Royal College of General Practitioners

Breaking the inverse care law in UK general practice

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Foreword

Prof Kamila Hawthorne, Chair RCGP

I am delighted to introduce this report on health inequalities, a crucial topic that lies at the heart of the College's strategic priorities but is also a personal mission. As a GP, I have witnessed firsthand the profound impact of social disadvantage on the health of individuals and communities. Therefore, I am acutely aware of the enduring barriers that stand in the way of achieving health equity for all and am committed to addressing this pressing issue. Professor Julian Tudor Hart, who first coined the phrase 'The Inverse Care Law' in the 1970s, also said that medicine, without a sense of social justice, is not medicine at all.

Addressing health inequalities has been a longstanding focus for the College, reflecting our unwavering commitment to ensuring equitable access to healthcare for all. We recognise that health disparities not only compromise the wellbeing of individuals but also undermine the integrity of our healthcare system as a whole, and our national productivity.

This report arrives at a critical juncture, amidst a backdrop of escalating social inequalities and a cost-of-living crisis gripping communities across the United Kingdom. As we navigate these turbulent times, it is imperative that we confront the stark reality of health inequalities with unwavering resolve and concerted action.

Drawing upon the expertise and dedication of our members, the report sheds light on the multifaceted nature of health disparities and the improvements needed to ensure that general practice as an anchor institution can lead on reducing health inequalities within our communities From service access and quality to the broader socioeconomic factors shaping individuals' life chances, the analysis underscores the urgent need for targeted interventions and systemic reforms.

As advocates for our patients, general practitioners play a pivotal role in addressing health inequalities. But social inequalities under pin health inequalities, and we can't eradicate the latter unless we address the former. If we do this, we can make significant strides towards narrowing the gap in health outcomes. In the meantime, we must do what we can with the limited resources we have in health.

Addressing health inequalities requires more than just the efforts of individual healthcare professionals. It demands systemic changes and the necessary support for practices in areas of deprivation, who work harder with less funding. As such, we call upon politicians, policymakers and healthcare leaders to join us in this vital endeavour.

As we confront the challenges posed by the current landscape of social and economic upheaval, we must draw strength from our shared values and collective determination to build a fairer and more inclusive society. Together, let us redouble our efforts to champion the cause of health equity and ensure that every individual has access to the healthcare they need and deserve, and ultimately, the opportunity to live a healthy and fulfilling life.

Executive summary

Since its foundation, the NHS has as a principle sought to provide the same high level of service to all. However, as repeatedly proven by research, access to healthcare has proved elusive for those who need it the most across the UK. Health inequalities have worsened further in recent years and tackling them has become one of the key challenges our health systems face now.

GPs have a pivotal role to play in addressing health inequalities as they witness first-hand, the health and social issues experienced by the most socioeconomically deprived communities. Deprived parts of the UK are significantly under-doctored, with practices in areas with the highest levels of income deprivation having on average 300 more patients per fully qualified GP than practices with the lowest levels of income deprivation.[1] This is compounded by the fact that after accounting for the increased workload associated with greater health needs in more deprived areas, GPs in deprived parts of England received 7% less funding per need-adjusted patient than GPs in affluent areas.[2]

This report analyses healthcare inequalities within general practice across all four nations of the UK and focuses on critical areas where improvements can be made: access to and navigation of healthcare services, equitable funding distribution, workforce development, data utilisation, and the impact of social determinants on our population's health. The following recommendations aim to foster more equitable and inclusive healthcare provision that can help reduce the health inequalities gap, specifically within the realm of general practice:

1 Access and navigation to healthcare services

- Access for all regardless of characteristics or deprivation level is a key aim of the UK health system, yet challenges persist for certain groups, especially in processes such as registration. Patients experiencing homelessness, for instance, are some of the most affected by this as they often struggle to provide a valid ID or proof of address. Similarly, data shows that certain segments of society are more likely to struggle to book and attend appointments with their practice across the UK.
- General practice staff interacting with patients along their healthcare journey should receive training packages that equip them with the skills and confidence to engage appropriately with all patient groups and provide tailored support.
- Technological improvements in general practice are positive but can potentially exacerbate inequalities, particularly for the elderly, rural communities, and inclusion health groups if not implemented appropriately. It is imperative to acknowledge the different levels of access to connectivity, digital tools, and digital literacy, and continue to support access to care through traditional routes where required.
- Continuity of care provides multiple benefits for patients' health outcomes and for practitioners, as well as having the potential to contribute to health inequalities reduction, particularly among inclusion health groups.

Recommendation:

- Policymakers, commissioners, and providers of health services across the UK should offer tailored support for socioeconomically deprived, underserved, and inclusion health groups, as part of efforts to improve patient access.

  This should include:

  - Streamlining registration and appointment booking processes further and ensuring the provision of multiple routes to meet different needs
  - Improved support for addressing patient barriers
  - Improving ongoing training and support for practice staff to provide inclusive and accessible care
  - Supporting continuity of care for those who need it alongside providing additional support to practices to enable this

2 Equitable distribution of resources

- Core funding formulas, such as Carr-Hill in England and Wales, which distribute resources across general practice have failed to reflect the impact of socioeconomic deprivation on health needs. Thus, diverse organisations have suggested reviewing and updating them, in order to better address the inverse care law and help achieve proportional universalism.
- There are other funding streams that enable practices to meet the needs of their patients, among them incentive schemes that require reaching targets. This can be particularly difficult for practices in areas of socioeconomic deprivation, where patients have more complex needs, resulting in lower funding coming through to practices.
- Local and regional structures across the UK have been entrusted with duties around health inequalities improvement but require ring-fenced and flexible funding support to accomplish them.
- Deep End projects have pioneered work on health inequality reduction in many parts of the UK, particularly in Scotland. The benefits of this could be spread by supporting and resourcing Deep End projects across the UK.

Recommendations:

- All general practice funding streams should be reviewed to better match resources with needs, in alignment with the principles of proportionate universalism, alongside increased investment across general practice.
- Ring-fenced and flexible funding should be allocated across the UK to all regional or locality-based structure levels in primary and community care to better respond to the needs of their populations and comply with their duties on health inequalities reduction.
- Governments across all four nations of the UK should commit ringfenced funding for Deep End projects, which bring together GPs working in areas of socioeconomic deprivation to identify practical ways to address health inequalities, and to learn from one another.

3 Workforce enhancement

- Workforce shortages are greater in rural, coastal, and socioeconomically deprived areas of the UK, compounding the fact that GPs across the board are overburdened, with many considering leaving the profession. The evidence emphasises the urgent need for increased support to expand recruitment and retention programmes for new and experienced GPs, especially in under-doctored and socioeconomically deprived areas.
- Similar challenges are experienced across the wider practice team. Roles such as mental health practitioners or social prescribing link workers can be beneficial in tackling the social determinants of health. However, in England, the current Primary Care Network (PCN) contract which supports the employment of these staff does not include weighting by population need or have mechanisms to ensure equitable distribution of new staff.
- To effectively address inequalities, new and experienced practitioners should receive appropriate training on health inequalities and social determinants of health. Similarly, there is a need for increasing general practice placements in socioeconomically deprived areas during undergraduate courses, which can be enhanced by strengthening and expanding health equity focused training programmes. This should be accompanied by an equitable distribution of GP training practices to address the inverse training law.

Recommendations:

Governments should evaluate existing GP recruitment and retention schemes across the UK to ensure they focus on supporting recruitment and retention in socioeconomically deprived areas and implement additional schemes where needed.

- Targeted and flexible funding should be provided for practices in areas of socioeconomic deprivation to recruit additional practice roles that have been shown to support the needs of those experiencing exclusion and health inequalities.
- Medical school curricula and training programmes for healthcare professionals across the UK should be reviewed to ensure curricula includes education on health inequalities and social determinants of health. In addition, support should be provided to expand health equity focused GP training programmes.
- Governments should expand training capacity in socioeconomically deprived areas by:
  - where possible, ensuring new medical schools are sited in areas of socio-economic deprivation, alongisde efforts to recruit medical students from these areas;
  - providing support to expand training capacity in practices in socioeconomically deprived areas so that more GP trainees can gain experience working in these environments.

4 Utilisation of data

- Population and health needs vary from one area to another. Thus, any initiative aiming to reduce inequalities requires a thorough assessment of those needs. Practices across the UK should have access to high-quality data and analytical tools to understand and analyse community health needs. This includes access to locally relevant data sets, analytical capacity within primary care, and staff training in data analysis.
- All national and local policies and programmes should be designed and implemented based on high-quality local and national data that assists in the identification of unmet needs and aids the improvement of resource allocation.

Recommendations:

- Ensure all practices across the UK have access to high-quality data and analytical tools that facilitate understanding of their community's health needs.
- All new health policies should be signed and implemented based on high-quality population health data and subject to a rigorous EQIA (equality health impact assessment) before they are rolled out, and monitoring and evaluation processes should be put in place to assess the impact and enable mitigation for any unintended consequences.

5 Impact of Social Determinants of Health

- It is clear that the root cause of ill health lies in the wider determinants of health, with research indicating 80% of health outcomes are determined by non-health related factors.
- GPs often hear of these issues in their patient consultations wherein employment, housing, and financial issues are amongst the most frequent non-health problems presented in general practice.
- Poverty, particularly child poverty, the cost-of-living crisis, housing issues, and unemployment/poor employment all have well-studied negative effects on population health. Addressing these systemic disparities is essential for reducing health inequalities.

Recommendations:

- Governments across the UK should produce a cross-government strategy to reduce health inequalities, which recognises and commits to reducing the impact of social determinants on population health, using every available policy lever and is underpinned by the necessary funding.
- Governments should prioritise and develop an integrated vision of child health and wellbeing. Governments of England, Scotland, and Northern Ireland should adopt a 'child health in all policies' approach, as has been done in Wales.
- Governments of England, Wales, and Scotland should commence the socio-economic inequality duty, section 1 of the Equality Act 2010.

By implementing these recommendations, politicians, policymakers, regional structures, and healthcare providers across the UK can take significant strides toward mitigating healthcare inequalities and fostering an inclusive and equitable healthcare system, responsive to the diverse and complex needs of the population served by general practice.

Glossary

Health inequalities: 'systematic, avoidable, and unfair differences in health outcomes that can be observed between populations, between social groups within the same population, or as a gradient across a population ranked by social position'.[3]

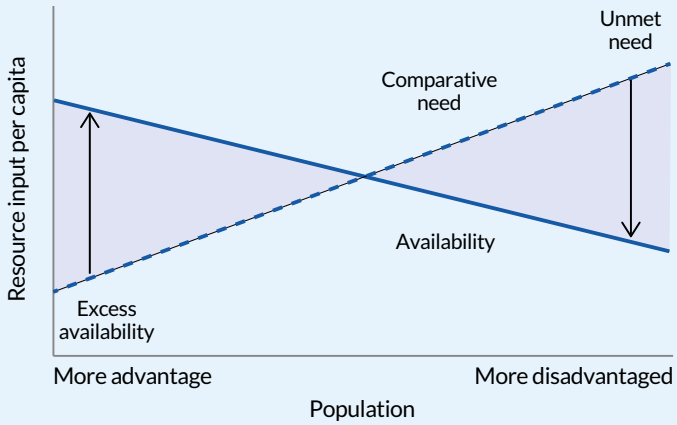
Examples of health inequalities are the differences in life expectancy at birth and health life expectancy:[4]

Nation	England	Wales	Scotland	Northern Ireland
Life expectancy at birth	9.7 years less for men and 8 years less for women in the most deprived areas, compared to the least	7.5 years less for men and 6.3 years less for women in the most deprived areas, compared to the least	13.7 years less for men and 10.5 years less for women in the most deprived areas, compared to the least	7 years less for men and 4.8 years less for women in the most deprived areas, compared to the least
Healthy Life expectancy	18.2 years less for men and 18.8 years less for women in the most deprived areas compared to the least	13.4 years less for men and 16.9 years less for women in the most deprived areas compared to the least	26 years less for men and 25 years less for women in the most deprived areas compared to the least	13.5 years less for men and 15.4 years less for women in the most deprived areas compared to the least

Inclusion Health Groups: term 'used to describe people who are socially excluded, and who typically experience multiple overlapping risk factors for poor health, such as poverty, violence, and complex trauma. This includes people who experience homelessness, drug and alcohol dependence, vulnerable migrants, Gypsy, Roma, and Traveller communities, sex workers, people in contact with the justice system, and victims of modern slavery'.[5]

Inverse care law: 'The availability of good medical care tends to vary with the need for it in the population served. This inverse care law operates more completely where medical care is most exposed to market forces, and less so where such exposure is reduced'. [6]

Cookson, R. et al. (2021)
The inverse care law re-examined: a global perspective.



