Health Equity
Evidence Centre

Evidence pack: What works to address health and care inequalities

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Introduction

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- We have decades of data describing the problem of health inequalities, but little good quality evidence of what works to address health and care inequalities.
- There are two key challenges to building an evidence base of what works
  - The drivers of health and care inequalities tend be structural related to the wider determinants of health or related to the structure of services, such as inequalities in funding, workforce or workload. Demonstrating impact of structural change is difficult because there is usually lots of noise within the data, i.e. other simultaneous structural changes, which is compounded by a long time period between the intervention and outcomes.
  - Interventions to address health and care inequalities tend to be specific to local populations, services, contexts and time. For example, just because an intervention improves health for a south Asian population in London doesn't mean that it will work for south Asians in Birmingham. Therefore it is unlikely we will ever have a set of specific interventions which we know will improve outcomes if implemented because of the large variety in underlying barriers to health across a plethora of intersecting disadvantaged groups.
- Despite the challenges of building the evidence base to address inequalities, there are common themes and principles which cut across multiple populations, services and conditions. For example, allocating resources proportionate to need consistently appears in the literature and can be applied across multiple services.
- Health and care services are going through transformation. Here we present a range of evidence based principles to address health and care inequalities with examples of these principles in action.

Evidence framework

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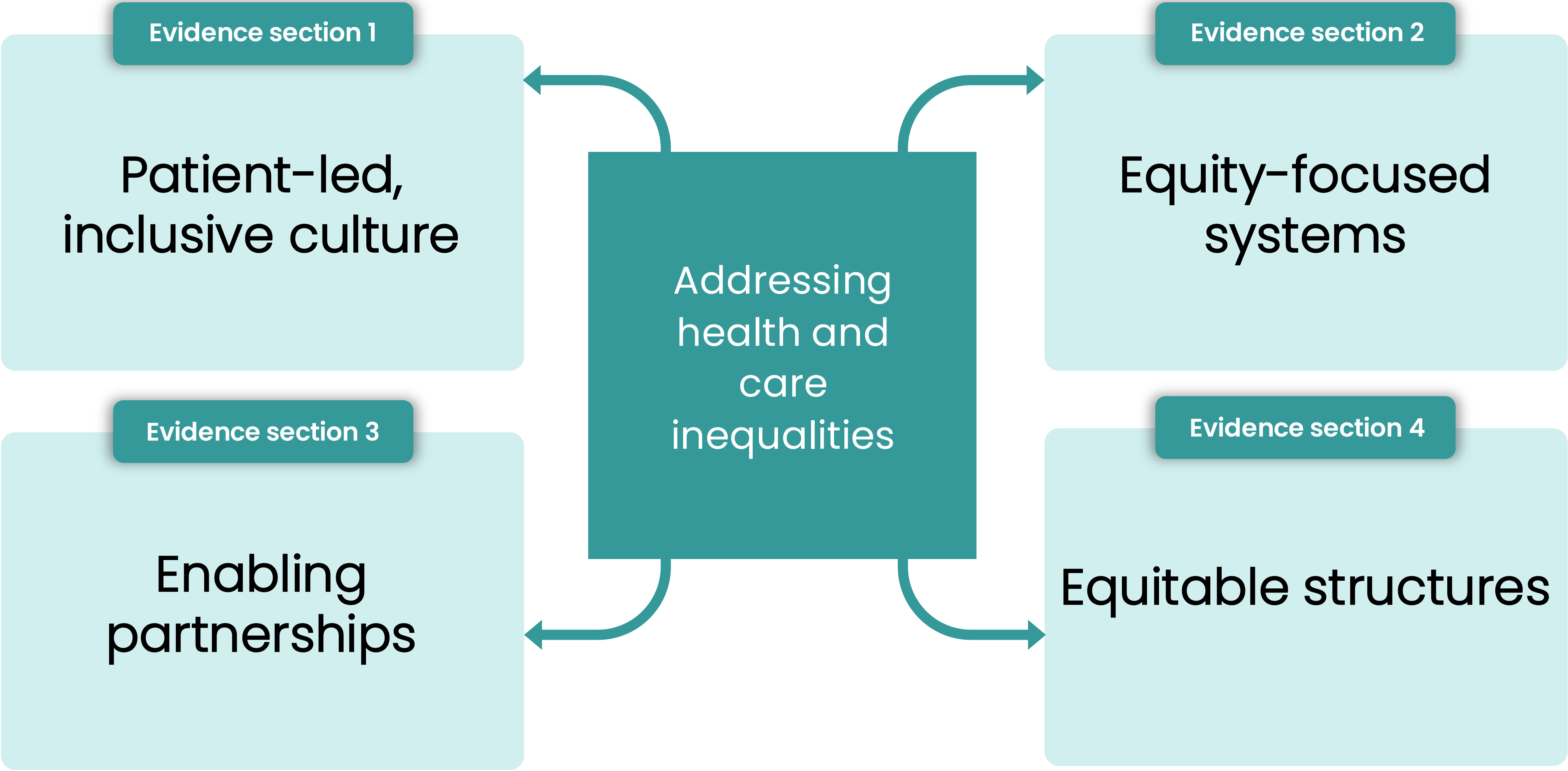

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Evidence Section 1

Patient-led, inclusive culture

> *“Every single person, with no exception, is valuable. All need to be seen, heard, and helped alike, with compassion – with rancour towards none."*
>
> *Jon, Annie & Quincy*
> *HEEC Citizen Panel*

Widening participation of disadvantaged groups in workforce and leadership

Evidence: Previous research demonstrates that diversity within the health care workforce improves clinical decision making, patient experience and outcomes, and financial performance. Further, when patients receive care from providers with similar life experiences they tend to report greater satisfaction and adhere more to medical advice. Multiple studies on cultural concordance between patient and physicians confirm this and suggest that diversity within health care workforce is key for equitable care. What is further needed is building inclusive working environments where individuals from disadvantaged backgrounds are supported to undertake leadership roles. NHS data shows that although ethnic minorities represent 19% of the workforce, only 7.7% is represented at the board level. A recent case study on health care organisations as anchor institutions in the UK shows that when people with lived experience of disadvantage are in senior leadership roles, they are more aware of health inequalities and their drivers, and more likely to invest in social value initiatives. Moreover, they are more likely to liberate other members of their organisation from bureaucratic obstacles and enable them to implement positive change.

