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‘Levelling up’ general practice in England

What should government prioritise?

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Contents

Key points

- Government's 'levelling up' agenda must include general practice. People living in socioeconomically deprived areas have the greatest health needs, but general practice is underfunded and 'under-doctored' in areas of high deprivation.
- The persistence of the inverse care law in general practice is a consequence of policies failing to allocate resource according to need. Government has an opportunity within the levelling up agenda to address this.
- Levelling up general practice must include updating the formula used to divide funding between practices. The current formula underestimates need associated with deprivation, contributing to inequitable funding across general practice.
- Current policies to reform general practice focus on developing primary care networks (PCNs) and expanding the use of digital technology. This includes a large expansion of the primary care workforce. But there are no mechanisms in place to ensure these staff are equitably distributed. Levelling up general practice requires action on funding and staff, otherwise health inequalities may widen further.

Why should levelling up include general practice?

Over 300 million appointments are made each year in general practice.[1] It is the part of the NHS the public interacts with most. And, despite well-publicised challenges of rising workload and workforce shortages, general practice retains high public satisfaction ratings when compared with emergency or inpatient hospital services.[2,3] Access to prompt, high-quality primary medical care is important for people of all ages. But access to high-quality general practice is itself inequitable.[4,5]

This government, elected on a promise to 'level up every part of the United Kingdom',[6] faces a gargantuan task to do so. Widening inequities in geographical, social, economic and health terms pre-dated the COVID-19 pandemic, and have been exacerbated by it.[7] General practice, which combines medical expertise with deep knowledge of local neighbourhoods, is well placed to tackle health inequalities, and policymakers expect it to play a central role.

50 years after it was first described, the inverse care law persists in general practice in England. General practice in areas of high socioeconomic deprivation – where health need will be greatest – is relatively underfunded and under-doctored.[4] There is wide acknowledgement that the formula used to distribute most funding to general practice does not sufficiently account for workload associated with the additional needs of people living in deprived areas.[8] Practices in deprived areas on average have lower Care Quality Commission scores, lower QoF performance and lower patient satisfaction scores.[4,9,10] People who live in areas of high deprivation have on average shorter GP consultations than those in wealthier areas, despite being likely to have more complex health needs.[11]

Primary care networks (PCNs) have been designed to improve access to primary care and expand the range of services available – including through better integration with community services and greater involvement of a wider primary care team.[12,13] The rapid expansion of online and digital technology may also offer opportunities to expand access to care.[13] But PCNs are early in their development.[14] Digital consultations may increase GP workload.[15] Access to 'digital first' primary care may not be equitable, and new models of 'digital first' primary care may not work for many patients with complex needs.[16,17] A broader digital care offer risks widening inequity in access to general practice; people living in deprived areas are more likely to be 'digitally excluded', and are also more likely to live with multiple health conditions than people living in wealthier areas[16,18].

Improving access to general practice is important, but unless policies are specifically targeted at tackling the inverse care law, health inequalities may widen. In deprived areas, where health needs are often greatest, general practice is under the most pressure, and is least equipped to act. When health programmes – such as screening or vaccination – are applied universally, the most affluent often derive the greatest benefit[19,20,21] Unless the principle of proportionate universalism is applied to the resourcing of general practice – ie unless universal services are resourced and delivered at a scale and intensity proportionate to the degree of need[22] – well-intentioned policies to increase access to

general practice, and reduce health inequalities will be ineffective at best, and at worst end up widening them. Levelling up health inequalities requires action to level up general practice, set within the context of a broader cross-government strategy to level up throughout the NHS and beyond.

Priorities for government

When government policy includes support for an overall increase in NHS resources to deprived areas – as it did between 2001 and 2011 – a reduction in absolute health inequalities from causes amenable to health care may result.[23,24,25] Tackling the inverse care law – and levelling up general practice – requires action in two fundamental but challenging domains: funding and workforce. These are the foundations on which other interventions can be built.

Funding

In England, most practices are paid according to how many patients they have, with an adjustment made for workload associated with those patients. Since 2004, the global sum allocation formula, colloquially known as the 'Carr-Hill' formula, has been used to make that adjustment. In his methodology, Carr-Hill measured workload by analysing the time that patients spent in consultation with GPs. But consultation length is a flawed proxy for need. Patients get what is available, and an effect of under-doctoring is that consultations were (and are) no lengthier in more deprived areas.[11] The formula has long been acknowledged to be inadequate at accurately weighting need associated with socioeconomic deprivation.[8,26,27]

In 2016 the GP Forward View acknowledged that Carr-Hill is 'out of date and needs to be revised', promising a new funding formula for general practice.[28] But 5 years later this has not materialised. Workarounds have been attempted (such as channelling additional funding for health inequalities through clinical commissioning groups (CCGs) – who implemented a new needs-based allocation formula in 2016) – but the ongoing funding gap suggests that these have been inadequate. In 2020, practices serving more deprived populations received around 7% less funding per need adjusted registered patient than those serving less deprived populations.[4]

The challenge of 're-doing Carr-Hill' should not be underestimated. Technical challenges are present, such as working out how to most accurately account for and then weight need associated with a range of factors (including health and social needs), but these are surmountable. Two other interrelated challenges are more stubborn: political will, and getting GPs to agree the change.

