

Research paper

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Tackling inequalities in general practice



An Inquiry into the Quality of General Practice in England

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The views expressed are those of the authors and not of the panel.

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Executive summary

Over the past 30 years there has been growing epidemiological evidence of a difference in health outcomes between people from different groups in society. Health inequalities have moved from being a fringe subject to a mainstream part of the political landscape. General practice is now poised to become the key commissioner of NHS services. Despite a co-ordinated approach by the previous government, health inequalities persist – and, in some cases, have become worse.

Health inequalities can be defined as systematic and potentially remediable differences in one or more aspects of health across populations or population groups defined socially, economically, demographically or geographically. The majority of the work around health inequalities relates to differences in health relating to socio-economic status.

General practice is well positioned to have a positive impact on health inequalities at a number of levels: through clinical care, wider patient advocacy, community engagement and influencing the wider political agenda. There remains a tension for clinicians regarding the care of individuals versus wider population health goals, which are often used in addressing health inequalities. Policy-makers advocate community engagement to tackle the wider social determinants of health, but it is not clear that this is something that the majority of general practitioners (GPs) are equipped or motivated to do. The evidence base on how best to tackle health inequalities is in its infancy.

One factor that may contribute to health inequalities is that there are fewer GPs in areas of deprivation. Training specific to addressing health inequalities, as well as mechanisms to ensure that the distribution of health professionals adequately reflects clinical need, should be explored.

Good clinical practice involves GPs being aware of key demographic data pertinent to health inequalities and actively seeking to address these when opportunities arise. The Marmot review advocates tackling inequalities across the social spectrum, while other bodies have recommended focusing interventions at the highest-risk patient groups – for example, for tackling cardiovascular disease.

Removing the ability to exempt patients from the Quality and Outcomes Framework (QOF) may act to increase coverage to more vulnerable patient groups, but this may have cost implications and could impact negatively on the doctor–patient relationship. QOF should be adjusted to include a greater emphasis on prevention, as well as adjusting scores to actively address health inequalities.

GP computer systems are rich in data that could support the monitoring of inequalities in general practice. Data monitoring systems offer a unique opportunity for GP consortia, primary care trusts and individual health professionals to monitor inequalities and adapt their activities to reduce or prevent them. Systems for monitoring and benchmarking inequalities in general practice have been developed in some areas, but their application nationally is patchy.

Monitoring systems enable general practices to identify inequalities in the quality of care that are not amenable to investigation at the level of the

individual consultation. Through monitoring, GP consortia may become aware of structural or systemic influences on health inequalities that are easily remedied through investment and service reconfiguration.

The 2010 White Paper *Equity and Excellence* imposes new, challenging roles for general practice in tackling health inequalities, working in partnership with local authorities. Delivering this agenda will require adaptation and an appropriate skill mix. Health inequalities should remain a key priority for general practice, complementing a cross-cutting government approach to the problem.

1 Introduction

The United Kingdom has led the way in researching health inequalities and attempting to tackle them. In the early 1980s, the publication of the Black report showed a clear correlation between levels of illness and mortality rates and social circumstances (Black 1982). Nearly 20 years later, a follow-up study, the Acheson report, showed a similar picture: 'Although average mortality has fallen over the past 50 years, unacceptable inequalities in health persist. For many measures of health, inequalities have either remained the same or have widened in recent decades' (Acheson 1998). Health inequalities is now recognised as a significant global issue (World Health Organization 2005).

After its election in 1997, the Labour government made a strong point of trying to tackle health inequalities. In 2003 the Department of Health issued its report *Tackling Health Inequalities: A programme for action*, advocating a cross-cutting inter-departmental approach to the problem (Department of Health).

The report acknowledged that the NHS alone could not tackle health inequalities. It recognised the need for early years support for families, the role of education for socially disadvantaged groups, and the importance of access to services and reducing unemployment. The government planned key interventions for particular groups, such as smoking reduction in manual workers, tackling additional factors for cardiovascular disease and cancer, and improving housing (Department of Health 2003).

The government also introduced Public Service Agreements (PSAs), with targets to reduce child poverty, improve educational outcomes for the poorest children, increase affordable housing and strengthen local communities (HM Treasury 2007). This included specific targets to reduce inequalities in infant mortality and life expectancy (Marmot 2010).

Spearhead areas were created by the government specifically to address the difference in life expectancy. These areas were made up of primary care trusts (PCTs) that had low scores for a number of key indicators, sitting in the bottom quintile nationally for three out of the following five categories: male and female life expectancy, cancer, and cardiovascular mortality at ages under 75, and Index of Multiple Deprivation (IMD) score (Marmot 2010).

In 2006, tackling health inequalities became one of the top six priorities for the NHS. The government introduced performance indicators to facilitate meeting this target, and created the Health Inequalities National Support Team, to support spearhead PCTs (National Audit Office 2010).

The Marmot review, *Fair Society, Healthy Lives: Strategic review of health inequalities in England post-2010*, reported in February 2010. It indicated some improvement, but highlighted persistent and diverse inequalities in health similar to those outlined by the Black and Acheson reports. While overall life expectancy had increased, the gap between the top and bottom of society persisted. In some cases the gap had widened (Marmot 2010). It is against this backdrop that the role of general practice in addressing health inequalities must be considered.

General practice

General practice is the key mode of delivery of primary care in the United Kingdom. There are 300 million consultations a year, over 90 per cent of all contacts with health care professionals occur in primary care, and virtually the entire population registered with a general practitioner (GP) (The Information Centre 2009). Traditionally, general practitioners work in partnership, usually with a number of other GPs, looking after a registered patient list of a few thousand patients. They act as gatekeepers, referring when appropriate to the rest of the National Health Service. GPs usually work with a practice manager, employ nurses and other salaried doctors, and work with allied health professionals such as health visitors.

Recently the number of part-time general practitioners and salaried doctors has increased, along with an expanded role for nursing staff (The Information Centre 2008). The Royal College of General Practitioners (RCGP 2008) has also identified a trend for GPs to work together in larger group practices with a number of other doctors (RCGP 2008). The configuration of care has also been radically altered, with GPs no longer having to provide 24-hour care to their patients (Koralage 2004), and with more recent proposals for GP consortia.

The Royal College of General Practitioners describes general practice as having a significant part to play:

With unrivalled access to the heart of communities, we can influence the health inequalities agenda as practitioners, commissioners and community leaders... Health inequalities are not just about health. They arise from a myriad of wider determinants of health, some of which lie within the remit of the GP. In addition to socio-economic status, race, gender, disability, age, sexual orientation and religion might also have a significant role to play.

(Ali *et al* 2008)

UK general practice has a strong association with efforts to try and address health inequalities. It was in the 1970s that Julian Tudor Hart, a GP working in Wales, articulated the much-quoted inverse care law: 'the availability of good medical care tends to vary inversely with the need for it in the population served.' (Tudor Hart 1971) In the 1990s the RCGP formed the Health Inequalities Standing Group to attempt to ensure that primary care remained accessible to all (RCGP 2010a). There have also been a number of GPs who have engaged more widely in addressing health inequalities (Hutt 2005). The potential of general practice to play a role in tackling health inequalities is acknowledged by the World Health Organization, which advocates primary care as a solution to both global and national health inequalities (World Health Organization).

General practice, which often focuses on individual health in the context of a community, and which has the potential for wider social advocacy, appears inherently well placed to take a key role in addressing health inequalities. However, research recognises that GPs working in deprived areas can find their work particularly demanding (Popay *et al* 2007a). Consultations in areas of deprivation have been found to be shorter and to contain more psychological distress (Stirling *et al* 2001).

The structure of general practice is set to change significantly. The coalition government, formed in May 2010, plans to abolish primary care trusts

and strategic health authorities, as outlined in the White Paper *Equity and Excellence: Liberating the NHS* (Department of Health 2010a). A number of GP consortia and an NHS commissioning board will be responsible for commissioning NHS services, while the public health agenda will largely be the responsibility of local authorities. While spending for the NHS has been ringfenced, it is recognised that savings will have to be made during what is a difficult economic climate (Kmietowicz 2010).