Example: **Key questions for assessing and improving board equality and diversity based on learning from the COVID-19 pandemic**

- Do the board and executive team reflect the composition of local population/staff demographic in terms of age, gender and ethnicity?
- Do we collect/analyse staff numbers with a minority background in relation to overall staff demographic for: permanent staff, temporary staff, locum staff?
- Do we analyse minority staff comparators in relation to the overall demographic: salary, seniority, successful job applications both internal and external, complaints including whistleblowing, sickness levels?
- What plans do we have in place to improve minority staff opportunities and safety?
- Have we conducted a deep dive or internal audit review to verify these details and progress against any action plans and risk registers?

Recommendations

- Offer work placements to people with protected characteristics and lived experience of disadvantage with practical and psychological support during at least the initial stages
- Enable all members of staff to undertake leadership roles through training and open communication channels across the organisation

Key sources: EQUALISE; Attracting, supporting and retaining a diverse NHS workforce. London: Nuffield Trust

Challenging biases

Evidence: Tackling implicit biases and structural racism among health care professionals is essential for delivering equitable care. Stigma is a barrier for disadvantaged groups in accessing healthcare, especially when interventions focus on behaviour change and risk factors like obesity or smoking. Medical narratives often frame these behaviours as individual choices and associate with a blaming culture against patients who, for example, smoke or are obese. Smoking and weight stigma are linked to stereotypes of weak character and socio-economic status and intersect with negative gender and ethnic stereotypes affecting particularly women from low-income or ethnic minority backgrounds. Implicit bias can also lead health care professionals to make decisions based on mental short-cuts (e.g. that women have a low index of suspicion for CVD). This often leads to delayed or missed diagnoses and even avoidable harm (e.g., heart attack symptoms being attributed to anxiety). Further, ethno-centric assumptions regarding the needs and preferences of patients associates with ineffective treatment plans and limited patient engagement among ethnic minorities. Adopting a personalised approach, engaging in active listening, valuing patient knowledge, and providing evidence-based information and counselling in a sensitive, non-judgemental way are all key components for building an inclusive culture for both health care staff and patients.

Example: Patient and carer race equality framework (PCREF)
The first ever anti-racist framework of NHS England aims to support mental health trusts and service providers on their journey to become anti-racist organisations. It offers concrete guidance on how organisations can meet their responsibility for co-producing and implementing actions to reduce racial inequalities within their services. The framework brings communities at the heart of service design and implementation and aims to encourage a culture shift where expertise by lived experience is as highly regarded as expertise by profession.

Example: Anti-Racism in Paediatric Psychology: The STYLE framework
A framework through which professionals in paediatric psychology can engage in anti-racist work.

Self-examination & critical reflection to better understand personal experiences of oppression, privilege, biases, & reasons for inaction.
Talk directly about structural racism in your work.
Yield time & space to anti-racism work.
Learn about structural racism, & how it impacts racialised youth & their communities.
Evaluate policies and practices through an anti-racism lens.

Recommendations

- Tackle stigma through agreed language, educational material and training for staff and community members
- Use local knowledge to identify underserved groups with unmet needs and develop tailored and empowering programmes

Key sources: EQUALISE; HEEC Evidence Brief: Improving access, uptake and optimisation of behavioural interventions in the health care setting to better meet the needs of disadvantaged groups

Reconceptualising trauma and trauma-informed care

Evidence: The NHS definition of trauma states that 'Trauma results from an event, series of events, or set of circumstances that is experienced by an individual as harmful or life threatening. While unique to the individual, generally the experience of trauma can cause lasting adverse effects, limiting the ability to function and achieve mental, physical, social, emotional or spiritual well-being.' This definition often leads to misconceptions that trauma refers to extreme or disastrous experiences that affect only certain people like victims of violence or substance users. However, trauma is subjective and can refer to a wide range of abusive or neglectful events or series of events that are experienced as being not only physically but also emotionally harmful.

Evidence: Childhood trauma has long-lasting impacts on adult behaviour, mental but also physical health. Increasingly, mental health researchers suggest that people who have been historically oppressed accumulate traumatic experiences which impact people even across generations (historical trauma). This broadened perspective reveals that trauma is more common among people than we possibly assume; it is not necessarily 'visible' and affects the overall health and wellbeing of people and their approach to health and care. Trauma-informed care is a model based on safety, trustworthiness, choice, collaboration, empowerment, and cultural consideration. Research suggests that it is a key dimension of equity-oriented health care.

Example: The Canadian EQUIP project: Interprofessional training to address trauma and violence

The Equip Project was implemented to make health equity a strategic priority at all levels from the Institute for Health Care Improvement in Canada. Its educational component on trauma-informed care was developed to focus explicitly on: (a) ongoing structural and interpersonal violence, as well as historical and intergenerational trauma; (b) how these factors intersect with poverty, racism, chronic pain, mental health problems and substance use, especially in the context of primary health care; and (c) how action is required at all levels including practices, organizational approaches and policy. The training included eight hours of face-to-face workshop-style content with opportunities for small-group discussion and applied learning via case studies. The intervention improved patient experience and confidence in the received care, self-management, depression and post-traumatic stress disorder symptoms. It also improved staff confidence to use trauma-informed care in practice.

Recommendations

- Organisations should encourage reflective dialogues on trauma and its meaning for health and wellbeing among health care professionals within a context of psychological safety
- Organisations should work with lived experience experts for the development of trauma-informed care models and training

Key sources: A Roadmap for Creating Trauma-Informed and Responsive Change; EQUIP Health care

Offering flexible services to accommodate social needs

Evidence: Socially disadvantaged people often need additional support to access and benefit from care, such as translation services, longer consultations, or help overcoming practical barriers like transport costs. Providing optimal care to diverse populations requires flexibility in identifying unmet needs and tailoring resources, staff, schedules, and communication methods to address them. Flexible care enables providers to make fair and inclusive decisions for every patient within the limitations set by that patient's health, material and psychosocial circumstances.

Example: More time for complex consultations in high-deprivation practices increases patient satisfaction

A longitudinal study was conducted in a general practice in an urban area of extreme socioeconomic deprivation in Glasgow. Health care professionals had the flexibility to subjectively decide whether a consultation was complex or not and tried different approaches in terms of extending consultation time. The findings showed: The GPs' targeting of complex consultations were indeed reaching the patients with the poorest health. The best approach (and the one adopted) was to leave an empty 10-minute slot after every fifth routine appointment. Therefore, when a consultation was understood to be complex, the GP could allow that patient to use up to 20 minutes. The length of complex consultations varied. However, it increased on average by 2.5 minutes compared to the baseline. This increase was associated with increased patient satisfaction, reduced levels of stress among professionals and opportunistic health screening.

