kohn R, Saxena S, Levee I et al(2004) The treatment gap in mental health care Bulletin of the World Health Organisation 82: 858-66

² <http://www.wmrdc.org.uk/silo/files/mental-health-promotion-toolkit.pdf>

³ <http://www.its-services.org.uk/silo/files/coverv2.pdf>

addressing the health inequality issues, which exist around mental health which exist around primary care.

- Health checks for people with serious mental illness have become part of QOF but should of course be extended to other people with mental health issues who are not on the register, for instance people with personality disorder, who arguably suffer some of the worst health inequalities of all. This is an example of where privileging treatment of people with certain conditions through the QOF mechanism can lead to people with other conditions being at risk of inequity.
- Health checks for people with intellectual disability have recently been introduced as a direct enhanced service within primary care. However, it was introduced as a direct enhanced service meaning that not all practices have to offer the health checks, which we understand to have led to patchy coverage of patients in the first few months. Offering a choice as to whether or not to provide this kind of public health intervention risks inequitable provision and further compounding existing inequity. Those responsible for negotiating primary health care contracts must be aware of the health inequality impact of their decisions
- In recent years, primary care teams, mostly trained through the RGCP, have taken on the management of substance misuse in primary care via shared care arrangements in partnership with local mental health trusts and drug action teams, thus providing non-stigmatising care integrated with primary care for a large proportion of those seeking treatment for substance misuse.
- Individuals within primary care have been motivated to offer tailored services to particularly disadvantaged groups, such as homeless people, refugees and asylum seekers, gypsies and travellers etc., a development which was greatly aided by the advent of the Personal Medical Service (PMS) pilots in the late 1990s and which is now struggling to survive the process of shedding of provider services by PCTs.
- Since the transfer of prison health by PCTs, GPs have been the chief providers of health care for offenders, with resulting opportunities for addressing the huge health inequalities that exist within this group.
- Primary care is an important employer within communities, offering stable jobs, usually (to date) with a pension, and, as a sector, can have a small but significant effect on their local economy.

16. All of this occurs despite the fact that addressing health inequalities is not actually seen as core activity for the majority of Primary Care Organisations (PCOs) or GPs. As described in the task group report on QOF, most GPs do not see addressing social determinants of health inequality as their role; at best they may realise that they should not, by their actions, make things worse.

17. Negotiations around introduction of changes in terms of service for General Medical Services (GMS) GPs (including negotiations around QOF) have to be undertaken with care and the negotiation process itself carries a risk of failing to prioritise the addressing of health inequalities. This could potentially be overcome by use of local enhanced services, provided to a set of well-designed standards, ensuring quality provision is available across the UK.

18. Thus, primary care already operates in upstream, midstream and downstream functions, and is active in a significant proportion of the areas which the Review has identified as areas where strategies need to be implemented in order to obtain reductions in health inequality.

19. Effecting a change of culture within health care generally, and within primary care in particular whereby equity sits alongside quality as a key standard, could potentially have a huge impact on the effectiveness of the NHS in reducing health inequalities as it could enable the benefits of these activities to be available more consistently for the whole population.

Developing a culture of inclusive practice

20. The NHS is said to provide universal access to health care in the UK. Based on this assertion, some assume that any differences in accessing health care must be due to deficiencies in the patient rather than deficiencies in the accessibility of the system. Dixon-Woods, in her review of health care for excluded groups⁴, challenges this assumption, stating that failure to engage with a service should be considered as a deficiency of the service rather than of the client. Services should be provided which empower and enable people to use them.
21. Primary care, along with the rest of the NHS, has taken on board the diversity agenda and has undergone various education, training and monitoring interventions in order to deliver the agenda. It is now inconceivable that a person would be turned away from care because of, for example, their race or sexual preference.
22. However, the culture of inclusiveness does not extend to people who are perceived as difficult or challenging to treat. Stigmatising attitudes and behaviours persist towards a number of groups including homeless people, people with addictions or mental illness and migrant populations, particularly those who do not speak English.
23. The Care Services Improvement Partnership (CSIP) produced a useful document outlining competencies for inclusive practice aimed at the mental health setting.⁵ However, the document is just as relevant to other health and social care settings. Interestingly, it outlines not only characteristics of the individual worker but also those of the organisation within which (s)he works which help to promote inclusive working practices.
24. Introducing inclusive practice capabilities into the NHS as a whole, and into primary care in particular, could have a profound effect on the accessibility and acceptability of services to all members of the population, thus reducing the element of health inequality that arises from stigmatising attitudes and exclusion from services.
25. Inclusive practice should to be introduced into training programmes and continuing professional development for all health and social care professionals. The General Medical Council (GMC), in its current revision of 'Tomorrow's Doctors'⁶ has included in the draft document mention of health inequalities for the first time, which is welcome development which can be built upon.