It is in this context, with health inequalities central to the political landscape and the role of general practice expanding, that we have attempted to meet the aims detailed below.

Aims

- Describe the role of general practice in tackling inequalities.
- Provide a current assessment of what is known about inequalities within general practices, including:
 - how quality varies from practice to practice
 - what represents good practice in tackling inequalities
 - how good quality care can be measured (including discussion of potential metrics).
- Review the measures, if any, that are used to assess or hold GP practices to account for tackling inequalities.
- Provide one or two practical examples of best practice, where these exist, and assess the importance of the role and availability of quantitative data and data-collection methods.
- Provide a commentary on the challenges faced by general practice in meeting this quality agenda.
- Consider how the proposed changes to the NHS structure will affect the role of general practice in tackling health inequalities.
- Make recommendations for stimulating and maintaining the tackling of inequality, and discuss the implications for the future of general practice as a profession and as an organisation.

Methods

Due to time limitations and the evolving nature of policy (the Marmot review was published after the first draft of this paper and there was also a change in government), we used a mixed methodology. This report should be regarded as a synthesis of the existing literature and key policy documents, informed by key opinion formers. It is acknowledged that although the focus of this report has fallen on GPs and more general configurations of care, there are a number of groups involved in delivering care in general practice.

We searched a section of the literature systematically to try and elicit key themes relating to tackling health inequalities in general practice, as opposed to particular types of health inequalities, given that large number of inequalities that may exist depending on the group of patients or the illness.

We used the following search terms: General Practice* OR General Practitioner* OR Primary Care OR GP* AND Inequality OR Inequalities. MEDLINE, HMIC, EMBASE and CINAHL databases were searched with the

following limits applied: papers written in English / English abstract, contains an abstract, and written between 1999 and 2009.

This search returned 594 papers after duplicates were removed. We then screened and retained titles if they fulfilled one of the following criteria:

- the article provided research on systems, general methods and/or large, widespread programmes for reducing health inequalities in general practice
- the article provided research on systemic or structural barriers to GPs' reducing inequalities
- the article reviewed or described systems for monitoring GPs' progress in reducing inequalities.

We rejected articles with no direct relevance to the United Kingdom, not from a reputable journal, policy documents/opinion pieces and those on particular conditions or groups. Two researchers independently screened 214 abstracts against the above inclusion criteria, and we discussed any discordance until we achieved agreement. This left a shortlist of 53 articles, which we then read in detail.

In addition, we analysed key policy documents from relevant organisations such as the Department of Health, the Royal College of General Practitioners (RCGP) and the World Health Organization.

We conducted semi-structured interviews with key opinion formers:

- Dr David Colin-Thomé, national director for primary care from the Department of Health
- Professor Steve Field, chair of the RCGP
- Dr Iona Heath, GP and former chair of the Health Inequalities Standing Group
- Dr Mike Grady, senior research fellow and former chief executive of Eastern Wakefield Primary Care Trust 2001–2006, who has undertaken research in health inequalities.

Finally, we drew on discussions that arose from The King's Fund seminar in March 2010, when preliminary findings of this report were presented.

2 What is known about tackling health inequalities within general practice?

This section describes the structural role of general practice in tackling health inequalities. It will consider examples of health inequalities and their complexity as a theme, before looking at key roles for general practice.

What are health inequalities?

Health inequalities can be defined as 'systematic and potentially remediable differences in one or more aspects of health across populations or population groups defined socially, economically, demographically, or geographically' (Starfield 2001a).

Many examples of health inequalities relate to socio-economic status. For example, the Marmot review reported a marked difference in life expectancy and disability-free life expectancy at birth between the most deprived areas of England and the least deprived (Marmot 2010).

Our literature review uncovered numerous examples of health inequalities pertinent to general practice.

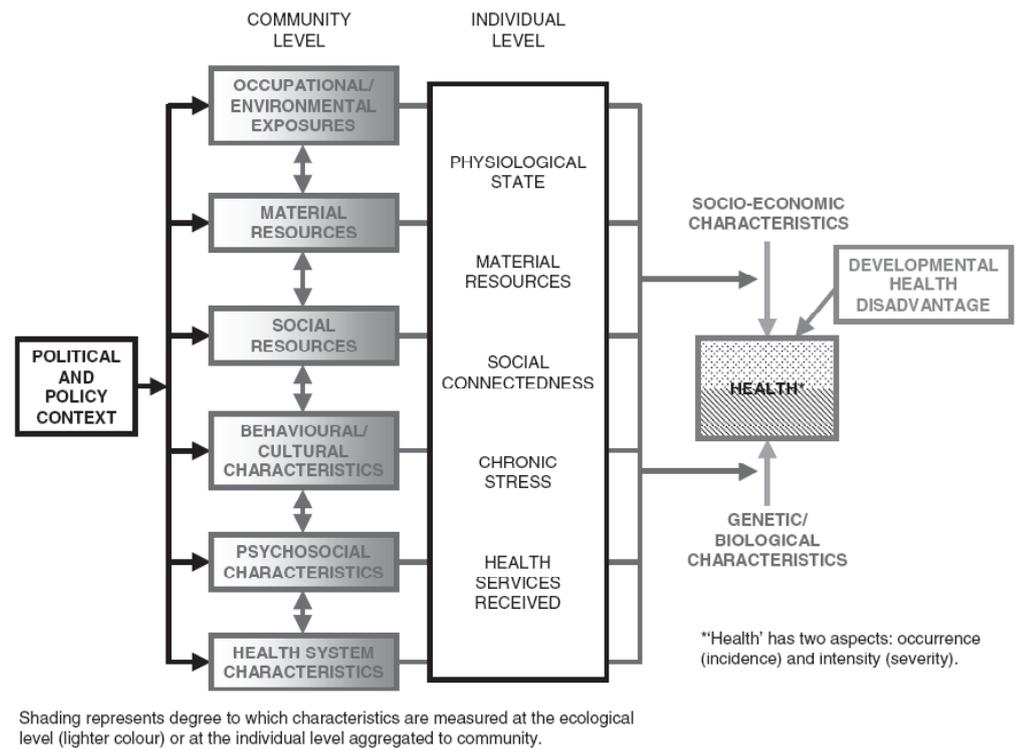
- Hypertension control has been found to be poorly controlled in older age groups – especially among socially isolated males (Shah and Cook 2001).
- People from black and minority ethnic (BME) community groups have been found to be poorly served by mental health advocacy services (Newbigging and McKeown 2007).
- Screening uptake for colorectal cancer was worse in deprived areas (McCaffery *et al* 2002).
- Vaccination uptake in the over 74 years of age has been shown to be worse in areas of deprivation (Mangtani *et al* 2005).

Equally there are studies that showed that where there was thought to be a possible health inequality, no inequality existed.

- Access to angiography in East London for South Asians was found to be similar to other ethnic groups (Jones *et al* 2004).
- A study looking over 30,175 consultations for first-time rectal bleeding showed no difference in referral rates for patients suffering with severe mental health problems compared to other groups (Parker *et al* 2007).

Such examples are by no means intended to be comprehensive or definitive. Instead, they are included to illustrate the potential complexity when researching the role of health inequalities in general practice, which deals with so many groups of patients and conditions. The factors that influence an individual's health – and thereby give rise to health inequalities – are multiple, as illustrated in the following diagram by Professor Starfield (Fig 1).

Figure 1 Influences on health at an individual level



Source: (Starfield 2001b)

Despite this complexity, and the contribution of the wider social determinants of health, it is recognised that health care systems have a key role to play in reducing health inequalities (Marmot). For example, the Department of Health estimates that 15–20 per cent of the differences in mortality rates due to socio-economic deprivation could be tackled by health interventions to reduce the risk of ill health (National Audit Office 2010).