Quote from participating GP

'… a patient who comes in with one problem and then you say, "by the way you've never actually come in for your review of your heart disease, so how about I just check your blood pressure and your weight and go through some of the other things and how is your angina" all in the same consultation, because they won't come in and have that done at other times.'

Recommendations

- Adjust working hours and contact time according to local need
- Tackle transportation barriers through contributing to community transport options, providing targeted home visits and remote consultation options
- Use diverse communication channels, material and languages (including non-spoken language), including offering digital and non-digital options
- Co-locate services within community spaces

Key sources: EQUALISE; HEEC Evidence Briefs: Designing health care inclusively for people with low incomes; Improving case-finding of long-term health problems in disadvantaged communities

Considering intersectionality in the design and delivery of care

Evidence: Increasingly, evidence suggests that delivering equitable care requires adopting an intersectional perspective. There is a consensus that there is not a one-size-fits-all solution for improving health care experience and outcomes for disadvantaged groups and that factors affecting these outcomes are not exclusive to socioeconomic status or deprivation levels. Programmes need to account for differences within disadvantaged groups that cut across ethnicity, gender, cultural factors like religion and language, histories of trauma, disabilities, and sexual orientation. Fair and inclusive environments of care work with, rather than despite, such differences and account for the fact that often people with the worst health outcomes are those who experience disadvantage across a number of these factors. Importantly, they encourage a reflection on how power structures within medicine and health care reinforce inequalities.

Definition: Intersectionality is a metaphor for understanding the ways that multiple forms of inequality or disadvantage sometimes compound themselves and create obstacles that often are not understood among conventional ways of thinking.

Example: A coordinated perinatal mental health care model based on intersectionality theory for socioeconomically deprived and ethnic minority women

An effectiveness study was conducted in the US with 67 perinatal women referred for mental health treatment at an outpatient psychotherapy clinic within a large urban medical centre. The study focused on an intersectionality-based coordinated model of perinatal care which aimed to neutralise the hierarchical relationships between patient and provider.

The main elements of the intersectionality-based model included:

- Understanding the perinatal period as a time of significant physical, psychological and social transition.
- Co-locating psychotherapy, obstetrics & gynaecology and paediatric clinics
- Multidisciplinary teams with shared leadership structures
- Training on how cultural factors affect patients
- Integration of trauma and recovery theory in case conceptualisation and treatment plans.
- Focus on creating a therapeutic alliance between provider and patient.
- Discussions on patients’ experiences of structural racism.

Recommendations

- Staff should receive training on patient-centred care models which acknowledge the compounding impact of multiple disadvantage
- Health care organisations should ensure diversity in care teams including people experiencing multiple oppression
- Where possible, data should take an intersectional lens and examine multiple disadvantages

Key sources: EQUALISE; Intersectionality: Moving women’s health research and policy forward; LGBT Foundation Trans + non-binary experiences of maternity services; Blanchard 2024 Bridging the Gap: The Role of Specialised NGOs in Inclusive Disaster Risk Reduction

Optimising preventive, proactive care

Evidence: People living with severe or multiple disadvantage tend to have multiple competing needs making engagement with preventive care less of a priority. In addition, socioeconomically disadvantaged areas get less exposure to health promotion. Health systems need to both identify and support patients from disadvantaged backgrounds to receive proactive care. Routine social needs screening can help by systematically identifying challenges relating to employment, housing, education, and social isolation. Outreach services can also assist with providing services closer to home or in trusted locations, such as faith-based organisations or mental health outreach programmes targeting homeless people and sex workers. An analysis of 49 English mental health trusts found that just under half had dedicated mental health services for people experiencing homelessness (e.g. outreach teams, co-located staff in the community).

Example: Culturally adapted motivational interviewing (MI)

Good evidence exists for culturally adapting motivational interviewing. Canadian researchers have designed a motivational interviewing method unique to South Asian people with hypertension to improve medication adherence. It focuses on norms around "collectivist culture" (importance of family), consequences of behaviour, and appreciating traditional medicine in their cultural context. It provided clinicians with the means to proactively engage with poor health behaviours in this population.

Example: Fulfilling Lives Programme (Lambeth, Southwark and Lewisham)

The Fulfilling Lives Programme is based on a belief that *"no person is hard to reach but systems can be hard to access"*. Their focus was on people living with multiple disadvantage in the form of mental ill-health, substance abuse, homelessness, or criminal justice service involvement. Their systems mapping identified themes including: 1) health systems need to be interconnected and cross-sectoral, 2) systems need to be trauma-informed in their approach, 3) systems need to be person-centred. They provide a practical guide for proactive health service design in this context.

Recommendations

- Collect and use social needs information across health and care services
- Implement outreach services and dedicated care coordinators to engage with people living with multiple disadvantage
- Culturally adapt health promotion interventions to better target racial and ethnic minority groups

Key sources: EQUALISE; HEEC Evidence Briefs: Improving access, uptake and optimisation of behavioural interventions in the health care setting to better meet the needs of disadvantaged groups; Designing health care inclusively for people with low incomes; Improving case-finding of long-term health problems in disadvantaged communities; Understanding the health care needs of people with multiple health conditions; Systems change for people experiencing multiple disadvantage

Evidence Section 2

Equity-focused systems

> *“Treat each patient as an individual with respect and no preconceptions or stereotyping.”*
>
> *Maurice*
> *HEEC Citizen Panel*

Ensuring representative and high-quality data

Evidence: Incomplete or poor-quality data can lead to inequitable health outcomes and be a barrier to achieving equitable digital health care. Factors that lead to inequality in data-driven health systems include:

- Logistical and organisational barriers for clinicians which impede the ability to collect representative data.
- Inconsistencies in data collection (such as with ethnic coding, or pulse oximetry readings for people with dark skin tone).
- Under-representation of disadvantaged groups in datasets due to exclusion or under sampling (such as with clinical research), or due to lower adoption or awareness of digital tools. A key example is with COVID-19 data collected through apps, with only 33% of black and minority ethnic individuals downloading the National Health Service's COVID-19 app, compared to 51% of people from a white ethnic background.
- Mistrust, lack of transparency or unawareness limit robust data collection around protected characteristics (e.g. sexual orientation – only 11% of GP practices recorded the sexual orientation of their patients in 2019).
- An absence of qualitative data in informing intervention and service design despite its importance in understanding the structural drivers of health inequality

Previous research has called for best practice guidelines and resources around improving and standardising data collection.