This is proved by ONS data that shows that practices in areas with the highest levels of income deprivation have on average 300 more patients per fully qualified GP than practices with the lowest levels of income deprivation.[7] Similarly, it was found that, when accounting for need, GPs in deprived areas in England receive 7% less funding per patient but look after 10% more patients than GPs in affluent areas.[8]

Proportionate universalism: to 'reduce the steepness of the social gradient in health, actions must be universal, but with a scale and intensity that is proportionate to the level of disadvantage'.[9]

Index of Multiple Deprivation (IMD): measures relative deprivation in small areas across each of the nations of the UK. Areas are ranked from the most deprived (rank 1) to the least deprived. Each nation measures deprivation slightly differently but the broad themes covered include income, employment, education, health, crime, barriers to housing and services, and the living environment.[10,11]

1

1. Better access and navigation of healthcare services

1.1 Registration with a GP and appointment booking

One of the guiding principles of the NHS is to provide a comprehensive service to all, irrespective of individual characteristics.[12] However, some population groups experience challenges in accessing, or even registering with, health and care services, including those who are homeless, vulnerable migrants, sex workers, and Gypsy, Roma, and Traveller Communities. This is of particular concern given that these groups often have increased healthcare needs.

For instance, **patients experiencing homelessness** face significantly reduced life expectancy, greater prevalence of long-term physical conditions, and high incidence of mental health problems.[13],[14] Concerningly, there remain many instances reported of patients having limited access to care or being refused registration to a practice as they cannot provide photo IDs or proof of address.[15,16]

The General Medical Services (GMS) contracts across the UK are clear that there is no requirement on practices to seek evidence of identity or proof of address. Practices should actively reassure patients that they will still be registered even if they cannot show these documents.[17] Practice staff can help to guide patients through the process and use a temporary address, such as that of a relative or friend, a day centre, or the practice's address.[18]

For patients experiencing homelessness, it is also crucial that the different parts of the system work together to provide joined up and responsive care that addresses complex needs. The NICE guideline on 'Integrated health and social care for people experiencing homelessness' provides useful direction and should be applied by local authorities and commissioners, as well as primary, secondary, social care providers.[19]

Case Study: Cardiff and Vale Health Inclusion Service (CAVHIS)[i]

Cardiff's population includes many vulnerable groups including asylum seekers and refugees, sex workers, people experiencing homelessness, and prison leavers. Each of them has specific needs, however, they share many common issues such as a higher than average incidence of post-traumatic stress, mental health problems, substance use, risk of infectious diseases, housing problems, and poverty.

CAVHIS, a health service for groups that face significant challenges when attempting to access health and social care, was set up to respond to these diverse needs. It is situated in the centre of Cardiff and managed by the Primary, Community, and Intermediate Care Clinical Board. The service has been developed over the past three years to deliver an integrated service with cross-sector partners providing care to traditionally excluded groups.

The service began as Cardiff Health Access Practice (CHAP) and was resourced to provide health screening to newly arrived **people seeking asylum** who were placed in Cardiff for Home Office initial assessment. The current model registers those newly arrived in Cardiff via the asylum 'irregular routes'.

The initiative was re-branded in September 2021 as CAVHIS to reflect the ambition to provide a wider service which now includes limited urgent primary care for multiply excluded single homeless individuals – via outreach clinics into frontline hostels – and primary care for individuals who, due to episodes of violent behaviour, are judged to need a security presence. The longer-term vision of the service is to develop, in partnership with local authorities and the third sector, services to provide **an integrated and co-located health inclusion service**. The service offers **full registration** for the multiply excluded **homeless**, high-risk **sex workers**, newly arrived people seeking asylum and **refugees** with care needs requiring more intense input, and **Roma Gypsy and Traveller** people who are mobile.

Dr Ayla Cosh, GP and Clinical Director of the initiative said: 'CAVHIS can also be used as a '**care of' address** which is critical because many people in these situations have significant health problems and need **a trustworthy address where they can receive correspondence regarding health appointments**. Our frontline admin staff take a proactive approach in reminding people of appointments both in primary and secondary care and often act as advocates'.

i GIG Cymru NHS Wales (2023) Cardiff Health Inclusion Service, Case Study

Beyond registration, data also shows how different groups are struggling to get appointments with their practice. In Wales, according to 2021/22 government data, 22% of people living in material deprivation and 23% of those living with a limiting long-term condition could not get a GP appointment.[20] Similarly, recent evidence examining patterns of high missed appointments – known as 'missingness' – in primary care in Scotland, indicates an alarming association with premature mortality.[21] For England, the 2023 GP Patient Survey[22] highlights particular groups – including several with higher health needs – as having a less positive experience of making an appointment.[23]

1.2 Staff training

To help improve patient experience and access, there is a need to consider staff training and to ensure that all staff are well-resourced and have the knowledge, skills, and confidence to engage appropriately with all patient groups and provide tailored support.

For England, the delivery plan for recovering access to primary care (access recovery plan) sets out a cloud telephony offer for every practice alongside the provision of care navigation training.[24] Similar training has been developed in Scotland. While it is positive that this care navigation training includes a focus on the wider determinants of health and the importance of 'Making Every Contact Count', practices will also be aware of the importance of developing a tailored approach with attention to inclusion health groups' needs at every stage of their healthcare journey. Additionally, engagement with patient groups and voluntary, community, and social enterprises will be critical for training to be effective.

An example of good practice in this regard is the Scottish National Trauma Training Programme, an evidence-based training programme that supports staff to adapt the way they work to make a positive difference to those who have been impacted by psychological trauma and adversity.

General practice staff interacting with patients at every stage of their healthcare journey should be mindful, empathetic, and understanding of the differences across patients' characteristics – such as ethnicity, sex and gender, culture, religion – and needs including language barriers.[25] This should be considered as an essential **part of training packages for practice teams**.

1.3 Digital exclusion

The COVID-19 pandemic led to a rapid expansion in the use of digital technologies in healthcare, particularly remote consultations. These technologies have the potential to improve efficiency and access for many. However, digital exclusion and digital poverty are significant problems for many.[26,27]

Ambitions to make greater use of technology, such as remote consulting, the NHS app in England, the new NHS Wales app, or the NHS 24 Online app in Scotland, assume access to a smartphone, the internet, and the appropriate knowledge and skills required to navigate these tools. However, in 2019, 7% of households in Great Britain reported not having access to the internet. Moreover, the cost of connectivity is a barrier that is further exacerbated by the cost-of-living crisis. [28,29]

Digital exclusion is defined as the "lack of access, skills, and capabilities needed to engage with devices or digital services.". When digital tools are the default or the only way of accessing care, it becomes a barrier, creating a risk of leaving people behind.

Some of the groups usually considered digitally excluded or who experience poorer healthcare via digital services include the **elderly**, people with **disabilities**, **ethnic minorities**, the **homeless**, **sex workers**, **Gypsy, Roma, and Traveller** communities, people living with inadequate broadband and mobile data coverage – more likely in **rural and coastal areas** – , those from lower socioeconomic backgrounds, and people with **low literacy or digital skills**.[1,2]

1 The Kings' Fund (2023) Moving from exclusion to inclusion in digital health and care.

2 NHS England (2023) Inclusive digital healthcare: a framework for NHS action on digital inclusion

Such connectivity issues are even more challenging in rural settings. Digital connectivity and internet services are poorest in deep rural areas, threatening the social and economic health of rural populations.[30] Inequalities are also apparent in the digital exclusion created by, for example, the lack of privacy for teleconsultation.[31] Similarly, a recent study by Verity and Tzortziou-Brown found that socially excluded groups face more barriers to accessing care due to reasons such as lack of translation availability, digital exclusion, and the complexities of the healthcare system.[32]

When digital tools are the default or only way of accessing care, ambitions to extend health technology and the use of digital devices to empower patient self-care, even if welcome, may inadvertently result in expanding inequalities. As a College, we are **supportive of the implementation of new technologies to improve general practice**. However, we are mindful of the different levels of access to digital tools and digital literacy, and the importance of face-to-face appointments. In our report 'The future role of remote consultations & patient 'triage', we recommend ensuring that **all patients are supported to access care through traditional routes when they need to, as well as supporting improving digital literacy and digital access where appropriate**.

While there are some changes practices could be supported to implement rapidly, many others are more structural and require significant investment, such as equipping patients and practices with appropriate infrastructure and skills to embrace technological improvements.

1.4 Continuity of care

The RCGP has consistently highlighted the benefits of relationship-based care and has developed the Continuity of Care Toolkit to support practices in improving relational continuity. Evidence indicates that continuity is strongly associated with increased patient satisfaction and experience,[33] increased adherence to medical advice,[34] enhanced health outcomes,[35] lower mortality rates,[36] lower costs, decreased use of emergency departments, and reduced likelihood of being admitted to a hospital,[37] alongside productivity benefits.[38]

However, the workload and workforce pressures facing general practice mean that continuity can be difficult to provide. The 2023 RCGP Tracking Survey reveals that more than half of GPs (53%) disagree that they can deliver relational continuity of care for their patients in a way they would like to.

Studies have shown that the number of patients able to see their preferred GP in England have been falling over time.[39] Of particular concern is the fact that populations from some **ethnic minority groups**, particularly those from Bangladeshi, Pakistani, black African, black Caribbean, and any other black background, have been shown to have lower continuity of care compared with white patients.[40]

Significant action is needed to support practices in delivering continuity of care and, ultimately, there is a need to reduce the workforce and workload pressures in general practice. However, from a health inequalities perspective, given the clear benefits of continuity for patients, it may be possible to **target efforts and seek alignment, in particular, to deliver continuity for inclusion health groups**.

Initiatives such as the Optimising Access Through Human fit (OATH), developed by the University of Manchester, look to provide a series of resources to help practices address inequalities around access and to improve continuity through gaining a better understanding of their patient and population needs.

Similarly, it is important to support existing good practice. **Rural practices** tend to achieve higher levels of continuity of care due to their unique staffing structures.[41,42] Supporting these practices against pressures to centralise care delivery is vital to maintaining or improving the continuity of care for patients in those settings.

Case Study: Multigenerational Household Outreach Programme in Slough – Frimley ICB

Frimley ICB includes five Places, Slough is one of them. Slough has the **highest levels of deprivation**, with more than 150 different languages spoken, at least a 10-year life expectancy difference from its neighbouring town, 15% of children live in low-income families, and there is a 20-year gap with regards to healthy lived years. It is also one of the places with the **highest number of multigenerational households** (MGHs) in England, with almost 14% of its population living in MGHs.

Attending to such a complex population, the Slough Clinical and Transformational team supported 15 practices to implement this project. The objectives of the programme were to address wider determinants of health; improve uptake of NHS health checks, QOF indicators, immunisations, screening for cervical and breast screening; treat the family as a unit; provide education on the use of urgent care services; encourage uptake of digital solutions; improve Primary Care productivity and efficiency while improving outcomes.

To do so, they implemented a population health management approach to offer home visits to MGHs with **outstanding immunisations and less than 40% of the QOF outcomes completed as of 31st March 2023**. The focus was on **outcomes rather than activity**. Therefore, the programme - with ICB funding - devised an incentive scheme remmunerating practices based on percentage improvement from baseline. Practices were incentivised to arrange home visits to assess the families' needs and deliver health interventions based on pre-defined needs and opportunistic case finding, focusing on incomplete QOF indicators such as serious mental health, asthma, COPD, diabetes, hypertension as well as encourage the uptake of cancer screening. The programme therefore supports 4 of the 5 focus areas of the adult Core20PLUS5 national strategy.