What is the role of general practice?

McWhinney (2003) describes ‘the essence of general practice’ as ‘an unconditional and open-ended commitment to one’s patients’. General practice has the potential to address a number of the contributing factors (Fig 1) that cause ill health, addressing the individual, the community and the wider political context. In this sense, there is a potentially ‘open-ended commitment’ to tackling the conditions that cause illness. The varying spheres of influence of general practice are recognised by the RCGP Standing Group on Health Inequalities (Ali *et al* 2008).

There is also a role regarding health service provision and practice: to ensure that access to general practice services are equitable, and that clinical practices act to reduce inequalities rather than exacerbating them. Some of the key themes that arose from the literature review and interviews are detailed below.

Generalism

One of the largest reviews of evidence regarding primary health care systems was carried out by a team at John Hopkins University. For the purposes of their analysis, primary care was defined as 'first-contact access for each new need, long-term person – (not disease) focused case; comprehensive care for most health needs; and co-ordinated care when it must be sought elsewhere' (Starfield *et al* 2005). This is synonymous with a traditional view of UK general practice and the RCGP-endorsed European Definition of General Practice (WONCA Europe 2005).

When similar health care system attributes, mirroring UK general practice, were introduced to Spain in the 1980s, those areas with strengthened primary care showed a reduction in deaths associated with hypertension and stroke (Starfield, Shi, and Macinko). In the United States, where there is not universal access to primary care, there is strong data to show that the supply of primary care physicians determines contributes to uptake of screening and immunisations, and that where there is good primary care available, patients are less likely to attend accident and emergency services (Starfield *et al* 2005).

Areas of social deprivation (relating to income) with a good supply of primary care physicians in the United States have been shown to have lower rates of post-neonatal mortality and stroke and much better self-reported health (Starfield *et al* 2005). In advocating primary care for the United States, general practice in the United Kingdom is held up as an example of good practice in order 'to reduce disparities in healthcare so prominent in the United States'(Starfield *et al* 2005).

While it is hard to draw significant conclusions about the best way to address health inequalities it is fair to say that UK general practice is held in high regard internationally, and that the comprehensive nature of the NHS is important in tackling reducing the impact of social differences on health outcomes. However, it is recognised within the United Kingdom not everyone is registered with a GP, and that levels of provision and quality can vary.

Patient advocacy

GPs tackle health inequalities by providing medical care and helping patients navigate a complex health system. As part of their role, GPs may have to deal with the medical consequences of conditions heavily influenced by social circumstances, such as obesity, tuberculosis, cardiovascular disease, depression or domestic violence. Speaking or writing on behalf of patients is inherent in the role of the general practitioner. In deprived areas, this may involve more letters relating to housing conditions. Qualitative work in deprived areas has stressed the GP's role as patient advocate, as provider of a 'holding environment' – a space in which people can reflect on their decisions and choices as they search for appropriate support to help them manage and/or resolve their difficulties (Popay *et al* 2007b).

Close links between GPs and patient welfare and benefits advice is a key feature of those health centres that are held up as model examples for approaches to tackling health inequalities (Marmot 2010). By working in proximity to general practice, these services help decrease the psychological stress that patients experience from money-related worries (Abbott 2002), and may also reduce the number of prescriptions that GPs issue and the number of GP consultations (Abbott and Davidson 2000). However, it

is thought that such interventions occur too late in life to impact on the incidence of disease, as those consulting with GPs tend to have established pathology.

The RCGP guide *Addressing Health Inequalities* (Ali *et al* 2008) recommends that all staff in the practice should be aware of local services (including voluntary organisations) that they can refer to, and argues that patient notes should reflect their wider social circumstances. It also suggests that practices should seek patient feedback, to shape service provision – either through questionnaires or patient participant groups.

It also highlights the role that other members of the practice team can have in addressing health needs in areas of deprivation – for example, nurse-led clinics for diabetic care, health visitors, community nurses, care workers and pharmacists. Nurse practitioners and community pharmacists may have a role to play, by increasing access to health care and freeing up GP time.

While the guide presents examples of good practice and community programmes, it does not offer a detailed approach on how to tackle particular health needs and GPs' response in addressing them is implied. However, it does advocate particular awareness of potentially vulnerable groups who may find services difficult to access, such as homeless people, travellers and asylum seekers (Ali *et al* 2008).

Vulnerable groups

Private Medical Services (PMS) contracts have been seen as one potential method for ensuring targeted care. By allowing local negotiation and commissioning of services, it was hoped that PMS practices would better meet specific local needs.

One qualitative study using in-depth interviews evaluated the professional experiences of PMS practices on 13 sites. The paper suggests that PMS allows better inter-sectoral collaboration (Riley *et al* 2003). In particular some felt that PMS configurations of service provision allowed people to 'embrace the idea of health rather than a biomedical approach' (Riley *et al* 2003) when dealing with vulnerable groups in society, arguing that PMS practices adopt a more 'community orientated/public health model' (Riley *et al* 2003).

Other qualitative research suggests that PMS practices are able to increase access to services by vulnerable groups (Carter *et al* 2002), and that these patients value the services provided (Lewis 2001). There have been calls for GP contracts to make addressing health inequalities an explicit part of the GP role (Marmot 2010).

There are also examples of particular outreach programmes for patients with particular health needs, such as South Asian groups who have an increased risk of diabetes and cardiovascular disease (Mathews *et al* 2007; Bandesha and Litva 2005; Patel *et al* 2007; Richardson *et al* 2008), but there is limited evidence relating to the cost-effectiveness of such interventions (Mathews *et al* 2007).

Community and population health

Traditionally, general practice has been focused on the care of the individual patient and their family (Balint 2008). However, Julian Tudor Hart, who articulated the Inverse Care Law, wrote in 1988: 'If social factors influence the behaviour of disease on a community-wide scale, GPs and other primary

care workers must concern themselves with them as a normal and central part of their work, not as a fringe option to be added by some doctors and ignored by others' (Tudor Hart 1988). More recently, the Marmot review encouraged GPs to take a more population-focused view of their community (Marmot 2010 – see The Quality and Outcomes Framework pp 15–16).

Addressing population health goals can pose something of a dilemma for general practice, and may sometimes result in poorer care. An example of this would be the doctor who is so keen to advise a patient to stop smoking that they fail to uncover that the patient's spouse has left them with their newly born child and that the patient is overwhelmed with thoughts of self-harm. It also felt by some GPs that they are a constant focus for carrying out wider public health programmes.

Doctors with a public health orientation can be quick to say what general practitioners should be doing on the basis of population data. Yet doctors and nurses in general practice face the frustration of being bribed or bullied by governments to achieve targets that many patients are not ready to accept for personal and social reasons.

(Stott *et al* 1994, pp 971–72)

Qualitative research stresses the importance of considering the patient's perspective when trying to address wider population health goals:

Equal attention is also required to the lived experience of inequalities at the individual level. Without this parallel micro focus, explanations for health inequalities will tend to be deterministic in their orientation, failing to recognise that the individuals involved are not passive victims of social processes, but consciously act to protect and promote their own health and that of others, albeit within structural constraints largely outside of their individual control.

(Popay *et al* 2007b)

Peckham and Hann looked at the role of the GP in relation to public health interventions – the mechanism by which many health inequalities are addressed on a population scale – for example, tackling cardiovascular disease and cancer. (Peckham and Hann 2008) (It is beyond the scope of this report to assess in detail particular public health programmes, but for further details see [A pro-active approach. Health promotion and ill-health prevention.](#)) The introduction of the Quality and Outcomes Framework (QOF), despite its potential to skew clinical activity away from the immediate concerns of patients, may have a role in 'incentivising general practice to undertake specific public health activities' (Peckham and Hann 2008).