⁴ Dixon-Woods, M. *et al. Vulnerable Groups and Access to Healthcare: a critical interpretive review.* Report from the National Co-ordinating Centre for NHS Service Delivery and Organisation R & D (NCCSDO). NCCSDO: London

⁵ <http://www.nmhd.org.uk/silo/files/dh-2007-capabilities-for-inclusive-practice.pdf>

⁶ General Medical Council (GMC): *Tomorrow's Doctors (2009)*: http://www.gmc-uk.org/education/undergraduate/undergraduate_policy/tomorrows_doctors/tomorrows_doctors_2009.asp

26. The Health Inequalities Standing Group (HISG) of the RCGP has taken as its theme for 2010, the issue of health inequalities in the curriculum and is planning a range of activities to develop this area in both undergraduate medical studies and in GP vocational training.

Addressing the social determinants of health inequality by social prescribing

27. An inclusive style of practice will go a long way to prevent making health inequalities worse, by reducing negative attitudes and behaviour.

28. However, to quote one of the overarching conclusions of the Social Inclusion Task Group of the Review: “groups who are more severely affected by exclusionary processes and their problems are not effectively addressed by our society, which largely caters for the contented and conformist “.⁷

29. The standard model of primary care in the UK is designed to operate well for educated, motivated and organised people with a stable address, who have the time and resources to overcome any barriers to access, who attend appointments on time, who present promptly with symptoms, respond to call and recall, who take their medication as prescribed and so on.

- However, for those who are “affected by exclusionary processes”, the standard model of primary care does not work so well. This is less because the standard structures of primary care do not work for the more excluded.
- Firstly, it is not safe to assume that registration with a general practice is universally available to all. There are a number of groups who are a risk of refusal for registration. Increasingly, we are seeing general practices asking for identification with proof of address in order to register with the practice. This discriminates against those with unstable accommodation and means that homeless and insecurely housed people have difficulty obtaining primary care.
- Secondly, there have been moves to refuse NHS care to failed asylum seekers. The RCGP have issued a statement opposing such a move.⁸
- Thirdly, some PCTs have chosen to provide primary care services to certain groups by means of services that do not provide registration, either within walk-in services or other tailored services. This policy is in itself discriminatory as it suggests that the standard of comprehensive, coordinated and longitudinal care provided by a registered primary care service is not applicable to certain groups. This commissioning practice should be discouraged.

30. People who are experiencing exclusion tend to have a large range of compelling needs across the social determinants, for which they frequently present to

⁷ Marmot Review: Report of Task Group 9 – Social Inclusion and Social Mobility (June 2009)
http://www.ucl.ac.uk/ghcg/marmotreview/consultation/Social_inclusion_and_social_mobility_report

⁸ RCGP: Position Statement on Failed Asylum Seekers / Vulnerable Migrants and Access to Primary Care (2008):
http://www.rcgp.org.uk/news_and_events/college_viewpoint/position_statements/failed_asylum_seekers.aspx

primary care, and for which standard primary care does not have a response. This results in frustration and difficulty for patient and health care professional alike.