By offering families an alternative way of accessing primary care, this initiative has changed the behaviour of and healthcare interactions with these families. When comparing the data year to year, **the programme has proved very successful so far** by improving QOF indicators by more than 16%, with an additional 45% improvement in public health indicators of which the MGH programme is a contributing factor. The analysis also demonstrated a decline in the use of urgent care services within the cohort, proven by a reduction in A&E attendances, admissions, and total bed days.

The key learning points from this project highlight the relevance of **co-creating solutions with the community** to achieve better outcomes, **applying a population health approach** in identifying the appropriate cohorts, and **using data as leverage to reallocate resources** to pockets of need illustrating the potential impact on health outcomes and wider system pressures. Also, this case study proves that it is possible for GPs and their teams to improve access to primary care services attending to different populations' characteristics and needs, with the appropriate system support and leadership.

Recommendation:

- Policymakers, commissioners, and providers of health services across the UK should offer tailored support for socioeconomically deprived, underserved,and inclusion health groups, as part of efforts to improve patient access.

  This should include:

  - Further streamlining registration and appointment booking processes and ensuring the provision of multiple routes to meet different needs.
  - Improved support for addressing the barriers that patients experience, such as lack of a home address, digital exclusion, difficulties communicating in English, lack of health literacy, or disabilities.
  - Improving ongoing training and support for practice staff on providing inclusive and accessible care.
  - Supporting continuity of care for those who need it the most and providing additional support to practices to make this possible.

2

2. More equitable distribution of resources

The second of the Bevan Commission's prudent healthcare principles emphasises providing **'care for those with the greatest health need first, making most effective use of all skills and resources'**.[43] This principle involves putting the most vulnerable first, as well as the sickest, and being mindful of this in terms of resource allocation.[44]

On that basis, as well as calling for a **much-needed increase in overall funding for general practice**, it is vital to **evaluate how to more equitably distribute the resources available using proportionate universalism principles**. While this report considers health inequalities across the UK, this section is mainly **centred on the English landscape**, given variations in funding streams across the UK. However, the content does apply to some extent to other nations and consideration of equitable resource distribution is urgently required in all nations of the UK.

2.1 Core funding

The way in which health provision and, particularly, general practice is funded varies across the UK, in terms of the number of resources allocated and how they are distributed. However, all parts of the UK have a national allocation that covers the core of the services provided by general practice.

Scotland, for instance, before the 2018 GP contract, allocated the money to GP practices through the Scottish Allocation Formula, which divided the Global Sum to practices based on their list size. This was later reviewed and replaced by the Scottish Workload Formula. However, this new formula is still considered to underestimate socioeconomic deprivation. With some structural differences and similar limitations, England and Wales use the Carr-Hill Formula.

Funding models: The Scottish context

Before 2018, GP practice resources were allocated through the **Scottish Allocation Formula (SAF)**, dividing the Global Sum to practices based on their list size. The Global Sum accounted for roughly 65% of total practice payments and was weighted by factors including patient age and sex, deprivation, and the additional costs of delivering general practice in remote and rural areas.[i]

The SAF age-sex adjustment gave a larger weight to practices with an older population, moving funding to more affluent areas, while the deprivation adjustment worked in the opposite direction. Overall, these different formula adjustments led to a relatively flat per-patient funding profile and a mismatch between funding and consultation rates.[i]

These issues in GP practice funding led to the Scottish Government commissioning a review of the SAF in 2016, resulting in a new **Scottish Workload Formula (SWF)**. The SWF was applied as part of Phase 1 of the new GP contract in 2018, alongside the introduction of GP clusters and extended Multi-Disciplinary Teams.[ii] Upon review, the most socioeconomically deprived decile was found to be under-represented in the analysis used within the new modelling, which may account for why deprivation funding is under-estimated by the formula. [iii]

There are no current plans to review the SWF, but an interim approach to has been the rollout of additional '**Inclusion Health Action funds**' as a pilot to deprived-area practices within Greater Glasgow and Clyde. [iv]

i Scottish Government (2019) GP Funding Overview

ii Mercer, S. et al. (2023) Health inequalities, multimorbidity and primary care in Scotland

iii Deloitte (2017) A review of GP Earnings and Expenses.

iv Scottish Government (2023) Tackling health inequalities.

The Carr-Hill Formula

Since 2004, the Carr-Hill formula has provided a tangible way of measuring workload and costs, but concerns have been raised that it does not equitably distribute funds. As Carr-Hill fails to include any adjustment for the impact of socioeconomic deprivation on health needs, it underfunds practices in deprived areas.

A 2019 study from the University of Leicester, analysed data for 6900 UK practices from 2013 to 2017 and found that **for every 10% increase in the practice's Index of Multiple Deprivation (IMD) score, payments only increased by 0.06%**. These results suggest that the current formula has 'very little redistributive potential and is unlikely to substantially narrow funding gaps between practices with differing workloads caused by the impact of deprivation'.[45]

These findings are supported by other research such as that conducted by Boomla, Hull, and Robson, which found that the general practice global sum funding formula in England masks major inequalities within areas of socioeconomic deprivation and estimated that for one of the top socioeconomically deprived boroughs in England, **a formula that responds to the additional workload would have provided 33% more funding.**[46,47]

The Carr-Hill Formula: An Explainer

The GP contract specifies the payment rate per patient, referred to as the **global sum income**, which is the core funding in the contract. The amount of money received by a practice, as a baseline, is calculated by **weighing the global sum with the Carr-Hill formula**. This formula, introduced in 2004, ensures resources are directed to practices based on an estimation of their patient workload. It is reviewed quarterly to account for changes to the practice's patient population.

The Carr-Hill formula considers six elements:

1. Patient's age and sex.
2. Additional patient needs (for instance, associated with morbidity and mortality).
3. List turnover (new patients have more consultations, so more funds are needed).
4. Number of residential and nursing home patients.
5. Staff market forces (differing staff costs depending on location).
6. Rurality (measured using tax information on GP expenses).

This research demonstrates that while the current formula accounts for drivers of workload, it lacks a real measure of socioeconomic deprivation. For these reasons, multiple organisations, including the Health Foundation,[48],[49] NHS England,[50] and the Health and Social Care Select Committee,[51] have **recommended revising and updating the formula to ensure core funding allocations are better weighted according to deprivation, addressing the inverse care law, and achieving proportional universalism**.

A study examined the extent to which the global sum determines practice funding spread across the UK – comparing England and Wales-, concluding that identical practices in both nations do not receive equitable pay, negatively impacting practices in Wales, because its population is older and has higher health needs.[i]

i Rhys G, Beerstecher HJ, Morgan CL. (2010) Primary care capitation payments in the UK. An observational study.

However, previous proposals to amend the formula[52] have been unsuccessful and met resistance from the profession.[53] This is not surprising given the need to ensure that any changes to the formula must be accompanied by additional investment, to avoid mere redistribution that creates winners and losers in a system where overall resources are too low.[54]

That is why in our recent Manifesto and 2022 report Fit for the Future – A new plan for GPs and their patients, the RCGP called for an **increase in the total budget for general practice, alongside more funding for practices serving socioeconomically deprived communities**.

In addition to these recommendations, any review of Carr-Hill must be comprehensive and well-evidenced. It will be challenging to define which factors should be considered and how best to measure workload and need. Political will is necessary to proactively push for a revision of the formula and secure the additional funding needed.[55]

One route to improve the allocation of funds could be adjusting how population is weighted in the formula. A recent report from the Health Foundation[56] highlighted the comparative benefits of the **PCN-adjusted population weighting** which is applied to the ICB primary care allocation formula. The PCN-adjusted population weighting incorporates 'health inequalities adjustments' and factors in deprivation through estimates of GP workload. Other options that could be considered are the **Distance from Target** (DfT) approach[57], detailed in the box below, or evaluate the extension of initiatives such as the alternative distribution formula implemented by the Leicester, Leicestershire, and Rutland ICS, presented as a case study on page 18.

Despite the complexities involved, review and reform of the core funding allocation formula is inevitable if serious efforts are to be made to reduce health inequalities in general practice.

Distance from Target (DfT) approach

The DfT approach weights population need and unmet need, considering three adjustments: market forces, emergency ambulance cost, and sparsity. The DfT approach sees areas – in this case, former CCGs – that are above target generally receive less than the national funding increase, while those below the target receive more, always moving towards the target. It is worth noting that under this approach, all areas receive a minimum per capita growth and a minimum cash growth. [i]

In other words, the areas that are underperforming because their population is older, have complex needs, or are more socioeconomically deprived, will receive a funding increase above the average to work towards reducing the gap and getting close to the national target. Conversely, areas with overall healthier or less disadvantaged populations will receive a reduced increase in the funds allocated, but which is intended to be sufficient to maintain a high service standard.

In that sense, this approach is aligned with the philosophy of proportional universalism and could gain better traction with the profession despite implying redistribution, as it is based on the premise of a constant increase in the core funding for all.

i House of Commons (2019) NHS Funding Allocations: Clinical Commissioning Groups

Case Study: Funding distribution in LLR ICS

In 2021, the Leicester, Leicestershire, and Rutland (LLR) ICS developed its own funding distribution formula to address the problems with Carr-Hill highlighted above. Some of the characteristics of the proposal were:

- Support a move towards prevention and community-based care.
- Use of anonymised data at diagnostic and patient level.
- Move to measure outcomes rather than inputs and outputs.
- A more flexible system that takes account of current needs.
- Investment in primary care with a no-losers approach.

The LLR proposal suggested the allocation should include **workload, morbidity, age, sex, care homes, deprivation, new registrations, and communication issues**. Practice payment is calculated using three main criteria:

- **Core staff** component, including rurality (41.3%).
- **Needs** related component (52.9%), adjusted for:
  - Multi-morbidity of actual patients
  - Communication issues (complex needs and language barriers require longer consultation time to deliver equivalent care)
  - List turnover (newly registered patients require more time)
- **Deprivation**, adjusted for IMD (5.8%)

The core of healthcare delivery cost is primarily staff, so to cover the expenses of the 'core staff component' and comply with the GP contract, they used the staffing component of the Global sum (48%), including rurality (1.5%). This equates to 41.3% of the total amount available for distribution.

The rest of the core contract (~50%) and other funding included in the model was then distributed to all practices based on **needs** and socioeconomic **deprivation**. The 'other funding' includes local additional payment (one fixed payment combining all discretionary primary care spending), LES, and others. QOF, DES, and reimbursements are excluded..

This funding distribution formula ran for 3 years until March 2024. A review was undertaken over the course of 2023, with feedback from practices and early outcomes reviewed. March 2024 saw an evolution of the practical implementation of the formula for 2024/25, with the LLR ICB taking the decision to continue to use the distribution formula 'in the background', so that it informs the level of health equity payment required by practices where the need is greatest.

The revised GP funding model for LLR includes **core funding**, a **community-based services payment** (addressing levelling of service provision), and a **health equity payment** (levelling of funding). This has facilitated a clearer implementation for practices to understand and follow, as the value of their core contract remains stable and predictable, and practices do not feel threatened by a potential future loss of income. The LLR GP funding model remains a true levelling up model rather than a redistributive model that helps to "level up" the relative worst-funded practices based on needs to be closer to the average practice funding in LLR.

Analysis of the **GP Patient Survey** shows early positive outcomes of the LLR GP funding model. Changes in indicators such as overall experience of making an appointment, satisfaction with general practice appointment times, or frequency of seeing or speaking to preferred GP, show a **narrowing of the gap for the lowest funded practices**, indicating that the funding model seems to have mitigated the overall deterioration of patient experience seen across the whole of general practice, thought to be due to the impact of COVID-19.

This case shows that regional structures such as an ICS can begin to lead change and implement new funding arrangements that contribute to proportional universalism.

2.2 Other funds

As general practice funding does not only come from the global sum, it is necessary to also think about how other income streams can help to reduce inequalities, especially those focused at a more local level.

Other Funding pots: An Explainer

Directed Enhanced Services (DES) are nationally defined services such as minor surgery, childhood immunisation, or health checks to patients with learning disabilities, that practices can sign up to deliver. The English PCN contract is also a DES. [i],[ii]

Local Enhanced Services (LES) are offered by local commissioners to local practices that can sign up to supplement services already offered in the core contract to help meet the needs of their populations.