The paper also points out that 'general practitioners are often untrained as health educators, and have a narrow view of health promotion and limited experience of community development activities' (Peckham and Hann 2008). This is a potentially significant conclusion because many of the recommendations about the role of general practice in tackling health inequalities are about engaging with community development (Ali *et al* 2008); (Marmot 2010).

For example, if a GP realises there is a problem with the supply of affordable fresh fruit and vegetables to their area then he or she could engage with members of the community to seek solutions (Field S, personal communication). Such a role might be included with commissioning and enhanced by leadership training for doctors (RCGP 2010b), but at the

moment appears to be taken up only sporadically.

The Quality and Outcomes Framework

When the Quality and Outcomes Framework (QOF) was introduced in 2004, it dramatically changed the way GPs were remunerated for their work. Under QOF, practices receive a proportion of their income in return for meeting certain targets related to disease or organisational and administrative processes for their registered population. Previously, surgeries had received a payment per registered patient, with certain rewards for additional work, but payment had not been so closely related to clinical work carried out. Part of the philosophy behind QOF was to try and reduce variations in clinical practice, thereby reducing inequalities in the delivery of health care.

The inverse equity hypothesis for public health interventions articulates the concern that with health system initiatives, people from lower socio-economic groups benefit the least, as these groups are less able to take up any new health intervention (Victora *et al* 2000) Following the first year of QOF, achievements were higher in affluent areas (Downing *et al* 2007). An analysis of 34 QOF clinical indicator scores over the first three years suggests that this gap narrowed significantly between practices from deprived and affluent areas. After three years of QOF a socio-economic gradient in practice performance was no longer apparent (Doran *et al* 2008).

The study still found that the poorest-performing practices were to be found in areas of highest deprivation. Exemption rates for QOF registers, whereby a patient can be removed from a disease register, showed a positive association within areas of deprivation. In addition to being associated with deprivation, exception rates are high for some QOF indicators, including those with a strong association with deprivation such as mental health.

Despite the study's conclusion that all patients are benefiting equally from QOF, this does not suggest that the health of people in deprived areas is increasing at a greater rate than those in more affluent areas – a requirement if relative health inequalities are to decrease.

Another study, looking at the first two years of QOF data, comparing practices in the least-deprived and most-deprived areas, concluded that urbanicity and deprivation could explain differences in performance. It proposed that these might be corrected by ensuring that well-organised primary care existed within these areas – in the form of teaching practices and group practices (Ashworth *et al* 2007). By 2007, QOF scores reached a plateau for asthma, diabetes, and heart disease, demonstrating an improvement in care compared to pre-QOF data. However, continuity of care has decreased since the introduction of the payment incentive scheme (Campbell *et al* 2009).

Given that continuity of care was identified as a key component in the quality of primary care systems, which have been shown to be effective in reducing health inequalities (Starfield *et al* 2005), QOF could thereby have had a negative impact on the potential of general practice to tackle health inequalities. The importance of the issue of continuity of care has been examined in the GP Inquiry through the work of Freeman and Hughes (2010 – see www.kingsfund.org.uk/gpinquiry).

There has been concern that practices in deprived areas, where the disease burden is heavier, have to work harder to achieve a similar QOF

score. Recent changes to QOF payments mean that practices are no longer discriminated against on the basis of list size, or because they may have a higher prevalence (Marmot 2010). Some primary care organisations have recognised the limitations of QOF as a tool for improving the uptake of disease screening, due to practices' ability to exempt patients from disease registers (see Case study 2, p 25).

The Marmot review has recommended that no patient should be exempt from QOF registers (Marmot 2010). Such a recommendation caused division among key opinion formers at The King's Fund seminar (see p xx). Some felt that the GPs' ability to exempt patients was fundamental to their ability to exercise clinical judgement, and to challenge targets that might not be applicable to particular patients. Equally, others acknowledged that low thresholds and high-exception reporting could reduce the population impact of disease management.

There is potential for QOF to be more closely attuned to tackle health inequalities. The Westminster Health Committee made recommendations about this in 2009, with emphasis being placed on disease outcomes (House of Commons Health Committee 2009)

GP distribution

Given that people from lower socio-economic groups have greater health needs, such as worse life expectancy and higher infant mortality, it has long been argued that areas with greater deprivation require more doctors (Gravelle and Sutton 2001). However, historically, it has been hard to recruit GPs into those areas with the greatest health needs – especially within inner-city areas.

Despite increases in the number of GPs during the 1990s, GPs were still distributed preferentially in more affluent areas (Gravelle and Sutton 2001). However, this trend was in keeping with other inequities, and GPs were better distributed than practice nurses, pharmacies and dentists (Gravelle and Sutton 2001).

This inequality persisted despite a number of incentives to attract GPs to poorer areas. Gravelle and Sutton argue that there can be a number of interactions between increasing supply, local recruitment incentives and entry regulation that may conspire to maintain the status quo despite absolute numbers increasing. For example, financial incentives to recruit GPs to deprived areas may actually result in a net loss of income for doctors in those areas (Gravelle and Sutton 2001).

Ding *et al* showed that the introduction of the new 2004 General Medical Services (GMS) contract, and a greater number of locally negotiated Private Medical Services (PMS) contracts, had not reduced relative inequality of GP distribution (Ding *et al* 2008). The contractual reforms were intended to increase employment flexibility and allow for a greater number of salaried GPs, free from the administrative responsibilities that GP principles were traditionally required to undertake.

Ding *et al* hypothesised that GPs without a financial stake in the practice as a business would provide better care. While the number of salaried GPs had increased, with greater geographical mobility, this study (using the GP census data in England) suggested that salaried positions were more likely to be located in affluent areas (Ding *et al* 2008).

The most recent data (2008) from the Department of Health shows that GPs continue to be fewer in number in spearhead areas (those primary care trusts in England specifically targeted as the most deprived areas): 65 per cent of spearhead areas had fewer GPs compared to the national average. (National Audit Office 2010) Further funding has been allocated to increase GP and health centre capacity, with the majority for spearhead areas (National Audit Office 2010). The RCGP suggests addressing health inequalities is not necessarily about increasing doctor numbers in areas of deprivation but looking at the type of work being done in these areas (Field S, personal communication) and increasing capacity by utilising nurse practitioners and pharmacists (Ali *et al* 2008).

Overall, the evidence suggests that GPs are disproportionately distributed in more affluent areas despite the number of doctors increasing.

Influencing national policy

The RCGP advocates influencing the national agenda with respect to the inverse care law, but does not advise GPs in detail on particular actions, other than the importance of using a 'positive media strategy' and for the royal colleges to work together on this subject (Ali *et al* 2008). General practice has a strong history of outspoken advocates trying to address national policy to reduce health inequalities. This has included doctors who have taken explicit political action (Hutt 2005) as well as the network of local medical committees and powerful professional groups, such as the British Medical Association and the RCGP. Doctors are still highly respected in society (MORI 2009).

GP employers and GP diversity

GPs operate as small businesses, and can therefore have some control in how they operate as employers. The Marmot review called for the NHS to look at its own practices in relation to the wider social determinants of health, including the support provided to its employees (Marmot 2010). There is potential for GPs to do this.

Students selected for medical school continue to be disproportionately from the highest social classes, although the number of doctors from BME groups and the number of female doctors have increased (BMA 2009). It is not clear that a more diverse workforce would result in better approaches to tackling health inequalities though it could act to increase levels of empathy amongst doctors.

GP commissioners

It has been argued that practice-based commissioning (PBC) has the potential to reduce health inequalities (Ali *et al* 2008). This role of GPs in commissioning NHS services looks set to increase dramatically following the 2010 White Paper *Equity and Excellence – Liberating the NHS* (Department of Health). The paper outlines plans to replace PCTs and strategic health authorities with an NHS commissioning board and an extensive network of GP commissioning consortia, arguing that, given their proximity to the patients they serve, GPs are best informed about what services are required. (Department of Health 2010a).