Example: Ethnicity Quality Dashboard

A team at the Cambridgeshire and Peterborough NHS Foundation Trust (CPFT) developed children's mental health services dashboard to view rates of ethnicity data completion compared with other teams, with the goal of improving the quality of ethnicity data collection. They ran meetings and workshops to educate staff about the importance of collecting ethnicity data to narrow health inequalities.

Example: Disaggregated Data Project

The Strengthening Disaggregated Sociodemographic Data Related to COVID-19 project was initiated by Ottawa Local Immigration Partnership in Canada to build organisational capacities to better understand, monitor, and mitigate the impact of the pandemic on immigrant and racialised communities. They produced a framework of engagement strategies for community members, such as raising awareness of the importance of disaggregated data, and co-designing data collection tools.

Recommendations:

- Disaggregate data by disadvantaged group to better measure quality of care and develop guidelines for data collection
- Train staff about the impact of data completeness in terms of ethnicity, sexual orientation, and other social determinants of health
- Engage and inform community members to raise awareness about the importance of health data

Key sources: Data Quality in Health Research, A Scoping Review of Approaches to Improving Quality of Data Relating to Health Inequalities, Improving the Recording of Ethnicity in Health Datasets, Views of healthcare workers on how to improve data quality, Recommendations for improving national clinical datasets for health equity research

Improving data granularity, linkage and patient-led outcome measures

Evidence: Data integrity and granularity can be lost in rigid ICT structures, and as data moves between local, regional, and national data systems. Self-reporting options for ethnicity, such as free-text fields, can improve granularity. This is particularly important given the increasing proportion of patients with *'Other'* recorded as their ethnic group, particularly in lower socioeconomic groups. Patient-reported outcome measures (PROMs) and patient-reported experience measures (PREMs) promote patient-led outcomes; however, PROMs are less likely to be completed by ethnic minority groups. Previous research has recommended that PROMS are made accessible by adjusting for different literacy and cognitive levels, linguistic differences, as well as variable digital access.

Lower socioeconomic groups with multiple long-term health conditions are more likely to visit several health care organisations. Linkage between datasets is important to enable patient-centred care across organisations and understand the patient's journey. However, the NHS does not yet have a fully linked patient record. Obstacles include a lack of standardised definitions and coding practices and poor interoperability of IT systems.

Example: Linked data for population health management

A population health management strategy to link data across the local population was initiated by the Suffolk and North East Essex (SNEE) Integrated Care System. The aim was to reduce health inequalities by better understanding the needs of the local population as it moved through the system, and to focus on preventative interventions that over time would be more effective at tackling health inequalities. Linking data increased ethnicity recording from 70% to 94%.

Recommendations:

- A single linked electronic record is needed across the NHS
- Patients should have the option to self-report ethnicity
- The use of PROMs and PREMs should be expanded and tailored to different disadvantaged groups

Key sources: Tackling health and social inequalities in data-driven systems, Role of Health Information Technology in Addressing Health Disparities, Patient reported outcome assessment must be inclusive and equitable

Leveraging Quality Improvement

Evidence: The NHS undertakes thousands of quality improvement (QI) projects every year. Embedding equity in these projects and using these techniques may address health care inequalities. However, without deliberate planning, QI can exacerbate inequalities. For example, initiatives that require significant patient effort or lack culturally tailored resources may disadvantage already marginalised groups. Equity-focused QI (EFQI) involves using diverse datasets, disaggregated by socioeconomic and ethnic factors, and actively including service user and staff input in programme design.

Examples of QI inadvertently worsening inequalities:
New York State published Coronary Artery Bypass Graft mortality report cards to enable patients to choose the highest performing surgeons and hospitals, while incentivising health care providers to improve care. The introduction of the report card increased racial and ethnic inequalities compared to areas without the report card, with white patients receiving more operations than their black or Hispanic counterparts. It took nine years for inequalities in surgery to return to pre-implementation levels.

A QI initiative aimed to improve blood pressure management among African Americans and white patients in the US. Although reductions in systolic blood pressure were observed in both groups, the improvement was larger in white patients (-7.8 mmHg vs -5.0 mmHg). The authors reflected that the lack of cultural tailoring in the intervention likely contributed to this disparity.

Examples of QI narrowing inequalities:
A QI programme focused on reducing ethnic disparities in maternal morbidity due to haemorrhage employed stratified data, in-depth case reviews, and updated clinical guidelines. The initiative led to a significant reduction in baseline inequalities, including a decline in haemorrhage rates among black women from 46% to 32%. This shows how QI methodologies, paired with targeted data analysis, can mitigate health care inequalities.

A QI programme improved physical health checks for patients in acute mental health units. The success was attributed to co-design with service users and a multidisciplinary team approach, which increased the rate of health checks from 81% to 97%. Active involvement of marginalised groups in QI planning contributed to the initiative's equity-focused design.

Recommendations:
- Integrate disaggregated data by socioeconomic and ethnic groups into all QI projects
- Design QI initiatives with culturally-tailored resources and multilingual materials, particularly for marginalised groups
- Include diverse patient and staff input from the planning stages to ensure the initiatives are equity-focused
- Allocate sufficient time and resources to support staff in equity-focused QI projects, avoiding them becoming tokenistic exercises

Key sources: HEEC Evidence Brief: Leveraging Quality Improvement to address health and care inequalities

Leveraging electronic health records

Evidence: Targeted searches of the electronic health record (EHR) for case-finding is more effective than opportunistic, population-wide case-finding, particularly for cardiovascular disease (CVD). For example, West Midlands general practices between 2009 and 2012 were able to identify high-risk people for CVD 15.5% more easily through targeted EHR searching. Combining searches followed by self-reported questionnaires may also improve case-finding for conditions, such as COPD. Embedding social needs screening within EHR infrastructure is another way of identifying disadvantaged individuals and is already considered acceptable to patients in primary care. There is evidence that integrating patient-level social determinants information into EHRs can help predict health care use and outcomes. However, there is a risk of bias with missing data and unintended consequences, such as further overloading complex data systems in the integration of social information into EHRs. Optimising EHRs using templates and prompts can support health checks in patients, such as with individuals with severe mental illness (SMI). One study found that 23% of primary care clinicians that used a template to record CVD-related data in patients with SMI had 'data-rich' records compared with only 8.5% of non-template users.