The services covered by the LES vary across the UK in scope and funding, as they are not agreed upon centrally, but include services such as immunisations, smoking cessation, or some sexual health-related deliverables. [ii]

Quality and Outcomes Framework (QOF) evaluates performance and rewards practices for providing certain pre-determined services. Points are given for achievement amongst indicators across three areas: clinical, quality improvement, and public health. [i]

Participation in QOF is voluntary but most practices subscribe to it, as QOF-driven payments represent 8% of the total income for most practices in England.

Scotland has removed QOF, and the money previously allocated to this is now included in the global sum. Similarly, Wales has reduced QOF and now has the Quality Improvement Framework (QIF), where the clinical and cluster domain indicators have been transferred into the core contract, so the funds are distributed to practices via the Carr-Hill formula.

Following the removal of QOF, the Scottish government intends to develop a new quality assurance model in collaboration with the RCGP and BMA.

Some concerns have been raised about the removal of QOF in Scotland with research finding that it was associated with significant reductions in recorded quality of care for most performance indicators measured.[iii]

Investment and Impact Fund (IIF)

The IIF was introduced in England as part of the PCN contract in 2020 and provides additional funding to PCNs through a point-based system that rewards performance against key indicators aligned with the objectives set out in the NHS Long Term Plan. [i],[ii]

i HMFA (2020) How it works – primary care finance and primary care networks.

ii BMA (2023) Enhanced services GP practices can seek funding for

iii D. Morales, M. et al. "Estimated impact from the withdrawal of primary care financial incentives on selected indicators of quality of care in Scotland: controlled interrupted time series analysis," BMJ, 2023.

2.2.1 Enhanced services

Enhanced services aim to attend to additional population requirements and can provide additional funding on top of the base payment for specific healthcare provision.[58]

As people in areas of socioeconomic deprivation have greater needs, targeted funds channelled through DES and LES to these areas **have the potential to improve access of deprived populations to critical services** such as immunisation, mental health support, smoking cessation, or alcohol and problem substance use.

However, these schemes would also need to be reviewed to ensure they successfully address health inequalities. For these purposes, having the right data to identify specific populations and their needs is key. This is explored in section 4 "Using the power of data".

2.2.2 Performance incentive schemes

Quality and Outcomes Framework

The Quality and Outcomes Framework (QOF) is also worthy of consideration. Achievement of QOF indicators can be more difficult for practices in areas of socioeconomic deprivation, where patients often have more complex needs (e.g., multimorbidity, alcohol and other substance use, homelessness, mental health issues) and there are often additional workforce shortages. This can result in **lower funding through QOF due to 'underperformance'**.

As this financial reward may not reflect the amount of work undertaken by practices serving more socioeconomically deprived patients, any **changes to the scheme should address fairness in terms of workload**.[59]

Similarly, the current scheme can be seen to result in reduced payments in socioeconomic deprived areas as it rewards chronic disease management more than prevention and early intervention in high-risk populations. Reviews of QOF have found that it does not incentivise the kind of holistic, patient-centred care necessary to improve outcomes for those most affected by health inequalities.[60]

Investment and Impact Fund

The Investment and Impact Fund (IIF) follows a similar model to QOF, and socioeconomic deprivation can similarly impact practice performance. For instance, IIF includes an indicator for the number of online consultations which may be difficult to fulfil in areas with limited digital connectivity, such as rural or socioeconomic deprived areas.

The number of indicators of this scheme has been progressively reduced over time, from 32 in 2022/23, to five in 2023/2024, and two in 2024/25. Last year's contract included reference to an explicit focus on health inequalities within the five indicators, however, these make up only 19% of total IIF funding for 2023/24, with 81% being channelled into capacity and access. A similar scenario is expected for 2024/25, as the two remaining indicators, linked to work on inequalities,[61] account for only 4.3% of the total IIF funding of the year. This is because a significant proportion of the IIF budget – from the three IIF retired indicators – is being shifted to the Capacity and Access Payment. This will significantly limit possible benefits associated with the reduction in indicators and the focus on health inequalities. As with all the funding streams covered, it is important that IIF is reviewed to ensure it can better take account of socioeconomic deprivation.

2.2.3 Other local and regional funding streams and responsibilities

In addition to the funding streams that have a significant impact on the resources received by practices, other sources of funding could be utilised to help reduce the inequalities gap.

In **England**, the Health and Care Act 2022 established **reducing health inequalities as one of the core duties of Integrated Care Boards** (ICBs). This mandates that 'each integrated care board must (…) have regard to the need to reduce inequalities between persons with respect to their ability to access health services and reduce inequalities between patients with respect to the outcomes achieved for them by the provision of health services'.

This report does not seek to cover the complexities of ICB funding in detail and the limitations imposed by current funding shortfalls are worthy of note. However, ICBs do have resources ringfenced for certain uses, and national budgets allocated for specific purposes and health programmes. It is also in their power to set strategic priorities for the commissioning of services and distribution of funds in line with the local health priorities and plans.[62] **Exploration of the use of these budgets and powers to target health inequalities could be highly beneficial**.

The English system also has Primary Care Networks (PCNs), established in 2019 to bring GP practices into local groups that can provide additional services to patients, improving population health. PCNs are asked to appoint health inequalities leads and deliver projects to address local inequalities, as well as consider inequalities in their wider work. More recently, in the 2024/25 GP contract, PCNs are being required as part of their core work to improve health outcomes and reduce health inequalities, 'using a data-driven approach and population health management techniques in line with guidance and the CORE20PLUS5 approach'.

Despite this, there is significant inequality between PCNs, and not all PCN funding and workforce allocations appropriately account for deprivation. The recent Health Foundation study described on page 17, highlights the benefits of the PCN-adjusted population formula which better accounts for need. It is estimated that if this formula was used for all population-based PCN funding streams, PCNs in the most socioeconomically deprived areas would collectively receive £18.6m more per year.[63]

In **Wales**, the Social Services and Well Being Act established an **objective for Regional Partnership Boards**[64] **of improving the well-being of the population** and how health and care services are delivered.[65] In addition, **Clusters** are expected to develop a Cluster Plan to address issues of **sustainability and access, health inequalities, and their wider determinants**, with a required minimum focus on 'robust population health approaches with specific reference to obesity, diabetes, mental well-being, and the wider health inequality agenda', among other topics.[66]

In **Scotland**, the Public Bodies – National Health and Wellbeing Outcomes Regulations 2014 established the duty that 'health and social care services [should] contribute to reducing health inequalities'. This commits Integrated Joint Boards (IJBs) Health, Social Care Partnerships (HSCPs) and local authorities, to **working jointly to address and reduce health inequalities in their local area**. In addition, **GP Clusters** in Scotland are described as having an intrinsic ('improve wellbeing, health and reduce health inequalities') and extrinsic ('ensure relentless focus on improving clinical outcomes and addressing health inequalities') **role in reducing health inequalities**.[67] However, Clusters are recognised as being currently unable to play this role in any widespread fashion, partly due to a lack of resources and support.

As different sources of funds flow through regional and local structures across the UK to cover a wide range of purposes, it is necessary to secure resources that are destined solely to accomplish legal duties relating to health inequalities. As part of this, consideration must also be given to any **unintended consequences** – for example, targeted funds sometimes **focus on deprived urban populations at the expense of rural or coastal regions**.

In addition, we advocate that strategic priorities of regional and local structures should also be **based on the principles of proportionate universalism** and that local service design takes account of the needs of underserved communities. The FAIRSTEPS framework and Building Equitable Primary Care[68] resources can provide a useful resource for commissioning and designing services sensitive to local health inequities.

2.3 Practices at the Deep End

Deep End projects have pioneered work on health inequality reduction in many parts of the UK, particularly in Scotland. These projects seek to **draw together GPs working in areas of socioeconomic deprivation to identify practical ways to address health inequalities, and to learn from each other**.

Key recommendations from the Scottish Deep End project include:

- Prioritising advocacy and amplifying the patient's voice
- Embedding Community Link Workers, Financial Inclusion Workers, and Mental Health and Addition nurses in practices

Deep End projects are increasingly spreading across England and a pilot in Wales has been funded by Welsh Government and delivered by RCGP Cymru Wales since 2022. Similarly, RCGP Northern Ireland is now looking for support to start their own Deep End project. However, in the case of Wales, the **future of funding is uncertain**, as well as in other places across the UK. The funding and access **challenges are greater when Deep End projects want to successfully include rural, remote, and coastal practices**.

It is important that general practice staff in all areas of the UK can benefit from coming together in Deep End projects and that this is appropriately resourced and supported.

Scottish Deep End: What does inclusive health care look like in general practice?

John is a 33-year-old man, who lives with his pregnant partner, Julie, and three young children. He was brought up in foster care from age 5, left school at 16, and spent time in prison for drug-related offences. He now lives with his family in a small flat and is registered at one of **Scotland's Deep End GP practices**. He is in financial difficulty and struggling to cover essentials.

John has had poor mental health for most of his life exacerbated by drug and alcohol use. He has low trust in systems and authority, and his early care-giving relationships were very damaged. He has been diagnosed with diabetes which is poorly controlled as he has limited access to affordable healthy food and low levels of health literacy. He has a history of frequent missed appointments at both practice and hospital clinics.

He presents at the reception of his general practice, as he has no credit on his phone to call in. He appears angry and frustrated. One of the receptionists finds a private space and establishes he is struggling with his mental health. She books him in for a face-to-face GP appointment. When he meets with the GP, John shares that he has been feeling depressed and suicidal at times. He's worried about his diabetes. Previous hospital clinic appointment letters did not arrive and he was removed from the waiting list. His financial stresses are a significant concern and he's drinking more.

His GP makes a plan with him to become John's 'named' GP with planned appointments and **continuity of care**. She **refers him to their Community Link Worker**, who involves him with a local volunteering project and refers him to the local food bank. She also connects him with their **practice Welfare Advisor**, who helps John with debt and benefits advice. He is also referred to **the Primary Care Alcohol Nurse**, for support with his low mood and alcohol use. Adopting the learning from the Govan SHIP project, John and his family's situation are discussed at the Practice MDT meeting and they agree on how they might best support the family. For continuity and consistency between MDT members, out-of-hours GP, and A&E services, John consents to the creation of a **care plan** which is stored in his notes and shared electronically, sharing details of his main problems and **'what matters to him'**. John agrees to a **social work referral** for additional support.

His **GP re-refers him** to the diabetic service, this time including an 'alert' highlighting John's vulnerability and risk of non-attendance which specifically asks the appointment officer to inform the practice and link-worker of his appointment details so they can support his attendance.

Over the following months with planned, longer appointments, a **relationship of trust and understanding builds between John and his GP**. He feels more able to accept, and engage with, his care. This enables his self-caring ability and appointment attendance. Low mood and anger management issues improve and his alcohol intake reduces with support from his alcohol nurses. His financial stresses ease with assistance from his welfare advisor. Household expenses including rent, energy, and food bills are supported with access to the correct benefits. He now can attend his hospital diabetic clinic, aided by the community link worker who joined his first appointment and helped him arrange transport for subsequent appointments.

Recommendations:

- All general practice funding streams should be reviewed to better match resources with needs, in alignment with the principles of proportionate universalism, alongside increased investment across general practice.
- Ring-fenced and flexible funding should be allocated, across the UK, to all regional or locality-based structure levels in primary and community care to better respond to the needs of their populations and comply with their duties on health inequalities reduction.
- Governments across all four nations of the UK should commit ringfenced funding for Deep End projects, which bring together GPs working in areas of socioeconomic deprivation to identify practical ways to address health inequalities, and to learn from one another.