31. Facilitated access via primary care to interventions which address the social determinants could revolutionise the health and wellbeing of people who are experiencing exclusionary processes, and the working lives of those who provide their health care.
32. The overall term for this process is social prescribing. It is well described in a document by Dr Lynne Friedli for CSIP as a mechanism for addressing mental health and well being but is equally applicable to physical health and wellbeing.
 - Friedli describes social prescribing as “a mechanism for linking patients with non-medical sources of support within the community. These might include opportunities for arts and creativity, physical activity, learning new skills, volunteering, mutual aid, befriending and self-help... [as well as] support with, for example, employment, benefits, housing, debt, legal advice, or parenting problems.”⁹ Social prescribing is usually delivered via primary care – for example, through ‘exercise on prescription’ or ‘prescription for learning’. However, there is a range of different models and referral options.
 - There are numerous schemes whereby various elements of social prescribing have been made available in local areas. However, there has yet to be a national mechanism to enable social prescribing to be available to all.
 - There is a potential here to obtain an impact in terms of health inequalities by differential introduction of such schemes according to need, with greater funding given to areas with the greatest inequalities but a duty to ensure that those who experience exclusion within more affluent communities have access to the same benefits.
 - Many, if not all, of the resources which would benefit communities and individuals, and could be the object of social prescribing, are already funded, many via local authority budgets. The challenge in introducing social prescribing would be to facilitate access to and coordination of activities and services, and to negotiate the budgets from which the funding was to be drawn in future. This would be a key task for Local Authority (LA) / PCT partnerships and could ultimately improve the commissioning of such services.
 - Inreach of employment, benefit, housing and debt advisers or “vocational advisers” working within primary care, rather than parallel to it, could lead to better communication and understanding between welfare agencies and primary care, with the potential for better and timelier outcomes for patients.
 - Generic health trainers are another mechanism whereby elements of social prescribing can be coordinated and delivered. Close working with the local community and third sector organisations and recruitment and training of local people as generic coordinators / trainers could have benefits in terms of effectiveness and also providing access to ‘good work’.

⁹ Friedli, L., Watson, S. *Social prescribing for mental health* (Northern Centre for Mental Health and the Scottish Development Centre (2007)

33. Introducing social prescribing and attached advisers to primary care would be seen as a benefit to GPs and their teams, who currently struggle to address the distress caused by the social determinants of ill health, without having the resources to do so.
34. As well as provision of on-site or closely networked advisers, the potential for IT driven social prescriptions, which interact with the GP clinical systems, such as provision of up-to-date printed information, introductions to local groups and facilities etc, is enormous. We are only aware of one PCT where this is being piloted in a very early version but feel that this is a proposition that is well worth developing.

Primary care and work

35. GPs have a key role in the interface between patients and employment, as has been highlighted in Dame Carole Black's recent review of Health and Work.¹⁰
36. They are the initial providers of advice if an employed person is sick, regarding ability to work, and providing certification, which is essential in the administration of statutory sick pay.
37. They are also often called upon to advise on capacity to work for people deemed unfit to work on a long-term basis, via the newer Employment Support Allowance mechanism.
38. GPs additionally perform a number of medical reports around specific work related licences, in particular in relation to driving.
39. Traditionally, GPs have not had anything other than basic training in occupational health and opportunities have therefore been missed for effective occupational health interventions within primary care in the context of the provision of sick certification, which could have impacts on health inequality through increasing access to work.
40. Access to occupational health skills within primary care could be of benefit to patients, especially if these result in obtaining 'good work'.
41. The impact of proposed changes to the sickness certification system, in particular the change of emphasis from 'sick notes' to 'fit notes' is yet to be seen, with pilots due to start soon.
42. The RCGP has been awarded a contract by the Department for Work and Pensions to provide support to doctors in the management of patients with health and work issues, particularly to help these patients stay in work or return to work. A National Education Programme of half-day workshops is currently being rolled out throughout the UK to help GPs increase their knowledge, skills and confidence in dealing with clinical issues relating to work and health.
43. The closer liaison that would be possible if Jobcentre Plus engaged more directly within primary care, perhaps with onsite advisers, would benefit patients who required a more staged return to work.

¹⁰ Dame Carole Black's Review of the health of Britain's working age population (March 2008): <http://www.workingforhealth.gov.uk/documents/working-for-a-healthier-tomorrow-tagged.pdf>

44. One of the greatest benefits would be a simplification of the benefit system and the removal of the cliff edge nature of the current return to work process.