Example: Electronic social risk scores

A US study aimed to improve the performance of social risk scores using EHR structured and unstructured data through natural language processing (NLP). NLP was able to capture data not perfectly prescribed in data fields in the EHR software, drawing on information typed freely by clinicians about their patients' social needs. The added richness of the data meant that the model performed better in populations with socioeconomic deprivation, with highest accuracy amongst black patients and those living in disadvantaged neighbourhoods, leading to better social needs prescribing.

Example: Data-led clinical prioritisation

A clinical prioritisation tool developed and trialled at Guy's and St Thomas' Hospital used EHRs to identify 6 risk factors that could be addressed to optimise diabetes care in the outpatient setting. The prioritisation tool identified 549 out of 4022 patients (13.6%) as being high-risk (i.e. having one or more risk factors). These patients were more likely to be from a minority ethnic background with greater socioeconomic deprivation and were at highest risk of attending A&E or secondary care settings. The tool was used to identify people needing earlier follow-up appointments.

Recommendations:

- Implement data-led clinical prioritisation to optimise both care and health system efficiency
- Embed social needs screening into health care systems
- Use EHRs for targeted case-finding

Key sources: HEEC Evidence Briefs: Case-finding, Health Checks for people with SMI, Equity and bias in electronic health records data, Patients in Context: EHR Capture of Social and Behavioural Determinants of Health

Ensuring equitable, representative research and evaluation

Evidence: Despite the abundance of studies on intervention effectiveness and evaluation, researchers rarely account for inequality in research and evaluation, and rarely assess intervention impacts across different groups. We also know that research is not undertaken where the burden of disease is greater. This means that often disadvantaged populations cannot benefit from advances in medical technology, treatments, and services. Making research equitable requires paying attention to potential unequal impacts across social groups and co-creating research with people who are socially marginalised. The National Institute for Health and Care Research recently announced the introduction of inclusion as a key condition for funding; applicants will now be required to demonstrate how inclusion is being built into all stages of the research. Evidence shows that non-academic stakeholders that co-create more than one research stage showed significantly favourable mental health outcomes. Meaningful co-creation and co-design of research requires equitable partnerships with those affected by the issue under study or those who will benefit from it. Building such partnerships with disadvantaged communities and sharing ownership of the produced knowledge is key, not only for achieving equitable outcomes, but also as an effective way to challenge established power imbalances between academic or clinical experts and lived experience experts. Furthermore, it contributes to the production of collective resources.

Example: The Kahnawake Schools Diabetes Prevention Project
The Kahnawake Schools Diabetes Prevention Project is a 23-year-old community-owned partnership between the Kanien'kehá:ka (Mohawk) community of Kahnawake, Quebec, Canada and academic researchers from neighbouring universities. Five community stakeholders and one academic (the principal investigator/champion) participated in interviews where they talked about the actions and strategies over the lifespan of the research which led to a shift in ownership and decision making from the original external academics to the community stakeholders. The synthesis of the interview data showed that key elements that enabled this shift were: the existence of a strong champion; stimulating 'outside' ideas; emergence of core people; alignment of project goals with stakeholders' professional roles; involving the right people; personal qualities of the champion; trust-building; and use of participatory engagement strategies.

Recommendations:
- Inequalities should be considered in all aspects of the research design and delivery
- Co-creation methods, which share ownership with local communities and longstanding partnerships, should be prioritised
- Research methods and topics which reflect the lived experience of disadvantaged groups and areas of greatest need should be prioritised

Key sources: Health Inequalities Assessment Toolkit (HIAT) ; NIHR guidance on co-producing a research project

Evidence Section 3

Enabling Partnerships

> *"An entire culture shift needs to be achieved; mandatory equalities training for all grades of NHS staff would help towards this."*
>
> *Marianne*
> *HEEC Citizen Panel*

Promoting cross-government action on health inequalities

Evidence: Cross-government action on health inequalities has shown to be effective in reducing the inequality in life expectancy and infant mortality. Comprehensive and multi-agency action across healthcare, early years, education, housing, employment, and neighbourhood renewal was key to reducing health inequalities. However, the exact mechanism of action is unknown and certain indicators such as obesity and smoking rates showed mixed results, reflecting the complexity of tackling entrenched inequalities.

Explainer box: National Health Inequalities Strategy (1999-2010) key components

- **Healthcare funding:** Allocating NHS resources to deprived areas using a health inequalities weighting formula from 2001 onwards, ensuring funding reflected higher healthcare needs in disadvantaged areas.
- **Social Policies:** Introducing upstream interventions, such as the National Minimum Wage, progressive tax reforms, and Sure Start Children's Centres to address poverty and early childhood development.
- **Targeting local areas:** Implementing area-based interventions like Health Action Zones and Neighbourhood Renewal Funds to improve infrastructure and services in socioeconomically disadvantaged regions.
- **National health inequalities targets:** Establishing specific health inequality reduction targets, including reducing the life expectancy gap by 10% and the infant mortality gap, by 2010.

Success of a Cross-Government Health Inequalities Strategy

Life Expectancy Gaps: The gap in male life expectancy between the most deprived areas and the rest of England decreased annually by 0.91 months during the strategy period, reversing a previously increasing trend. By 2012, the male gap in life expectancy was 1.2 years smaller than it would have been without the strategy and female gap in life expectancy 0.6 year smaller.

Infant Mortality Rates (IMR): A time-trend analysis demonstrated that the strategy was associated with a decline in geographical inequalities in IMR. Before implementation, absolute inequalities increased by 0.034 per year (1983–1998). During the strategy (1999–2010), inequalities decreased annually by 0.116, reversing prior trends. However, inequalities rose again post-strategy, highlighting the need for sustained investment.