3

3. Workforce

3.1 Incentives to recruit and retain GPs in areas of socioeconomic deprivation

As revealed in the last RCGP tracking survey, almost 2 in every 5 GP respondents reported facing some level of difficulty in recruiting GPs, with 27% saying it was very difficult. The difficulties recruiting and retaining GPs and other members of the primary care workforce **particularly affect rural areas, inner cities, and coastal areas, as well as areas of socioeconomic deprivation**.[69,70] Coastal areas also see challenges associated with a growing ageing population.[71]

Recent data has shown that English practices in areas with the highest levels of income deprivation have on average 300 more patients per fully qualified GP than practices with the lowest levels of income deprivation.[72] The Health Foundation also found that, after accounting for levels of need, GPs working in practices serving the most socioeconomically deprived patients are responsible, on average, for 10% more patients than GPs in more affluent areas.[73] Similarly, PCNs leaders have said that recruiting and retaining staff in socioeconomically deprived areas proved difficult in some cases and considered that funding is insufficient to respond to the additional workload of patients in socioeconomically deprived areas.[74]

Similar trends demonstrating the existence of the inverse care law in practice were found in Scotland[75] and Wales,[76] where the least socioeconomically deprived quintiles of the population have better access to GPs than the most socioeconomically deprived ones.[77] This shortage of GPs and practice staff is reducing capacity to meet the growing needs of patients, especially in areas of socioeconomic deprivation, causing, amongst other issues, reduced contact time.[78]

The evidence emphasises the need for rapid action from governments across the UK to address workforce shortages, and particularly **to increase investment to extend and accelerate workforce expansion programmes that incentivise both new and experienced GPs to work in under-doctored and socioeconomically deprived areas**. However, for any recruitment and retention initiatives to be successful and sustainable, **funding and working conditions** of practices in socioeconomically deprived areas **must be addressed in the first place**.

Some existing initiatives across the UK could be evaluated and built upon. In England, these include the **Targeted Enhanced Recruitment Scheme** (TERS) and the **Trailblazer scheme**. The TERS offers financial incentives to trainees who accept roles in under-doctored areas, but this depends on the accurate identification of these areas and such schemes must be consistently reviewed to ensure effectiveness. The Trailblazer Deprivation Fellowship Scheme gives specific support to newly qualified GPs to work in areas of socioeconomic deprivation.[79]

It is positive that the NHS Long Term Workforce Plan in England has acknowledged the inequalities in the distribution of the workforce, leading to inequitable access to services and difficulties in attracting and retaining staff. To overcome this, NHS England has committed to locating a higher proportion of new medical student postgraduate training places in parts of the country with the greatest shortages.

There are also relevant programmes across the UK that have improved the **recruitment** of GPs in disadvantaged areas, which deserve expansion and secure, long-term funding. The **Scottish GP Pioneer Scheme** supported the recruitment of younger GPs and retention of experienced GPs in Deep End areas.[80] This scheme delivered excellent outcomes but is no longer funded, which was a disappointment to many hoping to scale up its success. This scheme was part of the inspiration for the English Trailblazer programme.[81]

Also in Scotland, the **Golden Hello scheme**[82] was designed to improve recruitment in 'hard to recruit to' areas such as remote and rural, and deprived areas. However, its impact is yet to be evaluated. Likewise, the Welsh **Train, Work, Live programme** focuses on bringing GPs to rural and remote locations and could be expanded to include a focus on areas of high socioeconomic deprivation.[83]

3.2 The wider MDT

Certain additional staff roles in general practice can make a particular contribution to tackling health inequalities. However, there are also challenges in recruiting and retaining members of the wider practice team in socioeconomically deprived areas. For instance, recruitment of non-GP roles in the MDT has its own set of drivers and barriers for **rural practices**, often around transport costs and access, as well as isolation and lone working, which may not apply in equal measure across all primary care settings.

In the latest RCGP tracking survey, GPs across the UK have reported challenges in accessing some roles in areas of greater socioeconomic deprivation: [84]

Role	GPs in the most socioeconomically deprived areas	GPs in the least socioeconomically deprived areas
Social Prescribing Link Workers	64% have access	86% have access
Care Coordinators	30% have access	48% have access
Paramedics	29% have access	54% have access

These difficulties can have a specific impact in areas of socioeconomic deprivation where the wider MDT has an additional role to play in providing the support needed by inclusion health groups. As noted above, one of the recommendations from the Scottish Deep End project was for some roles to be prioritised in areas of higher deprivation and to be embedded within practices, so they can support the needs of those experiencing social exclusion and health inequalities.

As stated in our Fit for the Future report (2019), staff from across the MDT have a crucial role to play in meeting wider physical and mental health needs and supporting holistic healthcare delivery.[85] For instance, **mental health practitioners, social prescribing link workers, dietitians, or occupational therapists can help address some of the wider determinants of health** that can exacerbate the health challenges experienced in socioeconomically deprived populations. This is particularly relevant in rural contexts, where general practice requires a holistic and broader range of skills given the less immediate support from colleagues compared to urban areas.[86]

Various pilots and projects have explored similar possibilities. The Mental Health in the Deep End (MINDED) pilot in North East and North Cumbria aims to support patients with common mental health problems to see a clinical psychologist or another member of an in-house psychology team located within their practice. Similarly, trials in Westminster, London, making use of community health link **workers** to reach socioeconomically deprived, and traditionally hard-to-reach communities, have shown promising initial findings.[87]

In Northern Ireland, MDTs were launched in 2018, with an expected incremental roll-out over five years. However, according to a recent report by the Northern Ireland Audit Office, MDTs had only been fully introduced in one of the 17 GP Federation areas and partly introduced in another seven, and only around 8% of registered patients had access to the full range of MDT roles, by March 2023.[88] A crucial constraint for the full roll-out is funding. The same report notes that an additional £91 million per annum would be needed to sustain the operation of a full programme of MDTs. This creates additional challenges in addressing health inequalities.

In England, the **additional roles reimbursement scheme (ARRS)** allows PCNs to recruit a number of additional roles, including care navigators, social prescribers, and others highlighted above, and claim 100% reimbursement of the salary costs for these. However, the current PCN contract **does not include weighting by population need or have mechanisms to ensure equitable distribution of new staff**.[89] As with other funding streams explored in the previous section, **the scheme should be reviewed** to ensure it appropriately channels funding and staff to areas of greatest need.

It is critical that **we first ensure there are sufficient numbers of GPs across the UK, particularly in areas of deprivation**. However, the provision of targeted and sustained funding to expand MDTs in practices in areas of higher socioeconomic deprivation has significant potential in helping to address health inequalities, especially if recruiting and retaining roles that can support patients for whom social determinants are driving poor health outcomes. This should include **recruitment support for practices in socioeconomically deprived areas and support to develop suitable premises to accommodate additional workforce**.

3.3 Equip our workforce to tackle inequalities

Bolstering the general practice workforce in socioeconomically deprived areas and equipping them with the correct skills requires a proactive approach across the entire career pathway. To be able to effectively address health inequalities, incoming practitioners as well as those in post[90] need to be provided with appropriate education on the issues and challenges, and ways of tackling them.[91] **Including content on health inequalities within formal education curricula** is one way forward.

The Institute of Health Equity (IHE) and the World Medical Association (WMA) have suggested that "education on the social determinants of health should be a mandatory core element of all undergraduate courses".[92] Similarly, the RCGP and SAPC joint report, published in 2021, sets out improvements and guiding principles for undergraduate GP Curricula in UK Medical Schools. This recommended the inclusion of the "social determinants of health" and "preventing disease and promoting health" themes as part of a Population-centred Care principle. Likewise, it is important that postgraduate training also reflects this recommendation and includes training on health inequalities and social determinants of health.

As well as promoting the improvement of medical training, the College acknowledges its role in equipping GPs to address health inequalities. The College will continue to ensure that health inequalities remain well covered within the RCGP curriculum and the MRCGP examination, continually monitoring this aspect to ensure that the content remains up to date. In Scotland, the College has explored working with the GMC and NHS Education to develop resources to equip the profession with the skills to address health inequalities and care for patients with complex health and social needs.

To deal with the challenges of caring for patients with social and clinically complex needs, there is a need for widening participation at medical schools, increasing general practice placements, especially in more socioeconomically deprived areas,[93] during undergraduate courses, and more equitable distribution of GP training practices to address the **'inverse training law'**. Training practices are significantly underrepresented in areas of higher socioeconomic deprivation, largely because of workload pressures. This requires attention and corrective measures to be put in place if we want to train a workforce that is fit for the future and able to address health inequalities.

Part of the solution would be **making it easier for GPs working in rural areas or areas of high socioeconomic deprivation to be involved in undergraduate teaching**, as they can positively influence career choices for medical students,[94] particularly to incentivise them to work with inclusion health groups and in rural or socioeconomically deprived areas. **Supporting education and training in areas of socioeconomic deprivation and rurality** can help to encourage students and trainees to remain in those areas when they qualify, as these can be particularly beneficial training settings.[95]

An existing scheme that demonstrates the growing interest and need for training on social and health equity themes is the **Health Equity Focused Training (HEFT) programme**. This trains GPs, postgraduates, and doctors in training interested in a career in Deep End practices and/or with inclusion health groups.[96] This has been implemented in England and there is a planned pilot in Scotland, with the support of RCGP Scotland.

Promoting a more equitable distribution of trainees in areas of socioeconomic deprivation is key to reducing the inverse training law, but to make this effective, these **trainees must have access to adequate support, infrastructure, and training capacity**. That should be accompanied by access to appropriate education that equips them to better address inequalities. That is why a **revision and inclusion in the curricula of training on social determinants of health is vital**.

Recommendations:

- Governments should evaluate existing GP recruitment and retention schemes across the UK to ensure they focus on supporting recruitment and retention in socioeconomically deprived areas and implement additional schemes where needed.
- Targeted and flexible funding should be provided for practices in areas of socioeconomic deprivation to recruit additional practice roles that have been shown to support the needs of those experiencing social exclusion and health inequalities.
- Medical school curricula and training programmes for healthcare professionals across the UK should be reviewed to ensure curricula adequately include education on health inequalities and social determinants of health, so that all practitioners are better equipped to consider and address health inequalities. In addition, support should be provided to expand health equity focused GP training programmes.
- Governments should expand training capacity in socioeconomically deprived areas by:
  - where possible, ensuring new medical schools are sited in areas of socioeconomic deprivation, alongside efforts to recruit medical students from these areas.
  - providing support to expand training capacity in practices in socioeconomically deprived areas, so that more GP trainees can gain experience working in these environments.

4

4. Using the power of data to reduce inequalities

As noted by the Bevan Commission, GPs are well placed to know their communities, their problems, and needs, but having **access to high-quality data allows them to better understand the needs of the most vulnerable**. For the IHE and WMA,[97] monitoring health inequality consists of tracking the health of a population according to key socioeconomic variables. However, in many contexts, standard data collection omits considering social determinants.

There are multiple complexities and challenges to ensuring access to tailored local data that can support efforts to address health inequalities. These include the tension between local and national priorities for the design and delivery of data-driven systems. There is a risk that such differences mean that data collection overlooks local needs, leading to incomplete or poor-quality data, despite local insights being vital to flag and reduce inequalities.[98]

This highlights the importance of **involving practices and local level structures**, such as PCNs and clusters, **in efforts to capture data regarding the wider determinants of health**. An extension of this would be to actively **engage with people in the community**, to understand their needs and barriers, and involve them in **co-production processes**, so it is possible to deliver a sustainable change to reduce inequalities.

An example of the challenges posed by incomplete data is highlighted in a publication by the Race Equality Foundation and the Wellcome Trust which shows how inconsistent, incomplete, and inaccurate recording of ethnicity data could undermine efforts to address health inequalities and improve healthcare access, experience, and outcomes for black, Asian, and minority ethnic groups. Therefore, there is a **need to improve the quality of ethnicity data** and use it to identify the specific health needs of these groups, as underlined in a report by the NHS Race and Health Observatory and the King's Fund.

There is also a need to develop datasets and different methodologies to address health inequalities, such as improving risk stratification tools that **include clinical and non-clinical factors** (identifying high risk populations by clinical and socioeconomic criteria together with ethnicity, comorbidity, and poverty data).[99]

Capturing data about health conditions, socioeconomic deprivation, and wider determinants, in a timely and accurate fashion, provides a powerful tool to impact the effectiveness of policies and programmes that aim to tackle health inequalities at national, regional, and local levels, while also helping practices to better address the needs of their communities. Data collection should feed into personalised care, health planning, programme design, and policy decisions.[100]

In summary, there is a two-fold challenge, with **not all needs being well represented in datasets** used to make decisions about healthcare, as well as **practitioners and decision-makers** at different levels **not having access to sufficient and accurate data** to make optimal decisions, improve health outcomes, and reduce disparities.

