

POLICY BRIEF

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Building Equitable Primary Care

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SUMMARY

Right now, in parts of the UK, people are dying earlier than they should. Inequalities in primary care contribute to this; people with poorer access to primary care have poorer health outcomes and lives are cut short. We have decades of research describing these health inequalities, but practicable solutions have remained elusive.

Two independent research studies, EQUALISE – funded by NIHR and led by the University of Cambridge, and FAIRSTEPS – funded by Health Education England and led by the University of Sheffield, have combined their findings in the Building Equitable Primary Care toolkit. This toolkit equips healthcare practitioners and policy makers to redress the inequalities in primary care.

The case for change

Health inequalities in the UK have been well documented over the last 50 years, but in recent years we have seen a widening of these inequalities. In England, the life expectancy gap between the most and least deprived areas has increased from [9.0 years in 2011-13 to 9.7 years in 2018-20 for men and from 6.9 years to 7.9 years for women](#).

Primary care is not immune to inequalities; there are persistent inequalities in funding ([practices in deprived areas get less funding](#)) and workforce ([deprived areas have fewer GPs per patient](#)).

Emerging work at the University of Cambridge explored the effect of funding on workforce and patient outcomes. Patient experience improves with better funding and increased workforce, but funding is only part of the solution, and other changes are needed to achieve equitable primary care. The inequalities found in patient experience ([patients in the most deprived areas have a worse experience of general practice](#)) reflect inequalities in quality ([deprived areas have more practices with the lowest CQC ratings](#)) and health outcomes ([people living](#)

[in deprived areas experience a higher level of diagnosed illness](#)). These widening inequalities in primary care have driven two projects, EQUALISE and FAIRSTEPS, to seek practicable ways to build equitable primary care.

The recent Delivering Equitable Primary Care conference, organised by the EQUALISE and FAIRSTEPS research teams in July 2023, brought together health inequality leads of NHS England, representatives of GP professional bodies, patient representatives and researchers. Drawing on this conference, we argue that we need a positive vision of equitable primary care and set out a range of guiding principles and evidence-informed actions.

Policy background and ongoing efforts to address inequalities

There is a growing number of initiatives aimed at closing the health gap. To mention a few examples, the [Core20Plus5](#) approach is designed to support Integrated Care Systems to reduce inequalities in healthcare at national and system

level. [The Tackling Neighbourhood Health Inequalities \(TNHI\)](#) has been designed to help meet the NHS commitment to address health inequalities. The [Safe Surgeries Toolkit](#) lays out seven steps for practices to ensure that vulnerable migrant communities can access the healthcare they're entitled to. [Focused Care](#) works with the most vulnerable and seldom-heard households across Greater Manchester to help them access appropriate care via their Primary Care and Community teams. The [PRIME \(PRimary care MEntal health\) study](#) looked at [improving mental health in deprived populations through non-pharmaceutical interventions](#). It found that non-pharmaceutical interventions (not using medical prescriptions) can work, but social disadvantage can prevent people accessing this help.

What did we do?

[The EQUALISE study](#) explored what types of interventions in general practice increase or decrease inequalities among people with, or at risk of, cardiovascular disease, cancer, diabetes and/or chronic obstructive pulmonary disease. A realist review was carried out to identify for whom these interventions and aspects of care work best, why, and in what circumstances.

[The FAIRSTEPS study](#) produced guidance for action in primary care to address health inequalities. Through a literature review, the research team identified what made actions effective and through consultation with practitioners and patients, provided prioritised examples, by feasibility and usefulness.

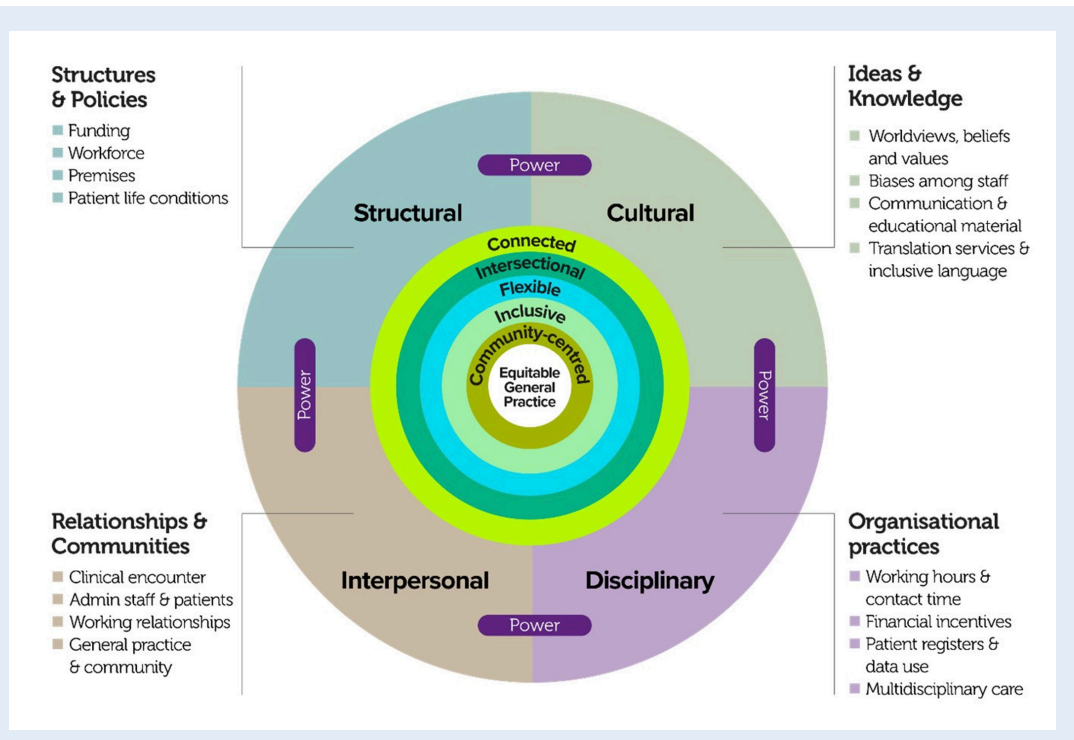
What did we find?