Recommendations:

- Maintain long-term, multi-agency approaches addressing the social determinants of health alongside healthcare-focused interventions
- Regularly assess progress using disaggregated data to refine strategies and ensure targeted support for underserved populations
- Invest in programmes that have demonstrated positive impacts on early childhood development in disadvantaged communities, such as Sure Start
- Enhance resource allocation models ensuring proportional investment in areas with the highest need

Key sources: Holdroyd 2022. Systematic review of the effectiveness of the health inequalities strategy in England between 1999 and 2010

Working in equal partnership with VCSE organisations

Evidence: A recent mixed methods study funded by NIHR looking at how to improve commissioning of Voluntary, Community or Social Enterprise (VCSE) organisations through quantitative analysis of NHS spending, case studies, action learning activities and qualitative interviews found multiple barriers to improving VCSE partnerships (see box below). The research identified actions which are likely to improve the commission of VCSE organisations:

- Co-commissioning through collaborative networks was shown to facilitate mutual understanding and trust between NHS commissioners and VCSE organisations
- Fair contracting: One recommendation was to ensure that VCSEs receive funding at the full cost of service provision to address financial precarity
- Longer-term contracts: Introducing longer contract durations was suggested to reduce instability for VCSEs and encourage more sustainable partnerships
- Supportive roles: Creating roles for individuals with expertise in both NHS and VCSE domains to foster collaboration and overcome regulatory hurdles

Current challenges: Many VCSEs report underfunding, with contracts often failing to cover the full costs of service provision, leading to financial precarity and high staff turnover. Strict procurement regulations frequently hinder collaborative approaches, with competitive bidding processes disadvantaging smaller VCSEs. The instability caused by short-term contracts and fragmented relationships further complicates the ability of VCSEs to deliver sustainable and impactful services.

Example: Sussex integrated Care System co-developed a VCSE Commissioning Framework to embed VCSE organisations as equal partners in health and care commissioning. The Framework sets out principles that promote partnership working, transparency, shared learning, embedding social value, and the reduction of health inequalities. It highlights the need for early engagement with VCSE organisations in planning, the necessity of multi-year contracts to provide funding stability, outcomes-based contracts to facilitate innovation, and support for smaller VCSE organisations.

Recommendations:

- The NHS should set out a national VSCE Commissioning Framework to promote co-commissioning
- Longer-term, fully costed contracts should be the default
- VCSE liaison roles should be created in the NHS to support VCSE organisations to collaborate and understand regulatory processes

Key sources: Sheaff 2024 Consequences of how third sector organisations are commissioned in the NHS and local authorities in England: a mixed-methods study

Maximising community engagement to address inequalities

Evidence: Community-centred approaches have been shown to reduce health inequalities effectively. These approaches enable better access to care, improved health behaviours, and stronger community resilience by integrating local insights and culturally relevant strategies into health service delivery. In particular, programmes that engage community members as Health Champions or Community Health Workers demonstrate notable improvements in health and social outcomes.

Example: In Westminster, a Community Health Worker programme visited 160 disadvantaged households over 10 months, leading to a 47% increase in immunisation uptake and an 84% increase in cancer screening participation compared to 502 unvisited households. This initiative also reduced unscheduled GP consultations by 7.3%. A national rollout of similar programmes is estimated to cost £2.2 billion annually but could generate a £4 return for every £1 invested in the most deprived areas by preventing chronic illnesses and improving health outcomes.

Example: Between 2013 and 2015, Altogether Better recruited over 1,100 Health Champions to support general practices, specialist hospital services, and city-wide programmes. Across 30 practices, champions facilitated activities attended by over 17,000 people, with 86% of participants reporting increased confidence and well-being. At The Ridge Medical Practice, where 75 champions engaged in activities such as cancer support groups, these efforts contributed to a 25% reduction in reactive GP visits. Champions also reported personal benefits, with 94% acquiring new knowledge related to health and wellbeing.

Recommendations:

- The NHS should ensure that community groups and representatives contribute from the inception of service redesign through to delivery and have membership of decision-making groups
- Community-based interventions, such as initiatives with places of worship and community-led peer support, should be designed in partnership with communities
- Community health workers, recruited and embedded within communities, should be rolled out in key disadvantaged neighbourhoods across the country

Key sources: EQUALISE, HEEC Evidence Brief: Community engagement and empowerment to address health inequalities

Integrating at neighbourhood level

Evidence: Integrating care services within local communities has the potential to improve equity, efficiency and cost-effectiveness. Evaluation of UK neighbourhood initiatives shows that most often neighbourhood health care teams address the needs of older frail patients or people with multimorbidity and other vulnerabilities. The operationalisation of integrated neighbourhood teams (INTs) is not yet crystalised and there is no evaluation of their impact on health inequalities. Transferable evidence on equitable primary care shows that there are four key principles that should inform the design and implementation of INTs to reduce health inequalities:

- **Community-centred care based on relationships of trust:** Everyone involved in care from health care professionals to service users, their families, and communities should be involved in design and delivery. Ways to build trust with communities involve outreach methods, group listening sessions, collaborations between trusted general practitioners, community champions and faith leaders, and regular attendance at community events and forums.
- **Co-location of multidisciplinary services that are easy to reach:** Proximity of care and co-located services are two distinct features of INTs that are particularly relevant for meeting the needs of disadvantaged patients and reducing health inequalities. Complementary health services together with welfare and/or legal aid services can make engagement with care easier and directly mitigate the impact of inequalities in the social determinants of health.
- **Integration of IT-systems and information sharing:** Patient and service information needs to be complete, up-to-date but also shared across different professionals and services. This requires good integrated information systems and that all providers involved in an INT are confident about accessing and using these systems.
- **Flexibility and autonomy in strategy and implementation:** Adopting a locally sensitive strategy that accounts for differences within populations is key for delivering equitable primary care. INTs need to have the autonomy to decide their approach, their targeted groups and desired outcomes with adequate resources.

Example: Neighbourhoods Mental Health Teams in City & Hackney
Eight Neighbourhood teams take a multi-disciplinary and trauma-informed approach to address all the health and social care factors and complexities affecting people's mental health. Each team looks at their specific area's referrals and follow up at a daily meeting. Once a person is referred, they become a 'member' of the service and can access support for up to 2 years. This makes support available fast and can prevent potential serious deterioration of patients' mental health. The range of groups and activities in each team are tailored to local need, working with the local voluntary sector and support services.