Health professionals need support to better understand the needs and outcomes of the populations they serve. Therefore, **NHS bodies should provide practices with access to robust local relevant datasets and the analytical skills and tools to use them**, either at a cluster/network level or at a health board/ICS level. For that to happen, practitioners and staff should receive relevant training in data analysis or be provided with the appropriate analyst and project management support to undertake this analytical work with them.

In addition, there is a proactive role that **leaders**, especially at the regional level, can adopt. ICS or regional structures could have a **greater role in linking and utilising existing data across the health system and outside** (e.g., social care, housing). That, of course, will depend on the availability of this data. Additionally, it is important to **share data with the community and involve them in co-designing** targets, programmes, or services.

Finally, it is important that when developing programmes and policies, leaders at regional and national levels have access to good quality localised and national data that assists in the identification of unmet needs, the improvement of resource allocation, and the implementation of initiatives. Of course, that would require active participation of primary care leadership in the ICSs decision-making space.

Overall, access to good data and the capacity to understand and analyse it will be a crucial tool to improve healthcare planning and delivery at every level, helping to create and evaluate services that focus on reducing health inequalities, and ultimately driving improvement across and beyond the health sector.

Recommendations:

- Ensure all practices across the UK have access to high-quality data and analytical tools that facilitate understanding of their community's health needs.

  This should include:

  - Access to high-quality locally relevant data sets, including public health data.
  - Analytical capacity and expertise based within primary care to provide practices and systems with digestible information to plan care and improve health services.
  - Training existing staff in data analysis where appropriate.
  - A focus on quality rather than performance management.
- All new health policies should be signed and implemented based on high-quality population health data and subject to a rigorous EQIA (equality health impact assessment) before they are rolled out, and monitoring and evaluation processes should be put in place to assess the impact and enable mitigation for any unintended consequences.

5

5. Social determinants of health

We know from studies that 80% of health outcomes are determined by non-health-related inputs such as socioeconomic factors (education, employment, income, family support), physical environment (environmental quality), or unhealthy behaviours.[101,102]

The Marmot Review 10 Years On has shown that life expectancy is decreasing in the lowest decile of women, and highlighted the mental and physical health effects of adverse childhood events on health in later life. The report also stresses that, despite life expectancy being an important health indicator, healthy life expectancy might be even more relevant as a measure of quality of life. It also highlights the **strong relationship between deprivation and healthy life expectancy at birth**.[103] In England, healthy life expectancy is more than 18 years higher for the least socio-economically deprived compared to the most deprived.[104]

The Government's 2022 Levelling Up White Paper made the commitment that 'by 2030, the gap in Healthy Life Expectancy (HLE) between local areas where it is highest and lowest will have narrowed, and by 2035 HLE will rise by five years'.[105] An analysis by the Health Foundation estimated that an improvement of five years in HLE will take 192 years based on current government policies, showing that significantly more ambitious action is needed if the government wishes to meet its own target.[106,107] The latest ONS data shows no significant change in healthy life expectancy between 2015-17 and 2018-20. The Labour Party has gone further by committing to halve the gap in HLE between different regions in England.[108] However, they have not specified a timeframe to accomplish this. There is a need for the development of a clear and ambitious but achievable HLE target which governments can focus on delivering.

Another way to move forward is by commencing the socio-economic inequality duty in section 1, of the Equality Act 2010, which requires a transparent and effective approach from public bodies to addressing socioeconomic inequalities. Concretely, this establishes that 'An authority to which this section applies must, when making decisions of a strategic nature about how to exercise its functions, have due regard to the desirability of exercising them in a way that is designed to reduce the inequalities of outcome which result from socio-economic disadvantage'.

Progress has been made around this duty. The Scottish Parliament enacted the Fairer Scotland Duty in April 2018, as a statutory guidance for public bodies subject to this duty in Scotland. Also, some local councils in the UK have adopted parts of the socio-economic duty. One example is the Newcastle Council, which has decided to treat this duty as if it were in force. However, after the approval of the Act, governments have not enacted it as a law.[109] That is why different coalitions are promoting the commencement and enforcement of this duty. Some of them are the #1ForEquality, integrated by the Equality Trust, Just Fair, and 60 other organisations, and the Inequalities in Health Alliance (IHA), led by the Royal College of Physicians and integrated by the RCGP, alongside over 200 other organisations.

Overall, **to truly reduce health inequality there is a need to address the wider determinants of health**. If we are to prevent physical and mental ill-health in the first place, we need actions focused on tackling issues such as poor housing, food quality, addictions, or employment, among others.

A study by Citizens Advice revealed the time spent by GPs on other issues other than health. This shows that the top three issues raised during consultations were personal relationships (92%), housing (77%), and work/unemployment (76%).[110] Similarly, it has been reported that one in five GP consultations – **over a million appointments a day – are for non-medical needs** such as loneliness, poor housing, issues with debt, or relationships.[111] The topics explored below have been selected according to these most common non-health problems presented to GPs in consultation.

5.1 Poverty

There is a self-evident relationship between poverty and health. Financial income is needed to cover basic and non-basic needs, including those that have an impact on our health.

Various research has analysed the interactions between health and income, and the findings point to four main ways in which resources impact a population's health:[112]

- **Material**: as initially mentioned, money allows families to acquire goods and services to improve health.
- **Psychosocial**: income constraints trigger stress, which can lead to biochemical changes in the body and cause ill health.
- **Behavioural**: for various reasons, including psychosocial factors such as **adverse childhood experiences**,[113] people with lower incomes are more likely to engage in unhealthy behaviours such as **smoking** and **drinking**.
- Reverse causation: poor health prevents people from taking paid **employment**, consequently, affecting their income.

Poverty is affecting the health of the UK population. Importantly, the data shows that this impact plays out in different ways, impacted by factors such as geography and life stage.

Data on poverty

- By 2021, **13.4 million** people were **in poverty** (around 20% of the UK population). Out of them, almost 8 million were working-age adults, almost 4 million were children, and 1.7 million, were pensioners. [i]
- People living with the 40% lowest incomes are **more than twice** as likely to say they have **poor health**, and more than 5 times as likely to say they have bad or very bad health. [ii]
- In 2016, it was calculated that poverty costs **£29bn per year** to the NHS and the social care systems. [iii]

i Joseph Rowntree Foundation (2023) UK Poverty 2023
ii The Health Foundation (2020) Living in poverty was bad for your health long before COVID-19
iii Joseph Rowntree Foundation (2016) Counting the cost of UK poverty

5.1.1 Child poverty

Research has shown that exposure to **poverty in childhood is associated with a wide range of adverse health, educational, social, and psychological outcomes**.[114] In terms of physical health, links have been demonstrated between child poverty and worse outcomes in infant mortality, low birth weight, asthma, obesity, tooth decay, and accidental health.[115] Research has also found links between child poverty and decreased educational attainment, as well as increased risky behaviours, delinquency, and criminal behaviour in adolescence and adulthood.[116] Infant mortality in England rose between 2014 and 2017, disproportionately affecting the poorest areas of the country and widening inequalities in infant mortality.[117] In the long run, childhood health can affect educational outcomes, limiting job opportunities and potential earnings.[118]

Experiencing poverty early in life also impacts mental health. It has been shown that children from households in the bottom fifth of income distribution are more than four times more likely to experience severe mental health problems, compared to those in the highest fifth.[119]

Child poverty rates have risen in the UK in the last decade.[120] As of June of 2023, seven in ten children experiencing poverty were living in working households, and the poverty rate for children in families with three or more children was 42%, compared with 23% and 22% amongst children in families with one or two children, respectively.[121]

Child poverty in numbers[i]

- In Northern Ireland, 22.2% of children are experiencing poverty. Areas such as Belfast West and Belfast North register rates as high as 28.5% and 27.6%, respectively.
- In Wales, 28% of children live in poverty after housing costs. Before housing costs, almost 4 in 5 children living in poverty live in working households.
- In Scotland, 24% of children were living in poverty before the full rollout of the new Scottish Child Payment.
- In the UK, 47% of children in Asian or Asian British households and 53% in Black households were in poverty after housing costs, while only 25% of those came from a White household.

Adverse outcomes of child poverty:[ii]

- Relative **infant mortality** risk increases by 10% for each increase in deprivation level.
- Children born into the poorest fifth households in the UK are 12 times more likely to experience a series of **poor health and educational outcomes** by the age of 17, compared with more affluent peers.
- Children who live in the most socioeconomically deprived areas are twice as likely to be **obese** than those in the least deprived areas.

i End Child Poverty (2023) Child poverty in your area.

ii The Academy of Medical Sciences (2024) Prioritising early childhood to promote the nation's health, wellbeing, and prosperity

It has been estimated that in 2021, the cost of child poverty in future lost earnings was £11.6 billion, with an associated loss in income taxation of £4.8 billion, and an additional future unemployment benefit cost of £2 billion.[122]

Politicians and decision-makers must acknowledge the prevalence and long-term impact of child poverty on health and try to look for effective ways to progressively reduce it.

Organisations such as the RCPCH are calling political parties to 'recognise that poverty is a key driver of poor child health outcomes and commit to reduce child poverty and ensure no policy exacerbates child health inequalities.'[123]

The RCGP has endorsed the IHA call for the adoption of a '**child health in all policies**' approach. Wales has spearheaded this vision by passing the **Wellbeing of Future Generation Act** in 2015. This echoes the 'Children in All Policies 2030', an initiative by the WHO, UNICEF, and the Lancet Commission. Similarly, a recent report by the Academy of Medical Sciences promotes a 'child health in all policies' approach while also calling for the development of a unifying vision across the Government to prioritise early years health and wellbeing.[124] The implementation of these recommendations should ideally be in line with the Marmot Principles.[125]

In sum, exposure to poverty in childhood has an important impact on people's health, development, and wellbeing for their whole lives. Therefore, the Government should recognise that poverty is a key driver of poor health outcomes for children and make commitments to reduce child poverty and ensure no policy exacerbates child health inequalities.

5.1.2 Cost of living crisis

The 'cost-of-living crisis' has undoubtedly exacerbated social and health inequalities in recent years, worsening the negative impact of the pandemic on the population. An analysis of financial wellbeing in June of 2022, revealed that 4.4 million UK households (one in six) were in 'serious difficulty' with consequences for their health.[126]

A poll conducted by the Health Foundation in 2022 revealed that 57% of people believe rising living costs are a high or very high threat to the health of UK citizens.[127] That perception is shared by those providing healthcare. A survey conducted by NHS Providers revealed that 95% of executive directors and chairs of the health and care sector think that the rising cost-of-living had significantly, or severely, worsened health inequalities in their local area. The survey also revealed that 72% have seen an increase in mental health presentations due to stress, debt, and poverty.[128] This echoes ONS data which reports that 34% of people agreed that the increase in the cost of living has negatively impacted their mental health.[129]Similarly, the RCGP 2023 tracking survey revealed that 93% of GP respondents were concerned that the rising number of patients needing support with the cost of living would limit their ability to provide the medical care that patients need. **73% of GPs had also noticed a worrying increase in patients presenting with problems linked to the rising cost of living**, such as poor diet and poverty, as compared to the previous year.

Data on the cost-of-living crisis

- Fuel poverty results in 9700 **premature deaths** per year as well as wasted energy and money.[i]
- **Cold homes** impact asthma, respiratory infections, hypertension, mental health, dementia, increased heart attacks and strokes, and can impact childhood development. [ii]
- Increasing **fuel poverty** will have a significant impact on general practice. For example, it has been shown that for each 1°C drop below 5°C external temperature, presentations to general practice increase by up to 19%. [iii]

i Faculty of Public Health (n.d.) Fuel poverty and affordable warmth

ii Institute of Health Equity (2022) Fuel poverty, cold homes and health inequalities in the UK.

iii Hajat S, Kovats RS, Lachowycz K. (2007) Heat-related and cold-related deaths in England and Wales: who is at risk?