Primary care and community engagement

45. Community engagement can serve as an important lever to reducing health inequalities by influencing service provision. This often operates best in small localities and in this context, the involvement of primary care practices is essential, both because of the previously mentioned focal position of GPs around health in the community, but also, because not involving primary care is likely to reduce the effectiveness of any intervention.
46. The Review Team may be aware of models such as those supported by the Improvement and Development Agency (IDeA) or the Healthy Communities Collaborative Model used by the Improvement Foundation which involves primary care with local people by providing education about health problems, taking on board local intelligence around that problem, designing small scale interventions, and undertaking and evaluating actions. Success in such interventions raises the community's appetite to take on new topics and the process is repeated.
47. Opportunities to develop community engagement initiatives around places such as schools, playgroups, day centre, pubs etc etc. could encourage a more settings-based approach to health promotion.
48. Benefits to the community could potentially extend well beyond the original target topic, through increased empowerment, confidence and skills among individual members of the community, leading to other opportunities in education or employment and many positive real life changes and improvements for the community as a whole.
49. Benefits to the practice could include reductions in locally-driven stressors and their knock-on effects for staff and patients alike, and the availability of volunteers who may well be able to assist in the work of the practice in various areas of health promotion and chronic disease management activity.
50. Other models, such as the Healthy Living Centre at Bromley-by-Bow, have literally hundreds of community engagement projects running alongside the primary care centre. These provide opportunities for social prescribing for the practice, as well as the physical, aesthetic and financial benefits of co-location with this community venue. While it may not be realistic to replicate this model in all areas, it should certainly be achievable to create a local healthy living hub for each disadvantaged area, to support primary care in addressing the social determinants and providing effective coordinated social prescribing.
51. **Offering GPs the opportunity to enhance practice income via development of such locally-driven community engagement initiatives could be a way of addressing the social determinants of health inequalities which is distinct from the biomedical reductionist scope of the QOF.**
52. Support and training in community development techniques for primary care teams may need to be offered, in order to maximise the impact of such initiatives.

53. The responsibility for local provider development is a key responsibility for PCTs and is written into the world class commissioning responsibilities. In a recession, it will be essential for PCTs to make better use of local resources and expertise rather than to rely on external agencies and 'solutions' offered by multinational organisations.

Alternative models of primary care for excluded groups

54. As described above, various models of primary care for excluded groups have developed through the flexibilities afforded initially by the PMS pilots.
55. These range from tailored services for groups such as homeless people offering full registration plus a range of additional services such as podiatry, dentistry, on site addiction services and in-reach from secondary mental health care, to practices which cater for a range of excluded groups, whilst also offering 'ordinary' GMS, to settings based approaches where members of the primary care team attend settings where excluded individuals are to be found and offer health care and advice.
56. The pattern of the service provision depends on the skills and availability / attitudes of local services, with the primary care services usually adapting to 'close the gap' between need and availability.
57. Little if any research has been performed to evaluate these services although we are aware that the Health Technology Assessment (HTA) programme has been considering looking at homeless health care. In addition, groups in Liverpool and Manchester are undertaking academic work in this area.
58. Commissioning expertise in this area is extremely limited. Many practices which have undergone tendering processes have felt that the understanding by PCT commissioners of the services they need to procure is poor and that they do not tend to involve the practices who have been performing the service to date in designing the tender. The consequences of these processes are yet to become clear as many of these tenders have only been procured in the last year.
59. Funding methods for these kinds of practice vary but usually depend on the negotiation of a local contract or the addition of a local enhanced service to a GMS contract.
60. The introduction of a weighted capitation formula for certain excluded groups might be an alternative way of encouraging registration of people with complex and multiple needs within mainstream primary care. This is essential in areas where there is not a large cohort of socially excluded people, and where bespoke provision might not be cost-effective. The level of weighting and the monitoring requirements would be key to the success of such an initiative, as would ensuring that the practices had access to the range of care pathways required by such excluded groups.
61. We are aware that one of the Associate Directors of Primary Care at the Department of Health is working on commissioning guidance for a innovative model of primary care for excluded people which includes the concept of social prescribing and co-located / closely networked welfare advisers, as well as in-reach / out-reach from secondary care and into settings such as prisons / schools

/ daycentres / accommodation etc. Development of these practices would help to establish the required pathways for management of excluded groups.

62. We feel that the introduction of such facilities and resources within areas of deprivation, involving existing staff in their development, could revitalise and provide much needed support and improved morale for existing primary care teams and would enable improved recruitment of additional staff to work in such areas, helping to solve the problem of 'underdoctoring' in a creative, inclusive and positive manner.

