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Guest editorial

Is it time to take primary care seriously in redressing health inequalities?

Zafar Iqbal
Deputy Director of Public Health, NHS Stoke on Trent, UK; Visiting Professor, Staffordshire University, UK

Ruth Chambers
General Practitioner and Honorary Professor of Primary Care, Staffordshire University, UK

Despite successive public health white papers, health inequalities are still widening in the UK and the government admits that policies have not worked sufficiently to achieve targets to reduce health inequalities.[1] The latest statistics for obesity, smoking habits, alcohol misuse and inactivity levels in the population of the UK are worse for particular subgroups of people such as teenagers, various ethnic groups, impoverished people, and those with mental health problems.[2]

The World Health Organization (WHO) Commission for Social Determinants of Health considers that social injustice is killing people on a grand scale, and makes a powerful case for tackling social determinants of health, in both developed and developing countries.[3] The report also recognises the value that the health sector can have in addressing inequalities and emphasises the crucial role of primary care services in reducing inequalities.

So how should we proceed? Can we realistically expect the health of the poorest populations in the UK to improve at a faster rate than those who are better off in the era of the 'credit crunch' and a stalling economy? Has the national strategy sufficiently engaged the health sector and frontline clinicians in minimising health inequalities? What does reducing health inequalities mean to frontline primary care clinicians? Do clinicians view addressing health inequalities as someone else's problem, while they deal with the social and health consequences of widening health inequalities?

The current target-based approach to primary care interventions in the UK has not achieved what it might have done. This is partly because the Quality and Outcomes Framework (QOF) was not designed to reduce health inequalities and is confined to delivery of health care rather than being focused on the wider determinants of health.[4]

In order to make an impact on health inequalities, we must optimise the potentially powerful collaboration of public health and primary care providers, and engage frontline clinicians. Primary care in particular offers previously unexploited opportunities to tackle both health and social inequalities. Historically, screening and immunisation programmes show the poorest uptake amongst disadvantaged communities, but the overall impact of these programmes has been to reduce health inequalities. There have been promising improvements in recent years in related areas in general medical practices across the UK, bringing about the steady decline in prevalence of cardiovascular disease, and improvements in the management of hypertension, secondary prevention of heart disease and smoking cessation.[1] Analyses of national QOF data indicate that the greatest benefits have been achieved by those general practices serving the most deprived areas because of their low baselines, although the pace of change has been slow and general practices serving deprived communities still attain the lowest scores.[5] There are also concerns that the system of exception reporting for QOF is having an adverse impact on deprived populations and increasing inequalities, because it is all too easy to exclude the hardest to reach patients who are the ones who might benefit most from good quality care of their long-term condition.[6]

Primary care has a crucial role in the effective management of chronic illnesses that impact on life expectancy such as cardiovascular disease (CVD), diabetes and chronic obstructive pulmonary disease. While impressive progress has been made towards secondary prevention of CVD, there is considerable potential to improve patient concordance with aspirin and statin use, particularly in deprived populations. There are enormous variations in disease attainment on practice-based disease registers. For example, diabetes care standards vary considerably within primary care, with differences in recording of prevalence on practice registers and diverse associated outcomes such as management of hypertension and lowering of glycosylated haemoglobin values.[7] Some practice teams actively seek to diagnose patients previously unknown to have

long-term conditions such as chronic heart failure, diabetes, or chronic obstructive pulmonary disease (COPD), and are scrupulous about adding newly diagnosed patients to their practice disease registers and undertaking comprehensive structured annual reviews, whereas other practices have lax systems, and are not penalised financially for poor performance.

Despite a strong evidence base for almost a decade, progress in the primary prevention of CVD has been negligible. The National Service Framework standard on primary prevention has largely been ignored and a systematic approach remains absent in the QOF, mainly because it has been difficult to implement. The general practices that are least likely to be undertaking primary prevention in a systematic way are those serving disadvantaged populations. But there are now grounds for optimism, with progress in information technology and a firm evidence base supported by the National Institute for Health and Clinical Excellence.[8] Implementing primary prevention should be a much higher priority over and above the introduction of population-based vascular checks, with a comprehensive system in place to tackle unhealthy lifestyles identified through the programme.[9] The recent House of Commons Health Committee report on health inequalities urges caution on implementing programmes like vascular checks without designing an evaluation framework at the outset.[10] General practices cannot undertake the NHS Health Check programme of screening all adults aged 40–75 years unaided, without a range of lifestyle support services to which to refer patients identified as being at relatively high CVD risk. Public health must take a lead in making such local services easily accessible to those with need, along with primary care organisations (PCOs), local councils and the voluntary sector.

Primary care has an important role in assessing individuals' readiness to change behaviour and providing appropriate brief interventions for a number of unhealthy lifestyle habits such as smoking, excess alcohol intake and too little physical activity. Clinicians are often poorly motivated to undertake these interventions because of low success rates in changing behaviour or attitudes. However, these low outcomes translate into large year-on-year cumulative public health benefits if the brief interventions are applied systematically across populations, particularly for smoking, alcohol and physical activity. There are large variations in smoking quit rates.[11] If best practice in smoking cessation was applied systematically in deprived areas, then this would make a significant public health contribution towards reducing health inequalities. The health service does not routinely collate data on clinician and practice referral rates to smoking cessation services or one-year quit rates. The importance of the latter is demonstrated by the recently published data collated through the Patients' Survey as to the proportion of patients who have been offered advice about smoking and alcohol by primary care clinicians.[12]

The QOF is leading to disease care at the expense of provision of a holistic approach towards the patient where personalised patient care is organised along integrated health, social and welfare pathways. An even more significant failing of the QOF is the lack of focus on patient groups who do not fit into QOF disease categories, but have complex social and health care needs, such as those with learning disability.

So can general practice teams make a significant impact on the social determinants of health? There have been several studies examining the advantages of providing welfare benefits advice in close proximity to primary care settings to improve uptake of financial benefits with a consequent reduction in poverty.[13,14] Primary care is in an ideal position from which to provide, or direct those in the greatest need to, structured services for a range of social issues including welfare services, housing services, counselling (in particular to address loneliness) and job centres.[15] PCOs, particularly those serving deprived populations, need to provide a range of accessible services to which those working in primary care can refer, thinking more widely than they have done in the past about how to meet the needs and preferences of particular subgroups of their patient population. In return, primary care professionals need to have full ownership of the biopsychosocial model of health, collate socio-economic data, and ensure that their patients receive the more structured care that Tudor Hart has advocated for the last 30 years or so.[16] It is time to 'take primary care seriously' in the battle against social and health inequalities.[17]

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PEER REVIEW

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CONFLICTS OF INTEREST

None.

ADDRESS FOR CORRESPONDENCE

Zafar Iqbal, Heron House, 120 Grove Road, Fenton, Stoke on Trent ST4 4LX, UK. Tel: +44 (0)1782 298130; fax: +44 (0)1782 298135; email: zafar.iqbal@stoke.nhs.uk

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