The White Paper makes explicit reference to services being equitable: 'GP

Consortia will have a duty to promote equalities and to work in partnership with local authorities, for instance in relation to health and adult social care, yearly years services, public health, safeguarding and the wellbeing of local populations' (Department of Health 2010a). It is not clear from the White Paper who will be responsible for maintaining the public health agenda in the context of general practice, or who will hold GP consortia to account and to what degree.

However, RCGP guidance on PBC commissioning, in the context of health inequalities, stresses the importance of serving the 'whole local population – not just those who come through the surgery door'(Ali *et al* 2008).

Summary points

- There are a number of health inequalities affecting different groups in society.
- General practice is well positioned to have a positive impact on health inequalities at a number of levels.
- A tension exists between the role of general practice in looking after individual versus wider population health goals.
- There are fewer GPs in areas of deprivation.
- GPs have a role as employers in tackling health inequalities.
- The White Paper imposes new, challenging roles for general practice in tackling public health and inequalities in partnership with local authorities. It will require adaptation and a new skill mix in order to deliver.

3 What represents good practice in tackling health inequalities?

This section attempts to extrapolate some key themes as to what good practice may consist of. It shall be framed in terms of individual clinical care and wider population approaches.

Clinical care

GPs need to be aware of how their interactions contribute to, or have the potential to reduce, health inequalities. This could be facilitated through having a working knowledge of national and local demographics. If a GP is not aware about the health risk associated with particular groups then health needs may not be identified. For example, cancer is diagnosed at a later stage in people from lower socio-economic groups, and screening participation is lower for colorectal, cervical and breast cancer (Marmot 2010). General practitioners and primary care health professionals are well placed to engage their patients. For example, mechanisms could exist to ensure that 'failure to attend' screening letters were discussed with patients, rather than simply being filed in the notes.

The Marmot review has recommended that the greatest emphasis be placed on reducing health inequalities during the early years. GPs are well positioned to ensure that their patients are aware of any local initiatives to tackle this and, for example, that the nutritional needs of pregnant mothers are met (see www.healthystart.nhs.uk – accessed on 25 August 2010).

With regard to addressing the wider social determinants of health, greater use of 'social prescribing' might be one approach – for example, referring patients to health trainers or community health champions (Marmot 2010). The Marmot review accepts that there is limited data about such interventions, but cites it as an approach that 'facilitates greater participation of patients and citizens and support in developing health literacy and improving health and well being' (Marmot 2010).

For example, a GP might refer a patient to a patient-led group for in-depth diabetes advice or to legal advice regarding their housing situation, or might suggest community groups for their children to join. The Marmot review recommends that such interventions are evaluated before being rolled out more widely. Evaluation of innovative solutions would therefore be part of the good practice we are seeking to define.

There are initiatives to increase GPs' knowledge of employment health issues, helping to ensure people are able to remain in or return to work – see, for example the National Educational Programme for GPs (Working for Health 2010). 'Good care' would involve knowledge of and referral to appropriate services, and would require doctors to feel equipped to offer advice on issues such as occupational health.

Proportionate universalism

Although the RCGP guidance focuses on some of the most vulnerable patient groups (Ali *et al* 2008), the Marmot review stresses that 'focusing solely on the most disadvantaged will not reduce health inequalities sufficiently'

(Marmot). However, it adds the caveat that universal actions must be with 'a scale and intensity that is proportionate to the level of disadvantage,' which it refers to as 'proportionate universalism'.

What does proportionate universalism mean for day-day clinical care? At a practice or patient level, it would require GPs to identify those patients who need most, those who need a moderate amount, and those who need least. For the most vulnerable groups, this might be obvious. For example, if a patient is known to be an infrequent attendee and is currently homeless, there will be an impetus to try and get as much done opportunistically during that clinical encounter. But how does a doctor identify a patient who has a level of disadvantage that is somewhere in the middle?

There are some clinical tools that utilise more specific demographic data, using postcodes to calculate clinical risk, such as QRISK2, for calculating cardiovascular risk scores. Meanwhile outreach work may be an effective way of tackling the health needs of hard-to-reach populations – for example, vascular screening in faith-based settings for South Asian groups – although there may be significant cost implications (Mathews *et al* 2007).

Such approaches may require a shift in GPs' attitude to see the wider social determinants of health, as well as the clinical components that contribute to them, as part of their day-to-day job.

Community and population health

The need for GPs to work in partnership is a key recommendation from the Royal College of GPs and in the Marmot review. This stems from the belief that GPs are located at the heart of their communities, and are well placed to act as a focal point.

Ali *et al* argue that 'the local knowledge that GPs have puts them in an ideal position to take part in local projects that affect the wider determinants of health and reduce health inequalities. These might range from work with the local authorities... to collaborations with the voluntary sector' (Ali *et al* 2008).

Some might argue that this is what general practice has been trying to do for many years. One example, established in 1935, was the Peckham Pioneer Health Centre, which was organised by its members and provided legal advice, sports groups and music events (Salisbury 1999). A more recent example is the Bromley by Bow Health Centre – see Case study 1, below.

Case study 1: Bromley by Bow Health Centre

The Bromley by Bow Health Centre was founded in 1984 in East London, as a charity. It takes a holistic approach to community health, with GPs working alongside other groups in partnership. It has a staff of over 100 people and an annual turnover of more than £4 million a year. The site contains a GP surgery and a Children's Centre. There is also onsite support for the Workers Enterprise, which offers benefits advice and support for accessing training to find employment. Language courses are also run for people who do not speak English. Local exercise classes are also available.

It is registered as a charity and has a number of local partners involved with the project.

Source: Adapted from www.bbbc.org.uk (accessed on 25 August 2010)

It has been noted that as health interventions, health centres such as the Peckham Pioneer and Bromley by Bow examples cited are harder to evaluate compared to more 'medical'-based interventions that focus more on giving medications to lower blood pressure, for example (Salisbury 1999). An editorial in the *British Medical Journal* stated:

The healthy living centres movement is encouraging innovation but is largely based on rhetoric rather than evidence. Some enthusiasts for healthy living centres are sceptical about whether the ideals can be reduced into measurable objectives – but their scepticism is matched by those who believe that user participation in planning health care and interagency partnerships are simply exercises in political correctness.

(Salisbury 1999)

As a model on which the more recent proposals for polyclinics and creating polysystems draw (Hutt *et al* 2010), these centres appear to be advocated by professional leaders as an approach to tackling health inequalities (Ali *et al* 2008; Marmot 2010). As complex health interventions, they require appropriate evaluation from the perspective of clearly defined goals for key service users (Salisbury 1999; Hutt *et al* 2010). However, it is clear that the introduction of such services needs to be highly applicable to the local context, not 'a consequence of large, centrally driven roll outs' (Marmot 2010).

Moreover, community partnership is still possible without specific buildings, and indeed a building is no guarantee that different groups will co-ordinate together well (Imison *et al* 2010). In this sense, good practice involves GP services being sensitive to the needs of its patient groups, and considering how it can link to other services in its area. This might involve actively utilising patient satisfaction questionnaires, patient user groups at the surgery, and sources of demographic data about the local population.

The White Paper implies that engaging with community and population health will become a policy imperative for GPs (Department of Health 2010a) though where exactly the emphasis will fall remains unclear. Currently the population data used by GPs tends to come from QOF or from primary care organisations. The restructuring of the NHS will need to find a mechanism for ensuring that GPs engage in practice that is pertinent to the needs of their community and local health inequalities.

Incentives

The Quality and Outcomes Framework actively encourages GPs to look at their local population, so it could be a key tool in helping to address health inequalities. The recommendation from the Marmot review regarding good practice is that 'the Quality and Outcome Framework should be revised to ensure that general practitioners are incentivised to provide 100 percent coverage of the quality of care for all patients.' The power of QOF scores is that all GPs are familiar with them, QOF could be adjusted to incorporate population data pertinent to health inequalities, and a greater emphasis could be placed on prevention rather than tackling established pathology (Marmot 2010).

