meaning of 'context'? How can this be integrated in the care process? What is the relationship between contextual evidence and ethical issues? At the same time there is a need to assess whether or not the actual developments in health care (more market forces, pay-for-performance, outsourcing of care, diagnostic-treatment-combinations) contribute to the integration of 'contextual evidence'. There is need for guidance in the reflection on data and experiences, and there is a need for practices to implement the new knowledge. This may be an opportunity for interdisciplinary health centres to take the lead.

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REFERENCES

1. World Health Organization. *Declaration of Alma-Ata, International Conference on Primary Health Care, Alma-Ata, USSR, 6–12 September 1978*. Geneva: World Health Organization, 1978. http://www.who.int/hpr/NPH/docs/declaration_almaata.pdf (accessed 27 Nov 2009).
2. Mackenbach JP. *Health inequalities: Europe in profile. United Kingdom Presidency of the EU.* Rotterdam: Erasmus MC, 2006.
3. World Health Organization. *The World Health Report 2008, Primary Health Care: Now More Than Ever*. Geneva, World Health Organization, 2008 http://www.who.int/whr/2008/en/index.html (accessed 27 Nov 2009).
4. McWhinney IR. *A textbook of family medicine.* New York, NY: Oxford University Press, 1989.
5. Portes A. Social capital: its origins and applications in modern sociology. *Annu Rev Sociol* 1998; **24:** 1–24.
6. Putnam RD, Feldstein LM. *Better together. Restoring the American community*. New York, NY: Simon & Schuster, 2004.
7. Paes M. *Gezondheid op menselijke maat. Over de positie en rol van gezondheidscentra in achterstandswijken.* [Health in a human way. About the position and role of health centres in deprived neighbourhoods]. Zwolle: National Centre for Community Development, 1999.
8. Paes M. *Wijkgezondheidswerk. Een studie naar 25 jaar wijkgericht werken aan gezondheid in Den Bosch-Oost.* [Community based health work. A study of 25 years community based health approach in Den Bosch-Oost]. 's-Hertogenbosch, Provincial Council of Community Health and Social Care of Noord-Brabant, 2008.
9. Alting DEM, Bouwens J, Keijsers JEFEM. *Review: community-interventions*. Woerden: Netherlands Institute for Health Promotion and Disease Prevention (NIGZ), 2003.
10. Rhyne R, Bogue R, Kukulka G, Fulner H. *Community-oriented primary care: health care for the 21st century.* Washington, DC: American Association for Public Health, 1998.
11. Art B, Deroo L, De Maeseneer J. Towards unity for health: utilising community oriented primary care in education and practice. *Educ Health* 2007; **20(2):** 74.
12. De Maeseneer J, Willems S, De Sutter A, *et al.* Primary health care as a strategy for achieving equitable care: a literature review commissioned by the Health Systems Network of CSDH (Commission on Social Determinants of Health), 2007. http://www.who.int/social_determinants/resources/csdh_media/primary_health_care_2007_en.pdf (accessed 24 Nov 2009).
13. Duyvendak JW, Kremer M. *Policy, people and the new professional. De-professionalisation and re-professionalisation in care and welfare.* Amsterdam: Amsterdam University Press, 2006.
14. De Maeseneer JM, van Driel ML, Green LA, van Weel C. Translating research into practice 2: the need for research in primary care. *Lancet* 2003; **362**:1314–1319.

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COMMENTARY

Addressing the social and economic determinants of health is largely an upstream task, beyond the scope of practitioners working on the front line, even if as Henry E Sigerist wrote, 'they are well aware of the factors which confound all their efforts'.[1] What then is the role of GPs and family doctors in addressing the social and economic determinants of health? The usual answer ('not much') is insufficiently imagined. Primary care could do lots more.

First, although most clinical care needs to take account of the social context, this is most true and necessary for patients with multiple problems, as found particularly in deprived areas. Practitioners whose lives are separate from those of their patients are less likely to understand this context. There is a clear challenge for education, training, and continuing professional development.

Second, the social capital and trust that is built up via long-term relationships between practitioners and patients is a crucial resource when discussing preferences and choices, especially in old age, when the consequences of impersonal care may result in healthcare experiences and expenditure that no one really wants.

Thirdly, as populations get older, it is clear that the problems of looking after people cannot and should not be over-professionalised. While services may be resource poor, communities are potentially people rich. In facing the challenges of ageing populations, professionals need to work in new ways with communities, reducing professional distance, while increasing partnership and accountability.

In these ways, practitioners can be important social and economic determinants of health in the populations they serve. Whether they perceive themselves in this way, and provide examples such as those described by Paes and De Maeseneer,[2] and pioneered by the likes of Sam Everington[3] and Scott Murray[4] in the UK, depends less on their professional knowledge and expertise, than on their values, on how they see their professional role and on their relationships with patients and communities. As yet we have only a few wild flowers, but with time, imagination and effort, this part of primary care could surely bloom.

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REFERENCES

1. HE Sigerist. *Medicine and human welfare*. New Haven, CT: Yale University Press, 1941.
2. De Maeseneer J, Paes M. What about the context in family medicine? *Br J Gen Pract* 2010; **60**: 56–58.
3. Social Enterprise Ambassadors. Sam Everington. http://socialenterpriseambassadors.org.uk/ambassadors/ambassador-details?amb=37 (accessed 1 Dec 2009).
4. Murray SA, Graham LJC. Practice based needs assessment: use of four methods in a small neighbourhood. *BMJ* 1995; **310**:1443–1448.

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