As witnessed by GPs, lower-income households are struggling the most with the **increased cost of basics** such as food, power and fuel, or housing, which now represent a greater proportion of their limited spending capacity. By October 2022, data showed that the poorest fifth of households in the UK spend 37% of their income on these essentials,[130] almost a quarter used credit to pay for essential bills, and over seven in ten of them were going without essentials.[131]

Additionally, almost 20% of low-income families[132] and more than 25% of families receiving Universal Credit experienced food insecurity in 2020/21.[133] Rising food prices have seen this increase by 13% in the 12 months to August 2022.[134] As a consequence, by the end of 2022, half of the poorest fifth of households said they had reduced spending on food for adults and almost 40% of families with children were spending less on food for their children. This can also be seen in the growing use of foodbanks.[135]

To protect the health of the population, **governments across the UK must monitor the impacts of the cost-of-living crisis to prevent more people from falling into poverty and adopt measures that ensure food and essentials are accessible to all**.

5.2 Housing

There is strong evidence for the impact of the high cost of poor housing conditions in the UK on the health of our population, particularly the most deprived. NHS England spends £1.3 billion per year treating health conditions caused by **cold, damp houses**.[136] Cold homes are associated with respiratory conditions, and an increased risk of hypertension, heart attacks and stroke, as well as with mental health problems in adolescents and adults, slower weight gain in infants, and higher risk of developing asthma and hospital admissions in young children.[137] Children growing up in cold, damp houses are more than twice as likely to develop respiratory conditions compared to their classmates living in warm houses.[138]

Housing and minority ethnic groups[i]

- The exposure to COVID-19 was higher amongst some ethnic minority groups because, among other reasons, these groups are more likely to live in high-density housing, multi-generation homes, and urban areas where transmission is higher.
- Disadvantaged home tenure: the proportion of people living in social rented housing is highest in Black, Mixed White-Black, and White Gypsy or Irish Traveller groups, while the proportion of homeowners is lowest in Black and Mixed White-Black groups, and overcrowding is highest in Bangladeshi households.

i The King's Fund (2023) The health of people from ethnic minority groups in England

Poor housing conditions, such as poor quality and overcrowding, are also associated with an increased risk of cardiovascular and respiratory diseases, as well as depression and anxiety.[139] Almost one third of English households facing **overcrowding**, problems of **affordability**, and **poor housing quality** have rated their health as less than good.[140] Disparities are evident in terms of affordability and quality, with **minority ethnic groups households** being more likely to live in overcrowded homes and to experience fuel poverty than white households.[141]

Swope and Hernandez's 2019 conceptual model addresses the complexities of the relationship between housing and health. The model illustrates how **housing has an impact on health inequalities** and how **structural disparities shape unequal access to housing** through four pillars: housing affordability-cost, housing quality-conditions, residential stability, and neighbourhood opportunity-context.[142]

This demonstrates that housing issues should be a top priority of UK authorities looking to improve health, particularly of those in the most socioeconomically deprived segments of the population. **Governments across the UK should address the link between housing and health and invest in ambitious national policies to improve housing quality and access to social housing, so no one is living in unsafe conditions that may negatively affect their health**.

It is important to note that as well as improving the quality of housing itself, we must also **ensure that support is offered to those who are homeless**. As previously mentioned, homelessness drives poor health outcomes and is a risk factor for premature mortality; it is also associated with extremes of deprivation and multi-morbidity. The annual cost of providing unscheduled care to patients experiencing homelessness is eight times that of the housed population.[143]

5.3 Employment:

There is a **complex relationship between employment and health with poor health limiting capacity to work, and conversely, employment status having an impact on health**. Unemployment is linked to lower life expectancy and poorer mental and physical health, with socioeconomic deprivation being associated with poor health as well as with unemployment. Data from 2019/20 shows that the employment rates in the most deprived decile was 68.4% while in the least deprived it was 81.5%.[144]

Unsurprisingly, **unemployment** is not evenly distributed. Data from early 2021 shows that the highest levels of unemployment were concentrated amongst **young people** between 18–24 years (14%), those with **fewer qualifications** (7.8%), and those from **minority ethnic groups** (7.6%). This compares to the English national unemployment rate of an estimated 5.1% in 2021.

Similarly, the evidence suggests that the employment rate of an area is linked to healthy life expectancy. People living in areas with lower economic inactivity or higher employment rates are more likely to have a higher healthy life expectancy.[145] It has also been found that, in England, areas of sickness (where more population is experiencing bad health) are associated with areas of low productivity, high poverty, and persistent unemployment.[146]

In addition, mental health and employment have a bi-directional relationship. Mental health has an influence on employability and retaining a job, while lack of employment can cause stress, impacting long-term physiological health and potentially triggering depression or anxiety. In January 2021, 43% of unemployed people reported having poor mental health.[147] Disparities remain apparent, with people from minority ethnic groups reporting higher levels of work stress than those from white groups.[148]

A recent study has shown that more than 2.6 million people in the UK are inactive due to **long-term sickness**, which has driven the surge in Universal Credit.[149] However, GPs are also seeing the impact of the cost-of-living crisis on health and employment, with anecdotal reports of patients refusing sick notes because they cannot afford to stop working. This may mean that patients are becoming more unwell and putting their health at further risk, which can increase the demand for health services in the future.

In attention to the significant impact of employment on health, the **Government should develop policies that appropriately support those unemployed or working under poor conditions so that they are not plunged into poverty, as well as supporting those who can safely return to work**.

5.4 Social determinants of health and general practice

GPs are first-hand witnesses to the struggles of their patients, including non-clinical ones such as financial constraints, housing, or relationship issues, as previously mentioned. In response to health inequalities and socio-economic deprivation, there have been changes to the operation of general practice to help address some of the issues patients are presenting with.

For instance, in many areas, **primary care social prescribing services** connect people with non-medical community-based services, when needed, that can help them meet their practical, social, and emotional needs.[150,151] It has been found that social prescribing link workers can help patients in primary care settings to develop confidence, motivation, and knowledge that allows them to better manage their own wellbeing.[152]

Similarly, **care navigation services** in general practice aim to make the best use of GP practice and wider primary care resources to help patients access the right person, at the right time and place. Well delivered, care navigation should improve the experience and outcomes of patients.[153]

General practice also provides direct support to mitigate some of the diverse issues facing patients. For example, GPs and other members of the practice team provide **fit notes and advise patients** on their recovery to help them safely return to work. GPs also follow good practice to **safeguard** adults and children, advocating for the most vulnerable patients wherever possible. In some areas, pilot schemes have even allowed GPs to provide prescriptions for boilers[154] to address problems associated with cold homes and the cost-of-living crisis.

The College firmly believes in the **significant role that non-health related factors play in health inequalities** and the need for decisive action by Governments and policymakers to address the social inequalities as a stepping stone to reducing the health inequality gap in our population.

Recommendations:

- Governments across the UK should produce a cross-government strategy to reduce health inequalities that:
  - Actively recognises the impact of social determinants on population health and commits to taking action to reduce them.
  - Considers and uses every government department and every available policy lever in tackling health disparities and the wider determinants of health.
  - Has clear measurable goals and metrics to measure progress
  - Is underpinned by the necessary funding settlement.
- Governments across the UK should prioritise and develop an integrated vision of child health and wellbeing. Governments of England, Scotland, and Northern Ireland should adopt a 'child health in all policies' approach, as has been done in Wales.
- Governments of England, Wales, and Scotland should commence the socio-economic inequality duty, section 1 of the Equality Act 2010*

*Section 1 of the Equality Act does not apply to Northern Ireland.

1 Office for National Statistics (2022) Trends in patient-to-staff numbers in General Practices in England: 2022

2 The Health Foundation (2021) Response to the Health and Social Care Select Committee's inquiry – The Future of General Practice.

3 McCartney G. et al. (2019) Defining health and health inequalities.

4 Sources: ONS, England (2019), ONS, Wales (2019), National Records of Scotland (2019-21), Department of Health, Northern Ireland (2017-19).

5 NHS England (n.d.) Inclusion health groups

6 The Lancet – Editorial (2021) 50 years of the inverse care law

7 ONS England (2022) Trends in patient-to-staff numbers at GP practices in England: 2022

8 The Health Foundation (2021) The Health Foundation's response to the Health and Social Care Committee's inquiry – The future of General Practice

9 Marmot, M. et al., (2010) Fair Society, Healthy Lives (The Marmot Review)

10 Consumer Data Research Centre (n.d.) Index of Multiple Deprivation (IMD)

11 As national indices of deprivation typically poorly represent rural disadvantage, there have been academic developments to build a new method to better depict deprivation in rural settings. For more information: 'Rural Deprivation Index' https://doi.org/10.1016/j.socscimed.2018.09.019

12 Department of Health & Social Care (2023) The NHS Constitution for England.

13 Homeless Link (2022) Unhealthy State of Homelessness 2022: Findings from the Homeless Health Needs Audit

14 CQC (2022) Looking after homeless patients in General Practice

15 Doctors of the World (2016) Registration Refused: A study on GP registration in England, 2016

16 Public Health England (2020) Case study: My right to Healthcare

17 BMA (2022) Patient registration

18 A tool that may help facilitate this process and improve patient access is the NHS Register with a GP surgery service, now used by 1 in 5 practices in England. This interface includes an option that allows new patients or those changing practices to skip the address field when registering, and similarly, with other identity questions. In addition, the tool allows patients flexibility regarding the time of registration, with 48% of all patients using the online tool doing so outside normal GP surgery opening hours. (Data presented in the NHS England Primary Care Bulletin 07.09.2023).

19 NICE (2022) Integrated health and social care for people experiencing homelessness – NICE guideline [NG214]

20 Welsh Government (2022) Hospital and GP services (National Survey for Wales): April 2021 to March 2022

21 McQueenie, Ross, et al. (2019) Morbidity, mortality and missed appointments in healthcare: a national retrospective data linkage study.

22 NHS England (2023) GP Patient Survey

23 These include the following: patients in the most socioeconomically deprived areas; patients with a disability; patients with two, three, or more health conditions; patients from Pakistani, Bangladeshi, and Indian ethnic groups; Sikh and Muslim patients, along with those who preferred not to say about their religion; gay or lesbian and bisexual patients, along with those who preferred not to say about their sexuality; non-binary patients, along with those who preferred not to say about their gender.

24 All practices can nominate one member of their staff, involved in triaging requests, such as reception staff and care navigators, for this virtual training. The aim is to support staff to be confident to communicate effectively and be able to signpost to the most relevant team member or local services, depending on patient needs.

25 Language barriers are understood not only in terms of proficiency with the local language, but also considering fluidity and different levels of lexicon, education, and health literacy of patients.

26 NHS Confederation (2019) Tackling health inequalities: Learning from each other to make rapid progress.

27 WHO European Region (2023) The ongoing journey to commitment and transformation

28 ONS (2019) Internet access – households and individuals, Great Britain: 2019

29 Citizens Advise (2023). One million lose broadband access as cost-of-living crisis bites.

30 Philip L. et al. (2017) The digital divide: Patterns, policy and scenarios for connecting the 'final few' in rural communities across Great Britain

31 The Kings' Fund (2023) Moving from exclusion to inclusion in digital health and care.

32 Verity, Aaminah & Tzortziou-Brown, Victoria (2023) Inclusion health patient perspectives on remote access to general practice: a qualitative study

33 Baker, R. & Streatfield, J. (1995) What type of general practice do patients prefer? Exploration of practice characteristics influencing patient satisfaction, British Journal of General Practice.

34 Warren, J.R. et al. (2015) Association of Continuity of Primary Care and Statin Adherence, PLoS ONE.

35 Atlas, S.J. et al. (2009) Patient–Physician Connectedness and Quality of Primary Care, Annals of Internal Medicine.

36 Pereira Gray, Denis J et al. (2018) Continuity of care with doctors-a matter of life and death? A systematic review of continuity of care and mortality

37 Barker I. et al. (2017) Association between continuity of care in general practice and hospital admissions for ambulatory care sensitive conditions: cross sectional study of routinely collected, person level data, British Medical Journal.

38 Kajaria-Montag, H. et al. (2023) Continuity of Care Increases Physician Productivity in Primary Care

39 Pereira Gray, Denis J et al. (2018) Continuity of care with doctors-a matter of life and death? A systematic review of continuity of care and mortality

40 Stafford, M. et al. (2023) Continuity of care in diverse ethnic groups: a general practice record study in England

41 Nuffield Trust (2018) Improving access and continuity in general practice

42 Mott MacDonald (2022) Increasing Continuity of Care in General Practice Programme

43 Bevan Commission (2020) Delivering a Prudent Approach to Primary Care in Wales.

44 Related to this, is the fourth principle: 'Reduce inappropriate variation using evidence-based practices consistently and transparently', which implies patients should be able to access high-quality standard healthcare across the different parts of the system and localities.