It is believed that by 2011, QOF payments will fully reflect the level of clinical need between practices (National Audit Office 2010). 'Good practice' may include QOF scores that actively contribute to reducing health inequalities on the basis of the best available evidence. Equally, there remain the

concerns about affecting the doctor–patient relationship, and potential cost implications in targeting some of the hardest-to-reach groups (National Audit Office 2010). For an example of PCT monitoring relating to health inequalities, see Case study 2, p 25.

Commissioning and funding

One of the stated aims of world class commissioning, introduced in 2007, was to reduce the inequalities between areas with the best and worst health (Department of Health). The experience of efforts focused on reducing health inequalities in the spearhead PCTs provides a basis for future considerations (National Audit Office 2010).

Despite specific targets and funding to reduce health inequalities, the gap between life expectancy among the better off and the worse off has increased, although overall life expectancy has increased (Marmot 2010). One of the concerns was that, unlike other disease pathways, there existed a poor knowledge base regarding health inequalities and cost-effective approaches to tackling them (National Audit Office 2010). It was subsequently hard to measure the interventions being implemented. Instead the focus was on measuring changes in life expectancy and infant mortality rates, which were longer-term outcomes.

The National Audit Office concluded that the Department of Health increased the effectiveness of strategies to reduce health inequalities, by:

- ensuring that PCTs were better aligned to local authorities
- establishing the Health Inequalities National Support Team (HINST), which provides a range of 'how to' guides on specific issues such as creating performance score cards to tackle health inequalities, and master classes for commissioners.
- making available the Health Inequalities Intervention Tool, which aims 'to help PCTs and local authorities identify the causes of death which are driving local health inequalities and quantify the impact that three key interventions (increasing the of drugs to control blood pressure by 40%, increasing the prescribing of drugs to reduce cholesterol by 40%, and doubling the capacity of smoking cessation services) can have on local health inequality gaps' (National Audit Office 2010).

However, cost-effectiveness regarding interventions to reduce health inequalities appears difficult to calculate, and more tools are needed to help commissioners (National Audit Office 2010) Good practice regarding commissioning will have a greater focus on prevention rather than cure (National Audit Office 2010;Marmot 2010). Achieving this will require expertise to ensure that commissioning utilises local demographic data appropriately – in other words, experts in public health – as there is still ongoing debate about how the groups should be identified and health needs calculated (Marmot 2010). Short-term funding for projects can be co-ordinated with longer-term goals, and with housing, planning, and early years education (Marmot 2010).

For GP commissioners, good practice will involve being aware of the need for this co-ordinated approach. Given the lack of conclusive data about effective mechanisms for reducing health inequalities, appropriate evaluation regarding programmes will be needed, and best practice must continue to be shared.

The Equality Act of 2010, which brings together a number of different legislations, will require commissioners of services to take account of inequalities stemming from socio-economic disadvantage and to actively try and address them. It protects against discrimination on the basis of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation. GP consortia will have to be compliant with this legislation.

Summary points

- Good practice involves GPs being aware of key demographic data pertinent to health inequalities and actively seeking to address them when opportunities arise.
- GPs can improve their working knowledge of occupational health to help patients remain in work.
- 'Proportionate universalism' needs to be applied for health inequalities to be tackled across the social gradient, as well as considering the health needs of the most vulnerable. Health professionals may need help in identifying those in the middle of the social gradient.
- Community-based health centres are advocated by policy leaders as a way to address health inequalities, although their impact is hard to measure.
- Removing the ability to exempt patients from QOF may act to increase coverage for more vulnerable populations but may have cost implications and meet resistance from clinicians.
- Commissioning by GPs in the future has the ability to address health inequalities, and could draw on the resources that the Health Inequalities National Support Team currently provides to PCTs.

4 Measuring and monitoring quality in tackling health inequalities in general practice

Monitoring is an essential tool in the reduction of health inequalities. Subtle systemic social pressures acting at the level of individual patient–GP interactions may not be noticeable in the environment of the individual consultation, but may be easily tracked in the aggregate at PCT or GP practice level. Various mechanisms can be put in place at a variety of different levels – individual GPs, practices, PCTs or GP representative bodies – to measure and counter (whether directly or indirectly) health inequalities.

General practice is rich in data to support such monitoring. For example, data is routinely available on patient demographics, consultations, prevention, referrals, secondary care usage, prescribing and outcomes. Through feedback about patterns of inequality seen at the level of GP practice or area, PCTs, GPs, PBC clusters and the Department of Health can identify necessary changes in policy, practice, investment, commissioning or individual GP activity that may serve to reduce inequalities between different sections of society.

Principles of monitoring GP activity

Although a useful tool for identifying and acting on health inequalities, monitoring is far from a panacea. It relies on two key principles.

- Routine monitoring tools utilise data collected by organisations as part of patient care processes, internal management and quality control systems, and do not require bespoke data collections.
- Monitoring is possible without interference in the daily workings of the organisation being monitored.

Historically, these principles have been difficult to implement – especially at the level of GP practice – because of the constraints of information reporting systems. However, in the recent past a variety of software companies have begun developing models that enable unobtrusive monitoring to be conducted in great detail, and now most health care providers collect detailed data on their own activities for a variety of purposes unrelated to monitoring health inequalities.

This enables monitoring to be conducted in both primary and secondary care, and within PCTs there is considerable scope for monitoring of the relationship between these tiers of the health system to be assessed. Local monitoring schemes are not nationally implemented, but the general approach of these monitoring systems is set out below.

- The PCT forms an agreement between an external provider of data services (usually private) and the GPs from whom it commissions services, to gain access to GP data.
- GPs agree to use data systems that collect data according to a common data definition, typically referred to as a 'data dictionary' or 'minimum dataset'.
- The data-services provider develops a system for extracting data from these data systems, merging it with hospital data and making it available to the PCT or department.

- The PCT is responsible for data governance issues, for using this data to monitor health issues of key importance to it, and for providing relevant feedback to primary and secondary care organisations from which it commissions services.

Under this model, routine activity data collected at primary and secondary care organisations is used for performance monitoring, and is of particular use in identifying practices with high or low levels of health inequality. Given that the NHS in England is set to move from a PCT-led system to a GP commissioner-led system by 2013 (Department of Health 2010a), there is an opportunity – indeed, a requirement – for these new statutory GP-led organisations to engage directly with their membership of general practices on the issue of inequalities. Though it is not clear how much leverage consortia will have over its members to influence GP performance, in the way PCTs currently do. Case study 2, below, provides a useful example (from Tower Hamlets PCT) of how this might be developed.

Case study 2: Tower Hamlets PCT monitoring

Tower Hamlets PCT uses monitoring to try and improve the uptake of screening and outcomes of care for key conditions informed by the Joint Strategic Needs Assessment. The PCT commissions packages of care over and above the core contract and QOF from clusters of practices in 'networks' or local federations of practices. In 2009/10, these were for diabetes and immunisations. Both have been very successful in improving outcomes with the PCT, making a dramatic improvement in achieving one of the highest MMR immunisation rates in the country, having started from a very low base.

All practices use the EMIS operating system, and individual practice data is mirrored in real time to a single central server. The PCT is able to search the data of 242,000 registered patients on the central server within agreed governance criteria, supported by an EMIS information governance group. The searches can be done daily, as in the case of the July 2009 flu pandemic, when individual practice data was available on a daily basis, using Emis Web.

The motivation for this is to enable the PCT to record outcomes across the population without any exception reporting. The nature of QOF thresholds for payment, often with ceilings of 70–80 per cent, along with exception reporting can mean that a significant proportion of the population is missed.