5 PRINCIPLES, 4 ACTION AREAS, 4 STEPS

The EQUALISE study found that equitable general practice is marked by five key principles:

- 1. Connected:** Interventions and services should be understood, designed, and delivered as connected components of coordinated action against health inequalities.
- 2. Intersectional:** Care should adopt an intersectional perspective to account for the different impact of services and interventions among patients according to their circumstances and experience of (multiple) disadvantage.
- 3. Flexible:** Care delivery should be flexible enough to make allowances for different patient needs and preferences in terms of time, accessible communication, location, and provided support.
- 4. Inclusive:** We need to cultivate an organisational culture that is less Western-centric and normative to ensure that people are not excluded due to wrong assumptions about who they are, what they need, and how they 'should' behave.
- 5. Community-centred:** Everybody involved in care should have a say in how it is conceived, (re) designed, and delivered including clinical and non-clinical members of staff, patients, and their networks.

Figure 1:
EQUALISE: An
action framework
for equitable
general practice



These five key principles should inform interventions and initiatives against health inequalities across four areas of action which cover: the structures and policies; the common ideas and knowledges spread; the everyday organisational practices; and the relationships among individuals and communities involved in general practice.

The FAIRSTEPS study provides an evidence-informed framework to guide the commission, design and delivery of interventions in primary care to address health inequalities involving four steps.

Step 1: Define the groups experiencing inequality

Step 2: Consider the issues

Step 3: Ensure key ingredients are included

Step 4: Co-design the intervention (involve service users, ensure sensitivity to local context and resources, establish responsibilities, plan evaluation).

In addition, the FAIRSTEPS study provides a set of tried and tested practical interventions, prioritised by feasibility and usefulness after consultations with practitioners and patients.

Figure 2: FAIRSTEPS: Framework Process



Building equitable primary care: a toolkit for practitioners and decisionmakers

The findings from the EQUALISE and FAIRSTEPS studies have been integrated in the [Building Equitable Primary Care toolkit](#) which supports healthcare policymakers and practitioners translate research into action. The toolkit presents a new vision of equitable primary care by discussing the evidence-based five key principles, four action areas and four steps in the context of real-life interventions delivered in the UK and beyond. The research teams have already shared the toolkit with NHS England health inequalities teams and aspire that it will drive the design of effective, locally focused interventions to reduce inequalities in health and healthcare outcomes.

What are people saying about the toolkit?

Initial responses from a feedback survey about the Building Equitable Primary Care toolkit suggest that the toolkit does effectively equip policy makers and practitioners to address health inequalities, and that users would be likely or very likely to share the toolkit with colleagues. In response to the question “What changes might happen as a result of your workplace using this Toolkit?”, responses have included: “Helping PCNs take practical steps to implement health inequality activities”; “Assessing impact at an earlier stage of planning”; “more evidence-based practice” and “reduced health inequalities”.

Key recommendations

- **Creating a positive vision:** Health inequalities in general practice emerge through complex processes and ways to tackle them require thorough long-term, multi-level action, rather than attempting to tackle complex problems with simple solutions. Policy makers can articulate a positive vision of what equitable general practice looks like.
- **Take action:** Practitioners and policy makers can use the Building Equitable Primary Care toolkit to engage with local stakeholders about the specific ways the toolkit can inform health inequalities action in their local area and context.
- **Balance autonomy with standardised care:** Interventions like the Quality Outcomes Framework show that standardisation of care improves overall quality, however, when it comes to inequality there is a need for flexibility as well. General practices need to have relative autonomy to decide how to do their work better in terms of reducing inequalities.
- **Equitable distribution of funding:** Funding across general practices can better account for differences in need of the served populations and the extra effort needed to take action to achieve quality targets in practices in disadvantaged areas.
- **Workforce support:** Workforce schemes are needed to promote the recruitment and retention of staff in disadvantaged and remote areas with people who, ideally, are representative of the local population.
- **Workforce training:** All GP training programmes can provide training in health inequalities and experience working with disadvantaged patients, such as those experiencing disadvantage because of socioeconomic position or cultural differences.
- **Make effective use of diversity:** Diversity needs to be employed in a way that promotes equity in care outcomes. This involves fighting structural racism and sexism, as well as inclusion work for patients and staff members related with sexual orientation, religion, disability, and caring responsibilities.
- **Invest in high-quality data:** Collecting and using high-quality data is paramount to recognising and acting against inequalities. Time can be provided before or during the consultation for data collection, including health-related and socioeconomic information.
- **Tackle accessibility barriers:** General practice services need to be accessible in terms of location, and to develop processes which will enable patients to overcome transportation barriers. This can take the form of co-locating practices with local services and community landmarks such as foodbanks and schools.
- **Increase continuity of care:** It is important that continuity between patient and healthcare professionals is enhanced. This could be achieved by providing incentives to increase staff retention and involve GP teams in invitation to prevention services.

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