## Leveraging primary care to address social determinants

Our health systems are not fit for purpose. Although social determinants play a substantial part in health outcomes,[1] countries like England allocate less than 5% of staff and health spending to public health.[2,3] The illness-focused biomedical model has delivered substantial gains; however, in the era of preventable chronic multimorbidity, this calculus is less convincing. Boosting public health investment is important but recalibrating primary care systems to shift emphasis from reactive management to proactive prevention could also make a huge difference.

At a meeting held on July 2, 2018, in Oxford, UK, we explored barriers to and opportunities for integrating public health and primary care. Primary care professionals work in neighbourhoods and communities where social determinants manifest.[4] In many countries (ie, England, the Netherlands, and Belgium) they are responsible for health outcomes of listed populations, and the introduction of capitated payment incentivises keeping people well. Primary care teams have unparalleled data and good ethnographic knowledge of local disease, trends, and social drivers. Primary care professionals are well placed to support public health teams in assessing and addressing causes of disease.

In England, public health teams have insufficient resources to operate at the neighbourhood level, and austerity has led to many teams prioritising high-risk programmes over population-level interventions. Although family physicians have listed populations and capitated payment schemes, activity remains focused on managing individuals in the waiting room. Primary care teams have insufficient skills, time, training, and incentives, and the wrong mindset to address social determinants. Even when staff or commissioners understand that prevention can reduce demand of health-care services, improve outcomes, and save money, financial and workforce pressures[5] inhibit experimentation with new ways of working. Local health intelligence generated by public health teams is rarely used by primary care teams because of absent or inadequate handover mechanisms.

Several reforms would help to integrate specialties. The most fundamental conditions for integration are aligned system-level incentives: dedicated time, money, staff, training, targets, and technical support. Placing emphasis on social determinants of health during medical school and speciality training schemes and joint continued professional development sessions for working practitioners would build relationships and imbue a shared population mindset from the outset.

Specialties could be formally linked through shared budgets and responsibility for population health outcomes, as well as interoperable information systems. Like safeguarding leads, each medical practice or local network of doctors should have a named professional who is responsible for assessing local drivers of disease (by analysing practice data and gathering peer feedback) and liaising with public health colleagues to develop interventions aimed at local social determinants. This work requires commissioners to make additional resources available for primary care and to see beyond the next 3–5 years. Cities such as Ghent and Glasgow already provide multiple examples of practices hosting in-house community health workers.[6]

The original signatories of the Alma-Ata Declaration understood that primary care is strategically positioned to assess and address local social determinants of health. 40 years later, misaligned incentives have stopped primary care from reaching its potential in England. Although reform isn't cheap or easy, leveraging primary care to address community-level primary prevention could save money, reduce demand, and improve health outcomes. Futureproofing health systems begins with reorienting primary care.

I report funding from the Global Challenges Research Fund.

*Luke Allen*
**luke.allen@phc.ox.ac.uk**

Nuffield Department of Primary Care Health Sciences, University of Oxford, Oxford, OX2 6GG, UK



1 McGovern L, Miller G, Hughes-Cromwick P. Health Policy Brief: the relative contribution of multiple determinants to health outcomes. Aug 21, 2014. https://www.rwjf.org/content/dam/farm/reports/issue_briefs/2014/rwjf415185 (accessed Aug 13, 2018).

2 NHS Digital. NHS workforce statistics January 2018. April 24, 2018. https://digital.nhs.uk/data-and-information/publications/statistical/nhs-workforce-statistics/nhs-workforce-statistics---january-2018 (accessed Sept 5, 2018).

3 Office for National Statistics. UK Health Accounts 2016. April 25, 2018. https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthcaresystem (accessed Aug 13, 2018).

4 Kawachi I, Berkman LF. Neighbourhoods and health. New York: Oxford University Press, 2003.

5 Baird B, Charles A, Honeyman M, Maguire D, Das P. Understanding pressures in general practice. London: King's Fund, 2016.

6 Deep End Group. Deep End Report 32: 8 years of the Deep End Project. October 2017. https://www.gla.ac.uk/media/media_557259_en.pdf (accessed Aug 13, 2018).

See **Editorial** *Lancet* 2018; **391:** 1

For more on the **PrimaPrev Network** see www.primaprev.com

For the **Alma-Ata Declaration** see http://www.who.int/publications/almaata_declaration_en.pdf