Tower Hamlets tries to motivate GPs by using Emis Web, setting additional targets and payments to those outlined by QOF. Targets are usually suggested in conjunction with the academic department at Queen Mary University of London (the Clinical Effectiveness Group, or CEG). Commissioners feel that this gives greater weight to the work GPs are encouraged to perform.

The CEG also has a track record as a PRIMIS facilitator in enabling the best use of GP IT systems such as EMIS. It is expert in the design and implementation of care 'templates' in EMIS to capture the key READ codes systematically, so that these can then be searched for in a streamlined manner. Payments (which are in turn triggered by READ codes) are typically area or network based rather than individual practice based.

Networks of practices only receive the payment if the area achieves the target. It is designed to promote working with other agencies, such as hostels for homeless people and voluntary organisations. In addition to the payment incentives, GPs are also incentivised by the way in which their performance is displayed relative to other practices in the area. The PCT regards peer comparison to be at least as powerful a motivator for change as financial incentives. In the case of MMR, the financial incentive was very minor: peer comparison was deemed the most influential factor.

Defining quality in GPs' management of health inequalities

There is a good body of epidemiological methods for identifying inequalities at the population level. As we have seen in previous sections, the ability of general practice to manage or reduce health inequalities depends heavily on the systemic influences on general practice. It is therefore appropriate to define quality in general practitioners' management of health inequalities not at the level of individual interactions (as one might with a definition of quality that pertains to treatment or referral), but at the aggregate level of the GP's performance – particularly as it is compared between groups using epidemiological methods.

Applying the principles of monitoring outlined above, quality in general practitioners' management of health inequalities can be defined as the absence of significant difference between different social groups in key epidemiological measures of quality of care, such as:

- rates of referral for key conditions
- prescribing of key drugs important in the management of long-term conditions
- time to referral for key conditions
- patient presenting to accident and emergency (A&E) for problems that could be readily be managed by general practice
- prevention, such as immunisation
- risk-factor management (for example, of smoking or obesity).

Practices could be grouped together with others with similar patient demographics, allowing best practice to be shared if, for example, one practice appeared to be particularly successful in managing a particular condition or patient group.

Examples of monitoring in action

There are several providers of data services actively providing the type of monitoring described here, and many PCTs are now using them for a variety of public health and quality management tasks. Two examples given here show how these systems can improve health care or address inequalities.

Monitoring local delivery plans

The company Health Intelligence provides a system for integrating GP practice and hospital records. PCTs that use this system are able to identify how well

their constituent practices are performing against benchmarks contained in Local Delivery Plans. They can investigate failure to attain these health benchmarks within population subgroups and give feedback to hospitals, practices and individual GPs on what they need to do to meet the requirements. This type of system enables PCTs and Local Government Areas to develop Local Delivery Plans that include significant health inequalities goals.

Monitoring prescribing activity

The University of Nottingham's PRIMIS system provides a variety of data services free of charge to enable PCTs to monitor GP activity. With this system, PCTs or GP practices can identify unsafe, high-cost or unsuitable prescribing activity and provide feedback sufficient to improve GP performance. With extension to area-based data analysis, and with collection of ethnicity data increasingly occurring at the GP practice level, it is possible for this tool to be extended to include assessment of inequalities in the prescribing of key drugs such as statins. The prescribing toolkit is a service that provides practice-level data benchmarked by like practices – for example, in terms of deprivation.

Future considerations

As the evidence base on health inequalities increases, there will be potential to better link national targets with local ones. Local data is potentially useful in finding out which groups are benefiting (or not benefiting) from wider public health initiatives such as the spearhead initiatives (Marmot 2010). One of the criticisms of the spearhead initiatives was that it was not necessarily the neediest patient groups who were making use of the service provision (National Audit Office 2010).

There might also be scope for considering the role of markers of organisational structure regarding health inequalities – for example, the number of connections being made between general practices and other community groups – or reflective exercises discussing the implications of the data that is fed back to them. PCTs and spearheads are likely to become defunct, but GP consortia performance and linkages with local authorities on public health, population health and social care will need to be monitored.

Summary points

- GP data systems are rich in data to support the monitoring of inequalities in general practice.
- Data monitoring systems offer a unique opportunity for GP consortia, PCTs and GPs themselves to monitor inequalities in health and in the quality of their care, and to adapt their activities to reduce or prevent health inequalities.
- Systems for monitoring and benchmarking inequalities in general practice have been developed in some areas, but their application nationally is patchy.

- Monitoring systems enable GPs to identify inequalities in quality of care that are not amenable to investigation at the level of the individual consultation.
- Through monitoring, GP consortia may become aware of structural or systemic influences on health inequalities that are easily remedied through investment and service reconfiguration.

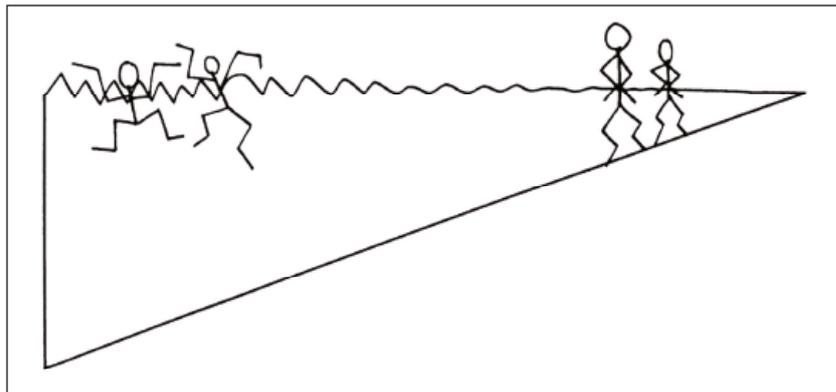
5 The challenges of meeting this quality agenda, and implications for the future

It is clear from the previous sections that general practice is extremely well placed to have an impact on the health consequences of inequalities in wider society; to ensure that its services are equally accessible to all, proportionate to the health needs of its patients; and to develop links with other agencies to contribute to tackle unemployment, education, and housing needs. This section outlines some of the challenges that are faced in meeting this quality agenda and discusses the implications for the future.

Clinical demands

We know that there are fewer GPs in some of the most deprived areas of the United Kingdom (National Audit Office 2010). We also know that those GPs working in the most deprived areas experience greater levels of stress than their colleagues elsewhere. Professor Watt uses the analogy of the swimming pool to describe how some GPs struggle to stay afloat (see Fig 2, below).

Figure 2 General practices serving affluent and deprived areas



Source: (Watt 2006)

Part of the solution would be to ensure that GP levels, and those of other health care professionals, adequately reflected population needs. There is a challenge to recruit and retain doctors to areas of deprivation. In some countries there are explicit incentives to work in underserved rural areas, such as funding medical school fees (Matsumoto *et al* 2008).

An ethnographic study examining the experience of GPs in dealing with health inequalities highlights the difficulties that GPs felt at being unable to respond to the social problems they encounter:

One GP felt constrained in acting further on a racist attack on a patient because there was no obvious mechanism for reporting these problems to the police. Another suggested that he would have preferred to refer his patient for debt counselling, but to his knowledge no such service was available locally.

(Popay *et al* 2007a)

The same study also explored patient experiences in two deprived communities:

A Middle Eastern man had consulted a GP with a hand injury that had been caused during a racial attack, and a middle-aged white woman, who consulted with depression, was living in a neighbourhood she felt to be dangerous and deteriorating, having recently witnessed the violent death of a teenage girl outside her front door.

(Popay et al 2007b)

Community boundaries

The White Paper *Equity and Excellence* plans to allow patients register with any GP surgery they like irrespective of where they live (Department of Health 2010a). This has the potential to further reduce the intimate knowledge of communities that GPs serve – which has been highlighted as one of general practice's strengths in its ability to reduce health inequalities. On the other hand, it may mean that patients are actively able to seek better care, which may impact positively on health inequalities. Many of the details regarding the specific configuration of future general practice remain unclear.