Adjusting a funding formula creates 'winners' and 'losers'. General practice everywhere is stretched – not just in areas of high deprivation – and it is understandable that GPs whose practices stand to lose out financially, might oppose such a move. Indeed, attempts to reform Carr-Hill in 2007 and

2015/16 met resistance from the General Practitioners Committee.[29] But political will – in the form of additional funding – could offer a way around this. As with CCG funding allocations, GP funding could be adjusted using a 'distance from target' approach.[30] Using this method, a new, more equitable funding formula could be applied, but with adjustments made gradually and with an overall increase in funding. The income of all practices would increase over time, but the income of some practices would increase more, and faster. Extra funding would be required, otherwise GPs would likely resist a reform that would reduce income to some practices.

Workforce

The workforce crisis in general practice is no secret, but its disproportionate impact on practices in deprived areas is less well-known. After accounting for different levels of need, a GP working in a practice serving the most deprived patients will on average be responsible for the care of almost 10% more patients than a GP serving patients in more affluent areas.[6] NHS England has introduced a raft of measures to try and improve recruitment and retention in general practice – and there is evidence that some efforts are working (a record number of doctors started GP training in 2020).[31] More GPs are needed everywhere, but there is a risk that additional GPs will gravitate towards more affluent areas, further increasing inequity in access for patients in more deprived neighbourhoods.

Initiatives to recruit and retain more GPs are necessary but not sufficient to level up general practice. Specific programmes are needed to ensure that additional GP capacity is directed to the areas of highest need. Efforts are being made, but equitably distributing GPs has been an enduring policy struggle. Attempts to reduce differences in GP numbers across areas of England have followed three broad strategies: targeted initiatives aimed at undersupply in specific areas, regulating recruitment in over-doctored areas, and general supply increases.[32,33,34] No strategy has resoundingly succeeded.[35]

Current attempts to improve equity in GP supply include NHS England's Targeted Enhanced Recruitment Scheme – which offers financial incentives to trainees accepting roles in under-doctored areas. But this will only be as successful as its ability to accurately identify under-doctored areas, to recruit and to retain GPs. Programmes such as the Trailblazer scheme – giving trainees and early career GPs working in areas of high deprivation specific training and support – are exciting and evolving. Another initiative, national post-CCT fellowships being rolled out by NHS England, could be targeted towards supporting GPs to work in areas of high need. And while patients must always have face-to-face appointments when needed, remote consulting – vastly increased during the pandemic – reduces the necessity for all GPs to be in physical proximity to the patients they consult with. These opportunities must not be missed.

And the primary care workforce is about far more than GPs. The government has promised an additional 26,000 allied health professionals working in primary care by 2023/24, funded through primary care networks (PCNs). Viewed as a mechanism to simultaneously ease workload pressures

on general practice, and deliver expanded and improved care, there is a lot riding on this policy. But there is no mechanism in the PCN contract to ensure equitable distribution of new staff, or indeed any weighting according to population need. Early evidence suggests that PCNs in more affluent areas are more able to recruit these new roles.[36] If continued, the expanded primary care workforce is likely to be skewed towards wealthier areas, which will derive the greatest benefit from the extra staff. Health inequalities may widen further. Policymakers must urgently explore ways to prevent this from happening. Options include offering additional recruitment support to PCNs in deprived areas, varying funding/staffing allocations for networks based on the demographics of the populations they serve, and supporting networks to develop appropriate premises to accommodate the additional workforce (small practices – which are particularly likely to struggle to find space for additional PCN staff – are more likely to be in more deprived areas).[4]

Meeting manifesto commitments and levelling up at the same time

Government has promised a levelling up white paper later in 2021, setting out a range of policy interventions, including education, employment, infrastructure and health.[37] Levelling up general practice – the chief provider of NHS care to the nation – must feature in these plans.

Government's manifesto promised 6,000 additional GPs, 26,000 allied health professionals and 50 million more appointments in general practice by the end of the parliament.[6] Investment in primary care has lagged behind spend on hospitals and the acute sector for the past 20 years,[38] so promises of increased funding for general practice are welcome. But unless the government also commits to ensuring that additional resource – including workforce – is distributed in proportion with population need, health inequalities stand to widen, not narrow. Policies to level up general practice will need to be set in the context of a wider set of strategies to reduce inequalities across the NHS, and to better integrate NHS and community services.

General practice has a role to play in reducing health inequalities but must be properly resourced to do so. Levelling up will be impossible unless access to high-quality general practice is equitable. The inverse care law is not inevitable or irreversible. It is a consequence of the failure of policies to align resource with need.

Tackling underfunding and under-doctoring in areas of socioeconomic deprivation is a weighty challenge. Cost, and fear of opposition from the profession, may tempt policymakers to stay away from the thorny issue of funding reform. But doing so risks widening inequalities and misses a huge opportunity for meaningful change. Forthcoming work from the Health Foundation will look in more detail at previous attempts to tackle the inverse care law in general practice in England, analysing what was promised, what was tried, and what has (and has not) worked.

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Supporting information

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