strapped councils has to be changed if we still want to have our bins emptied, as well as care for frail older people.

The challenge for GP partners, as the power brokers in this, is to take action and make their practices ready now for integrated care; waiting for the next contract to sort it out will not make us fit for purpose quickly enough.

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Health inequalities in primary care: time to face justice

I read Dr Moscrop's review article regarding health inequalities in primary care¹ with interest. It is an excellent article that clearly distinguishes differences between inequities and inequalities. However, although the article attempts to raise awareness of health inequality to GPs in the wake of the Marmot report of 2010,² it did not highlight the 2-year update published by the UCL Institute of Health Equity in February 2012 which found that health inequalities had widened in most areas of England.³

The Equality Trust has been set up by authors of *The Spirit Level*⁴ to 'gain the widest public and political understanding of the harm caused by inequality'. The striking messages are that members of more equal societies tend to live longer, have less mental health illness, less illegal drug use, less obesity, and higher levels of trust, with lower rates of homicide, and childhood violence.⁵

People are not oblivious to rising inequality — a *Harris/Financial Times* poll in July 2007 found that 78% of responders felt that the gap between rich and poor was getting larger in Britain.⁶ I feel the challenge is to engage people to tackle the issues — my suggestion is that by ending the article with 'GPs (and GP leaders) surely have an obligation to take on ...' is vague, political rhetoric, and an abstract idea for most GPs.

In Scotland, work assessing ways to reduce inequalities includes the asset-based

approach, which combining social and health care, aims to improve the sense of control a person has over their life by empowering individuals and communities; data are being gathered that may provide evidence for the effectiveness of this approach in the longer term.⁷

I believe to narrow the unjust gap of health inequities the solution lies with the whole of society. Initially raising awareness of health inequality issues is important, this has partly been done by previous national press coverage. With greater public awareness it is likely that developing and implementing government policies to tackle underlying socioeconomic problems would stay a priority: this fundamentally needs to be addressed to solve this problem.

It has been written that 'Many of the policies and strategies designed to reduce inequalities appear to be beyond the scope of individual practitioners'.⁸ I suggest that individual GPs can tackle health inequalities by continuing to provide accurate tailored health promotion messages, signposting patients to local community groups and other relevant agencies (such as Citizens Advice Bureau). A job that I believe is done extremely well by the majority of dedicated GPs.

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Outside the Box: why are Cochrane reviews so boring?

Trish Greenhalgh asks why Cochrane reviews are so boring.¹ Strange that she should ask such a question on this particular platform. Many colleagues ask me the same question about the *BJGP* (identified as I am as the local RCGP stooge because of my varied faculty activities during the course of my career). My answer in both contexts is the same: of course they are boring to practitioners because the job of practitioners is (no surprises) to practice. Both Cochrane reviews and the research articles appearing in the *BJGP*, nevertheless, are essential to the progress of practical medicine. We turn to them when we need them.

To answer another question, I have read Cochrane reviews. Let me give the most recent occasion because the narrative illuminates the synergy between trial evidence and complex decisions. Faced with high rates of referral and surgery for carpal tunnel syndrome, our commissioning consortium sought to explore the alternatives. Many issues had to be taken into consideration: the influence of local expert opinion, secondary-care behaviour in the market, GPs' knowledge of the condition, whether GPs possess the skills for injection and last, but not least, whether splints and injections are effective and safe. My interpretation of the Cochrane reviews on the subject was that the evidence for the effectiveness of non-surgical interventions is weak. But they are safe. So what to do? In this complex situation, the decision to offer non-surgical intervention first line (with safety provisos for those with advanced disease) is sensible. Had the evidence been that non-surgical interventions only delayed surgery or were useless, such a decision would not have been sensible. The evidence was only one part, but a vital one, in the decision.

I do not find Greenhalgh's suggestion of a database of opinions and ideas at all 'outrageous' or even radical. It already exists, it is called the World Wide Web. You can use your favourite search engine to find opinions