Recommendations

- Foster partnerships of trust among services, and between services and community members, organisations and leaders, to agree on health needs, priorities and effective action
- Use community partnerships to identify groups with unmet needs and experiencing inequalities in health care
- Co-locate primary care and mental health services with legal aid and social care support
- Enable flexible access pathways tailored to the needs of the neighbourhood residents

Key sources: HEEC Evidence Brief: Integrated Neighbourhood Teams brief, EQUALISE study, HEEC review of co-location in general practice

Case-finding with partners, such as faith-based organisations

Evidence: Case-finding is a strategy for targeting resources at individuals or groups who are suspected to be at risk for a particular disease. It involves actively and systematically searching and allocating resources for at-risk people, in line with proportionate universalism. Case-finding is more successful if it takes place in spaces that are culturally or religiously concordant with minority or marginalised groups. This includes venues like barbershops, churches or mosques. Two main evidence-based strategies exist for case-finding of disadvantaged groups: 1) searching the primary care electronic patient record (EHRs) to identify at-risk people, and 2) opportunistic engagement in the community, workplace or when patients attend other health care settings, such as the emergency department. Opportunistic engagement particularly in faith-based settings has shown to be beneficial for racial and ethnic minority groups.

Example: CVD case-finding in Derby

A pilot study in Derby to address hypertension among at-risk populations (predominantly Black and South Asian) who were less likely to use NHS services was successful in case-finding by using two approaches: 1) using risk stratification tools and EHR searches to drive targeted outreach efforts, and 2) using community-based outreach involving volunteers in pharmacies and other local organisations. They were able to capture 30% of the population yet to be diagnosed.

Example: Substance abuse case-finding in mosques

Canadian Muslims, while having lower prevalences of alcohol misuse and addiction, have poorer rates of recovery due to stigma, and are therefore difficult to identify and treat. A Canadian study found that spiritually-adapted psychoeducation intervention delivered in mosques to address stigma around addiction and therefore improve treatment amongst Muslim communities was effective at not only increasing self-reported knowledge but also willingness to seek help from medical professionals. The 90-minute seminar incorporated Islamic readings and culturally adapted education around mental health.

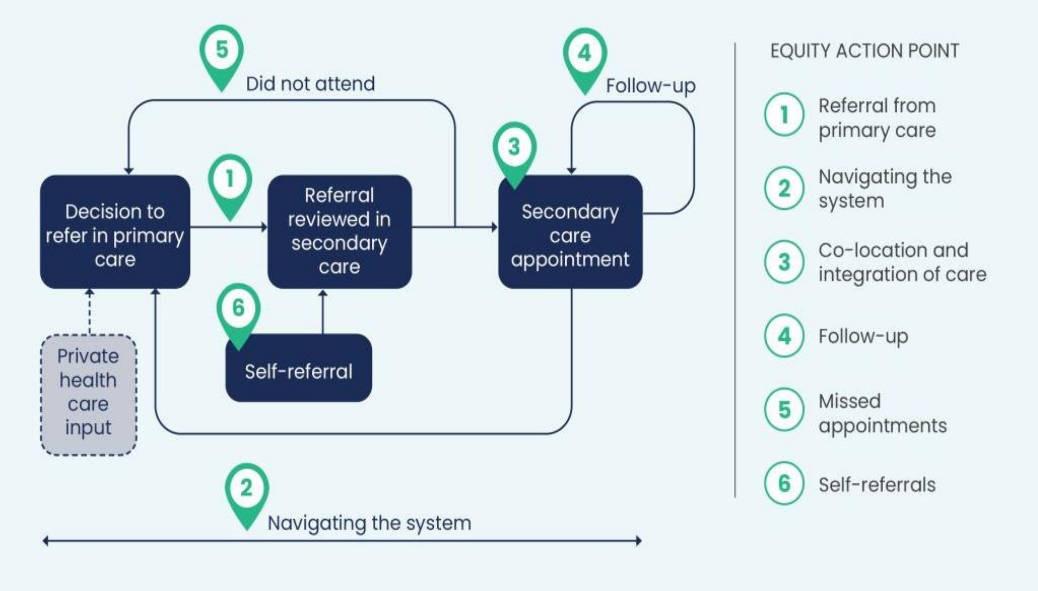
Recommendations:

- Employ targeted case-finding interventions through venues that are ethnically or religiously concordant with disadvantaged groups for better implementation
- Engage community organisations to implement opportunistic case-finding
- Use electronic health records to identify potential undiagnosed conditions

Key sources: HEEC Evidence Briefs: Improving case finding of long-term health problems in disadvantaged communities, Improving access, uptake and optimisation of behavioural interventions in the health care setting, Mosques and Public Health Promotion: A Scoping Review of Faith-Driven Health Interventions

Addressing inequalities in the interface between primary and specialist care

Evidence: Inequalities at the interface between primary and specialist care disproportionately impact disadvantaged populations, especially inclusion health groups, with patients falling between the gaps in services. Referral processes, missed appointments, and digital barriers exacerbate these inequalities. Addressing inequalities at the interface between primary and secondary care requires targeted interventions that improve access, navigation, and coordination for disadvantaged populations. Effective approaches include care coordinators who provide continuity and support for patients with complex needs, reducing hospital readmissions and improving quality of life. Referral systems that integrate decision-support tools and e-consultations have shown promise in reducing delays and ensuring appropriate care pathways. Co-location of services, such as community diagnostic centres, can bring care closer to underserved communities, improving access while addressing logistical challenges like transport.



Example: In Australia, an integrated diabetes service targeted Aboriginal Australians in remote communities. By co-locating specialist outreach services with primary care and incorporating culturally tailored approaches, the programme achieved significant improvements in HbA1c levels and cholesterol management. This underscores the importance of culturally competent, integrated care in reducing disparities for disadvantaged populations.

Recommendations

- The NHS should expand support mechanisms for disadvantaged groups to help care transitions, such as care coordinators
- NHS communication should be reviewed to ensure it is inclusive and culturally tailored
- Services should be flexible with co-location
- Patient-initiated follow up on a case-by-case basis

Key sources: : HEEC Evidence Brief - [Addressing inequalities in the primary and secondary outpatient interface]

Providing digital education hubs to address digital exclusion

Evidence: In 2024, 33% of the British public do not have the digital skills necessary for day-to-day life, with 23% and 9% having 'very low' and 'low' digital capabilities. One in two adults who were offline had difficulty engaging with digital organisations, most commonly government services. A survey of almost 2,500 respondents asking about attitudes towards technologies found that nearly a fifth (19%) did not have access to a smartphone, and another 14% did not have internet access. Economic and financial barriers to digital inclusion disproportionately affect minority ethnic groups. The shift from analogue to digital requires improving digital literacy and addressing infrastructure barriers (i.e. broadband, connectivity) that disadvantaged communities face. The NHS has a role in identifying and referring patients with low digital health literacy or digital and data poverty. Adapting digital interventions to appropriately meet linguistic, cognitive, and cultural needs of particular groups is also essential. Having space to upskill and educate on the use of digital platforms (through partnership with community spaces, providing Wi-Fi hubs and educating staff to identify people at risk of being digitally excluded) also helps bridge the divide.