Education and training

The General Medical Council (GMC)'s policy document *Tomorrow's Doctors* states that it will be a requirement for doctors' training to include reference to health inequalities (General Medical Council 2009). The Royal College of Physicians is encouraging doctors to take up the wider social determinants of health, but again in quite general terms (Royal College of Physicians 2010). There are already examples of interesting selective study modules in the undergraduate curriculum with regards health inequalities (see Case study 3, below).

Similar approaches could be considered for GP training, which currently requires GP trainees to have an awareness of health inequalities (RCGP). The GP assessment process could be developed to ensure that health inequalities form an explicit part of trainee learning. For example, one of the case discussions that are requirements for RCGP membership could be approached with explicit reference to health inequalities and doctors' wider advocacy role. Given the diversity of training placements, and the varying attitudes to health inequalities, it is important to ensure that trainees' approaches to health inequalities are not met with responses that are dismissive or cynical but are closer to the ethos of the Bromley by Bow Centre 'assume it's possible' (see www.bbcb.org.uk/pages/mission.html – accessed on 25 August 2010).

Case study 3: Cheshire and Merseyside Health Inequalities Programme for Students

Cheshire and Merseyside Health Inequalities Programme for Students (CHIPs) is an experiential training programme on health inequalities for undergraduate medical students. It is a four-week elective module in the

undergraduate course. The aims are to:

- understand the causes and consequences of health inequality, and to be up to date with current literature in this area
- learn about the main clinical problems of the socially excluded, focusing on four key groups: asylum seekers, homeless people, travellers, prisoners
- explore the best ways to provide health and other services for hard-to-reach groups, in a sustainable fashion
- reflect on these issues and relate them to their future role as qualified professions
- consider ways to manage stress and avoid burnout.

The first two weeks of the course are part of an immersion programme that introduces students to key service users, and involves time in placements such as non-governmental organisations. The second two weeks are used to write a 3,000-word interpretive essay that includes case histories and a personal reflection.

One of the challenges about teaching health inequalities is that there is often a strong ideology underlying the different members of the workforce involved in working with some of the most vulnerable groups in society. Rather than imposing an ideology on the students, the course is taught from a human rights perspective for service users, which then invites students to consider possible solutions for the groups they encounter.

There is scope to understand better the profiles of GPs who work successfully with some of the most vulnerable groups, or in areas of high deprivation. Are they part time? Do they have links to academic institutions? QOF data implies that training practices in areas of deprivation appear to exempt fewer patients, but this is only one measure. Qualitative work could explore this further to feedback into GP training and job planning.

Proportionate universalism

Proportional universalism, as advocated by the Marmot review, encourages health inequalities to be tackled across the social spectrum. While its sentiment is that reducing the gap between rich and poor will benefit everyone, it is not clear how this might translate in day-to-day practice for individual clinicians. Work on appointment systems, which vary from practice to practice, might allow flexibility to allocate greater time to those patients with most needs (Mercer *et al*). Monitoring systems might allow GPs to incorporate the breadth of demographic statistics into their day-day practice. At present, the National Audit Office recommends that interventions regarding health inequalities should be focused on those with the highest risk of premature death (National Audit Office).

The Marmot review advocates a greater role for early years interventions. GPs could play a role in this. However, changes in health care configuration have meant that a significant proportion of child surveillance occurs outside GP surgeries, involving programmes such as Sure Start. GPs also have less

contact with health visitors than they did (Ford 2010). It is not clear whether plans to programmes such as Sure Start will be carried out. A recent report by The King's Fund has advocated that GPs should playing a greater role in pregnancy care, which might foster greater opportunities to tackle health inequalities in early years (Smith *et al* 2010a).

Configuring and commissioning

It was stressed in earlier sections that UK general practice, as part of a National Health Service, has been thought to reduce health inequalities by its generalist approach and continuity of care (Starfield *et al* 2005). However, there is still a dearth of research into health care system configuration (Atun 2004), and research could be considered to assess the implications of large-scale changes to the NHS with regard to health inequalities. For example, will GP commissioners be any better at addressing health inequalities compared to primary care trusts? Will competition between providers reduce health inequalities? The implications of giving patients increased choice of providers, which is an active policy goal in England (Department of Health), could be compared to the situation in Wales and Scotland, where the issue is not as high on the agenda.

The Marmot review advised against significant system restructuring, 'as there was widely voiced concern to avoid advocating disruptive system changes' (Marmot 2010). The extent to which PCTs and strategic health authorities (SHAs) can be abolished smoothly and replaced with widespread GP consortia could be seen as contrary to this philosophy – and potentially disruptive. It is also unclear how far GPs will collectively have the skills to successfully commission services on such a large scale, combined with the pressures of being accountable for large-scale budgets. It should be noted that there are already areas of the United Kingdom where GPs work in consortia, pooling resources to commission appropriate services – for example, **East London Integrated Care (ELIC) in Hackney.**

GP consortia will not commission themselves or other key community services (Department of Health 2010a). However, the White Paper stipulates that GP commissioners will be required to take a population view, ensuring that even those who are not registered have services provided for them (Department of Health).

One of the structural successes of the United Kingdom's approach to tackling health inequalities has been the way in which it has been cross-cutting through government departments. Plans for the Department of Health to reduce its involvement in directing professional bodies, including its role of medical training (Department of Health), could have implications for the health inequalities agenda.

Ensuring that health provision is representative of the needs of the whole population – not just those who are vocal, or those who are better at seeking health care – will be a challenge. There is a role for GPs to ensure that their new working arrangements involve systematic, rather than sporadic, approaches to health inequalities.

Conclusion: implications for the future

General practice already plays a significant role in tackling health inequalities stemming from the wider social determinants of health, as well as having

a responsibility to ensure that the service it provides and its practices are equitable.

The United Kingdom remains one of the most unequal countries in the developed world (Wilkinson and Pickett 2009) and social inequalities remains a key political issue (Conservative Party 2010). For this reason, the role of general practice in tackling health inequalities should complement wider efforts to address the root causes of health inequalities, rather than replacing them.

In the future, data needs to be routinely available to all clinicians, so that they are actively aware of how their actions are contributing to health inequalities. This might relate to particular conditions, or referrals for key conditions, and may include demographic data such as age, gender and ethnicity. Such data needs to be informed by high-quality research into best practice for tackling health inequalities. GPs are well placed to work towards QOF scores that incorporate parameters relevant to address health inequalities.

There is scope for GP commissioners to address health inequalities, just as there currently is for primary care trusts. The Equality Act 2010 means that the social determinants of health will have to be given due consideration when services are commissioned. Toolkits to help commissioners, such as those provided by the HINST (see p 22), would be useful in helping GPs commission appropriate services.

Educational programmes for GPs need to ensure that doctors are aware of the issues regarding the complexity of health inequalities, as well as enabling them to feel that there are practical steps that can be taken to help reduce inequalities – either within their practice or more widely. There is a role for GP services to link in more effectively with welfare and housing advice, as well as with education and community development. GP consortia may encourage community engagement by GPs, but at present this is not routine.

Workforce planning should ensure that GP numbers are not disproportionately located in more affluent areas. Efforts to tackle health inequalities need to remain co-ordinated nationally, as well as responding to local health requirements. A greater emphasis needs to be placed on prevention, as well as an appreciation from policy planners of the complexity of cases seen in general practice – especially in areas of high deprivation.

Summary points

- GPs working in areas of high deprivation face high levels of clinical demands, and have to deal with a number of complex and pressing concerns from patients. Resources and training should reflect this.
- Medical undergraduate training and GP training has the potential to actively equip future doctors with knowledge and skills that are specifically relevant for tackling health inequalities.
- Health inequalities should continue to be co-ordinated nationally, as well as incorporating the need for particular local needs.
- Changes to the configuration of the NHS should ensure that tackling health inequalities remains a high priority.

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