45 Levene, Louis et al. – BJGP (2019) Socioeconomic deprivation scores as predictors of variations in NHS practice payments: a longitudinal study of English general practices 2013–2017

46 Boomla, K., Hull, S., and Robson, J. (2014) GP funding formula masks major inequalities for practices in deprived areas.

47 This study, focused on East London, found that consultation rates were similar among individuals of 50 years in the most deprived quintile and of 70 years in the least deprived, which demonstrates the different levels of workload associated with deprivation. In terms of funding, they recalculated the age-sex workload element in the formula, weighting the population by the observed consultation rates in each deprivation quintile. For Tower Hamlets, they estimated that a formula that responds to the additional workload would have provided 33% more funding.

48 The Health Foundation (2021) 'Levelling up' general practice in England

49 The Health Foundation (2023) Doing more for less?

50 NHS England (2016) General Practice Forward View

51 House of Commons, Health and Social Care Committee (2023) The future of general practice.

52 BMA (2015) Focus on the global sum allocation formula.

53 The Health Foundation (2021) 'Levelling up' general practice in England

54 BMA (2015) Focus on the global sum allocation formula.

55 The Health Foundation (2021) 'Levelling up' general practice in England

56 The Health Foundation (2023) Doing more for less?

57 The Health Foundation (2021) 'Levelling up' general practice in England

58 In England, enhanced services account for more than 10% of the total GP budget, according to a BMJ publication.

59 Glidewell, L., et al. (2015) Does a local financial incentive scheme reduce inequalities in the delivery of clinical care in a socially deprived community? A longitudinal data analysis

60 Castle, Laura et al. (2020) Shortfalls of funding for general practice in deprived areas.

61 The indicators are health checks for people with a learning disability and the use of FIT testing in cancer referral pathways. This last one is linked to one of the priority areas of the CORE20Plus5 approach.

62 HFMA (2023) Resources and funding to reduce health inequalities.

63 The Health Foundation (2023) Doing more for less?

64 Regional Partnership Boards bring together health boards, local authorities, and the third sector to meet the care and support needs of people in their area.

65 Welsh Government (2020) Regional Partnership Boards (RPBs).

66 NHS Wales (2021) NHS Wales Planning Framework 2022/2025 – Cluster Annual Plans 2022/2023, Frequently Asked Questions guide

67 Scottish Government (2017) Improving Together: A National Framework for Quality and GP Clusters in Scotland

68 Jackson, B., et al. (2023) The FAIRSTEPS Study: Framework to Address Inequities in pRimary care using STakEholder PerspectiveS – short report and user guidance

69 National Centre for Rural Health and Care (2023) Response to the NHS Long Term Workforce Plan

70 It is important to note that the solutions to the recruitment and retention challenges may be very different for rural settings, compared to urban areas, and between rural settings. Therefore, solutions need to be flexible by locality and determined by rural-proofing policy against local requirements.

71 The King's Fund (2024) Staff shortages: what's behind the headlines?

72 ONS (2022) Trends in patient-to-staff numbers at GP practices in England: 2022

73 The Health Foundation (2021) 'Levelling up' general practice in England

74 The Health Foundation (2023) Doing more for less?

75 Mercer S., et al. (2023) Is Scotland's new GP contract addressing the inverse care law?

76 Welsh Government (2022) General practice and primary care cluster population and workforce by deprivation

77 There is no data about the number of GPs per quintile of deprivation available for Northern Ireland. However, according to NISRA (2020), patients from the most deprived and least deprived quintiles in Northern Ireland lived closest to a GP Practice on average, while those in the middle quintile lived furthest on average. These findings may be influenced by the often-urban location of GP Practices typically characterised by areas of high and low deprivation.

78 McConnachie, A., et al. (2023) Quantifying unmet need in General Practice: a retrospective cohort study of administrative data

79 The Health Foundation (2021) 'Levelling up' general practice in England

80 Dhanani, S. & Blane, D. (2022) The Deep End GP Pioneer Scheme: a qualitative evaluation

81 Fairhealth (n.d.) GP Trailblazer programme

82 Scottish Government (2018) National health and social care workforce plan: part three

83 GIG CYMRU NHS Wales (n.d.) TrainWorkLive.

84 Most socioeconomically deprived areas consider IMD ranking 1-3, and the least socioeconomically deprived areas consider IMD ranking 8-10.

85 'The expert generalist skills of GPs, together with the core values of holistic, relationship-based care, will remain at the heart of multidisciplinary teams. GPs will lead practice teams, hold risk, and retain overall clinical responsibility for their patients. They will continue to provide hands-on patient care, where their expertise and skills are needed most, managing multimorbidity, undifferentiated illness and making diagnosis and referral decisions. Other members of the practice team will undertake a range of tasks which need not be performed by a GP. Some practitioners will have a high degree of independence, for example, being able to prescribe, whereas other roles will require more supervision. The GP will also play a role in upskilling and supporting their practice staff to develop generalist skills.'

86 National Centre for Rural Health and Care (2023) Response to the NHS Long Term Workforce Plan.

87 Junghans, C. et al. (2023) Learning from the universal, proactive outreach of the Brazilian Community Health Worker model: impact of a Community Health and Wellbeing Worker initiative on vaccination, cancer screening and NHS health check uptake in a deprived community in the UK.

88 Northern Ireland Audit Office (2024) Access to General Practice in Northern Ireland.

89 The Health Foundation (2023) Doing more for less?

90 A good example of training available for the profession in this area is the South Yorkshire Primary Care – Workforce & Training Hub, which has developed sources for Health Inequalities Training.

91 Institute for Health Equity & World Medical Association (2016) Doctors for Health Equity.

92 Institute for Health Equity & World Medical Association (2016) Doctors for Health Equity.

93 In England, the LTWP sets out an expansion of the number of medical school places (projected to rise to 15,000 by 2031) and includes an ambition to reform education and training while tackling health inequalities where possible. Also, it commits to focus on new medical schools and additional places in geographical areas with the greatest staff shortfalls and unmet healthcare needs.

94 RCGP & MSC (2017) Destination GP Medical students' experiences and perceptions of general practice.

95 Singleton, Rose (2020) The benefits of rural training: Producing the expert generalists of the future.

96 NHS England (n.d.) What is HEFT?

97 Institute for Health Equity & World Medical Association (2016) Doctors for Health Equity.

98 Ada Lovelace Institute (2022) A knotted pipeline: data-driven systems and inequalities in health and social care.

99 NHS Confederation (2019) Tackling health inequalities: Learning from each other to make rapid progress.

100 Institute for Health Equity & World Medical Association (2016) Doctors for Health Equity.

101 Institute for Clinical Systems Improvement (2014) Going beyond Clinical Walls: Solving Complex Problems.

102 The Health Foundation (2018) What makes us healthy? An introduction to the social determinants of health.

103 Marmot M. et al. (2020) Marmot Review 10 Years on.

104 The King's Fund (2024) Health inequalities in a nutshell.

105 UK Government (2022) Levelling Up the United Kingdom.

106 The Health Foundation (2022) Healthy life expectancy target: the scale of the challenge.

107 According to the King's Fund, the government's commitment to improving health life expectancy is inconclusive. The latest ONS data – from 2018-20 – show no significant change in healthy life expectancy between 2015-17 and 2018-20.

108 Labour (2023) Building an NHS Fit for the Future.

109 The Equality Trust (n.d.) Socio-Economic Duty.

110 Citizens Advice (2015) A very general practice: How much time do GPs spend on issues other than health?

111 LBC (2023) One in five GP appointments taken up by people who are just lonely, or need relationship, debt or housing advice.

112 Joseph Rowntree Foundation (2014) How does money influence health?

113 California Department of Public Health (2022) Trauma-Informed Approaches to Tobacco Prevention and Cessation.

114 Lai ETC, Wickham S, Law C, et al. (2018) Poverty dynamics and health in late childhood in the UK: evidence from the Millennium Cohort Study.

115 Wickham S, Anwar E, Barr B, et al. (2016) Poverty and child health in the UK: using evidence for action.

116 Le Menestrel, S. & Duncan, G. (2019) A roadmap to reducing child poverty

117 Taylor-Robinson D, et al. (2019). Assessing the impact of rising child poverty on the unprecedented rise in infant mortality in England, 2000–2017: time trend analysis.

118 Joseph Rowntree Foundation (2014) How does money influence health?

119 The Kings' Fund (2022) What are Health Inequalities?

120 The Health Foundation (2022) Trends in poverty.

121 End Child Poverty (2023) Child poverty in your area.

122 Hirsch, D. (2021) The cost of child poverty in 2021.

123 RCPCH (2023) Our manifesto for the next UK General Election: support children's health and wellbeing in a changing. world.

124 The Academy of Medical Sciences (2024) Prioritising early childhood to promote the nation's health, wellbeing, and prosperity.

125 Marmot Principles:

1. Give every child the best start in life.
2. Enable all children, young people, and adults to maximise their capabilities and have control over their lives.
3. Create fair employment and good work for all.
4. Ensure a healthy standard of living for all.
5. Create and develop healthy and sustainable places and communities.
6. Strengthen the role and impact of ill health prevention.
7. Tackle racism, discrimination, and their outcomes.
8. Pursue environmental sustainability and health equity together.

126 Evans J. & Collard Sh. (2022) Under Pressure: The financial wellbeing of UK households in June 2022.

127 The Health Foundation (2022) The cost-of-living crisis is a health emergency too.

128 NHS Providers (2022) Rising living costs: the impact on NHS, staff, and patients.

129 ONS (2023) Tracking the impact of winter pressures in Great Britain: 18 to 29 January 2023.

130 The Health Foundation (2022) The cost-of-living crisis is a health emergency too.

131 Joseph Rowntree Foundation (2023) UK Poverty 2023.

132 This refers to households living below the average income.

133 Joseph Rowntree Foundation (2023) UK Poverty 2023.

134 The Health Foundation (2022) The cost-of-living crisis is a health emergency too.

135 Joseph Rowntree Foundation (2023) UK Poverty 2023.

136 NHS Confederation (2022) Could the energy crisis cause a public health emergency?

137 Faculty of Public Health (n.d.) Fuel poverty and affordable warmth.

138 NHS Confederation (n.d.) Fuel Poverty.

139 The Kings' Fund (2022) What are Health Inequalities?

140 The Health Foundation (2021) Relationship between health and number of housing problems.

141 The Kings' Fund (2022) What are Health Inequalities?

142 Swope, C. & Hernandez, D. (2019) Housing as a determinant of health equity: A conceptual model.

143 Institute for Health Equity & World Medical Association (2016) Doctors for Health Equity.

144 The Kings' Fund (2022) What are Health Inequalities?

145 The Health Foundation (2022) Relationship between employment and health.

146 Institute of Public Policy Research (2024) Revealed: Sickness epidemic creating new wave of economically inactive in 'bad health blackspots'

147 The Health Foundation (2021) Unemployment and mental health.

148 Public Health England (2018) Local action on health inequalities.

149 The Centre for Social Justice (2023) Two Nations: The State of Poverty in the UK.

150 NIHR (2023) Who's who in General Practice? Research can help practices introduce new roles.

151 Despite the arguments favouring social prescribing improving health and wellbeing, and reducing inequalities, current evidence fails to provide sufficient detail to judge either success or value for money of social prescribing programmes, as some research present. Source: Bickerdike et al. (2017) Social prescribing: less rhetoric and more reality. A systematic review of the evidence.

152 Tierney, S. et al. (2020) Supporting social prescribing in primary care by linking people to local assets: a realist review.

153 Healthcare Improvement Scotland (n.d.) Care Navigation in General Practice: 10-step guide.

154 A pilot scheme was implemented in Gloucestershire in 2022 to help patients with a higher risk of hospital admissions due to exposure to cold homes. A similar pilot was implemented in Sunderland almost ten years before, impacting the reduction of GP appointments for COPD patients.

Published May 2024

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