Complex adaptive systems for people with complex problems

63. The Review helpfully highlights the importance of privileging complex adaptive systems over reductionist linear models of health care.
64. Nowhere is this more relevant than in the care of the people who experience the greatest health inequalities. Almost without exception, these are people who have to contend with a range of social and health issues, and who find it extremely difficult to access services which can address all their issues.
65. Such patients have to decide which issues to prioritise and frequently, health is neglected until it is so critical that it cannot be ignored.
66. When they do access health it is via low threshold services such as emergency departments or primary care. The more complex their cocktail of needs, the less likely it is that they will access specialist care for any of them.
67. This results in primary care 'doing its best' to manage extremely complex patients with combinations of conditions for which there is no evidence base to guide care. This may be in fact the preferred model, emphasising the value of the generalist with excellent consultation skills and the ability to manage uncertainty.
68. Historically, informal help may have been sought from specialist colleagues where necessary, but this is increasingly difficult due to the intervention of referral centres into the referral process, and also due to the advent of Payment by Results.
69. The document, "Teams without Walls"¹¹ written by the RCGP and RCP and endorsed by the NHS Alliance, seeks to address this issue and to promote a model of integration of primary and secondary health care based on clinical collaboration, rather than inter-organisational competition.
70. The "Teams without Walls" concept would allow primary care and specialists to liaise in such a way as to design local services to address health inequalities in the locality, and to enable GPs and primary care teams to provide the best possible care to the most complex and chaotic of patients, thus minimising the impact of their socially determined inequalities on the quality of their health care.
71. Such approaches could automatically address the problem of untreated mental illness in people with physical illness and untreated physical illness in people with

¹¹ *Teams without Walls: the value of medical innovation and leadership* (RCGP & RCP, 2008)
<http://www.rcplondon.ac.uk/professional-Issues/Documents/teams-without-walls.pdf>

mental illness, by breaking down the silos and allowing the more holistic approach, which is characteristic of complex adaptive systems.

72. The Department of Health has developed a range of pilots for integrated care which are due to report in several years time. Although it is encouraging that wide scale reform is not being introduced on this occasion without piloting, five years seems a long time to wait before any efforts are made in integration of services on a wider scale. "Teams without Walls" identifies several hundred different examples of integration across the UK which are working within our current system, and which could be emulated more widely within a shorter timescale.

Conclusion

73. The ten-year period during which this Review is intended to address health inequalities is likely to be a time of extraordinary fiscal pressure. This means that methods need to be developed to address the social determinants of health inequality that maximise the utility of the currently available workforce and infrastructure.
74. The primary care workforce is the largest in the NHS, has the greatest interface with the UK population, when it comes to health related contacts, and has a track record of adaptability and achievement.
75. It therefore follows that any implementation of proposals to address health inequality need to make maximal use of the available energy and expertise in the primary care field.
76. A strategy which gives primary care the tools to address the social determinants of health via social prescribing, community development initiatives and innovative collaboration with secondary care and welfare agencies will not only empower primary care teams to address the health inequalities in their communities, but also empower the communities themselves.
77. Encouraging activity in this area within primary care by the provision of training, facilitative staff, tailored services where required and funding for initiatives would offer an alternative incentivisation model to complement the more biomedical model of the QOF, and has the potential to concentrate resources in the localities which need most input around health inequalities.
78. It also has the potential to achieve many of the public health priority aims identified by the Review through ensuring that comprehensive, coordinated and longitudinal primary care is offered to within a model which enables clinical staff to work appropriately with clients who are more socially excluded and by acting as a focus for and coordinating community engagement.
79. In preparing this paper, we have become aware of a wealth of practitioners within primary care with valuable insights and expertise in this area. It has not been possible within the timeframe to maximise the value of their potential contributions.
80. **We would like to propose that, should the Review feel it appropriate or feasible, a formal mechanism be developed in order ensure that the full potential contribution of primary care to the Review is realised. We would**

value the opportunity to discuss ways in which this aspiration could be operationalised.

Post script

81. It is remarkable that the role of social services has not arisen during this paper. This is symptomatic of the extent to which social services and primary health services run parallel to each other rather than cooperatively.
82. Access to help from social workers is so limited that many primary care staff now rarely making referrals, except in the case of child or vulnerable adult protection or extreme disability.
83. The situation is particularly acute for individuals with a complex range of needs which add up to significant vulnerability but none of which individually reach the threshold for triggering a social services response.
84. Alternative methods of obtaining support, for instance by signposting to voluntary sector agencies and faith groups, are often the only way in which primary care can help individuals to address these complex and multiple needs. Such peer support models, with the skills and competencies they embody, should be a key component of the care available, but staff and volunteers should always have access to appropriate support and supervision themselves, as part of a care network.
85. Systemic change to deliver improved joint working between primary care and social services, and the recognition of complex and multiple needs, perhaps via a cumulative scoring system, within the accessibility criteria for social services could result in improved availability of services which address the social determinants of health inequality.

Acknowledgement

86. I would like to thank Dr Angela Jones, Chair of the RCGP Health Inequalities Standing Group, for producing this paper.

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