Example: Digital Hubs

100% Digital Leeds is working in economically deprived wards in Leeds to establish networks of Digital Health Hubs. Digital Health Hubs are trusted community organisations in key locations with supportive staff, and they offer a wide range of digital inclusion support, such as providing access to devices and data connectivity, and helping people to build their digital skills and confidence. Through workshops, network meetings, and conversations with organisations, 100% Digital Leeds and Leeds local care partnerships built a digital support infrastructure across local voluntary and community sector organisations. They also worked with GP practices, community healthcare, social prescribers and others to promote the offer and provide a simplified referral and signposting route.

Example: The Digital Exclusion Risk Index

The Digital Exclusion Risk Index (DERI) was designed by Salford City Council, and expanded upon by The Greater Manchester Authority to help visualise the risk or likelihood of digital exclusion for England, Wales and Scotland. The score is based on three component scores: demography, deprivation and broadband.

Recommendations:

- NHS organisations should adapt digital health interventions to the cultural, linguistic and cognitive needs of disadvantaged groups
- Staff should be trained to identify people with low digital literacy skills would be benefit from upskilling and digital exclusion risk score should be considered
- Co-locate digital hubs to better address data poverty

Key sources: HEEC Evidence Brief – What works to address health and digital literacy in disadvantaged groups, Digital literacy brief, Addressing the Digital Divide in Health Education , Stop the Divide: Facilitators and Barriers to Uptake of Digital Health Interventions Among Socially Disadvantaged Populations, Can digital mental health interventions bridge the 'digital divide' for socioeconomically and digitally marginalised youth?, Mitigating Risks of Digital Exclusion in Health Systems | Good Things Foundation

Evidence Section 4

Equitable structures

> *“Better protection for staff who raise complaints about discrimination would encourage accountability."*
>
> *Marianne*
> *HEEC Citizen Panel*

Allocating resources proportionate to need

Evidence: Socioeconomically disadvantaged areas receive less general practice funding, have fewer GPs per head of population and shorter consultations than richer areas. Previous research has shown changes to the NHS funding formula to increase funding to a reduction in inequalities in healthcare amenable mortality. Allocating resources proportionate to need does not just mean funding, but also other resources and staff time.

Definitions box: Need should be defined as the ability to benefit from health care across the life course. This helps decision makers focus on early intervention and prevention. If need is simply defined according to the number of health problems and current health care use, funding, time and resources will invariably be directed to areas with older populations which also tend to be in more affluent areas.

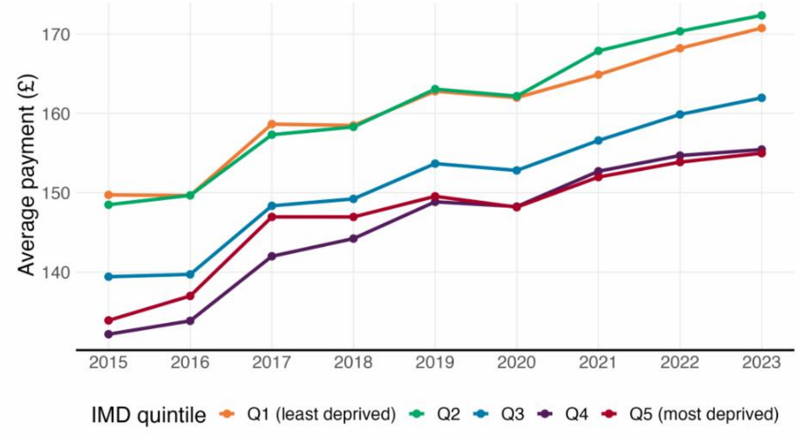


Figure: Funding to general practice across socioeconomic groups

Example 1: A primary care centre in North Carolina have implemented enhanced primary care for patients with severe mental illnes which involves six proactive appointments per year of 30 minutes with a multidisciplinary primary care team. Patients receiving this care had clinically significant reductions in blood sugar and blood pressure compared to usual primary care.

Example 2: Between 2001 and 2011, the NHS introduced a new funding formula to allocate more funding to more deprived areas. This resulted in an 81% increase in funding per capita for the most deprived areas compared to 70% in affluent areas. During this period, the gap in mortality amendable to healthcare in the richest and poorest areas narrowed from 72% in men to 67% and from 52% to 47% in women.

Recommendation:

- Funding, time and resources should be allocated proportionate to need across the NHS as business as usual
- The Carr-Hill formula should be reformed to allocate resources proportionate to need

Key sources: HEEC Evidence Brief Funding models to address health inequalities, Structural inequalities in primary care – the facts and figures

Funding mechanisms to address healthcare inequalities

Evidence: The NHS has multiple ways of distributing funding. Our review of funding mechanisms to address inequalities found that capitation was associated with more equitable outcomes than fee-for-service. Fee-for-service is useful to drive specific activity, such as vaccinations and screening. Financial incentives without equity considerations, such as the Quality Outcomes Framework, can compound funding inequalities by directing more money to areas of lower clinical need. Increased privatisation is associated with increased inequalities. Targeting funding to specific disadvantaged groups can improve health inequalities.

Definitions box: Capitation pays organisations a fixed amount per patient adjusted for patient factors. Fee-for-service pays organisations a fixed amount for each health care activity provided, such as appointments, investigations or procedures. Financial incentives pay organisations for meeting quality standards. General practice has a mixture of capitation, financial incentives and fee-for-service. Hospitals are paid using activity-based funding, not dissimilar to fee-for-service, where they are reimbursed a fixed amount for specific treatments or procedures.

Example 1: Researchers in Canada examined primary care access for people who recently moved to Canada, include refugees and asylum seekers. The researchers compared two funding models: fee-for-service (fixed amount for each appointment) and capitation (fixed amount per patient adjusted for patient factors). Access to primary care was higher for people who had recently moved to Canada in a capitation model rather than fee-for-service. This is likely because a fee-for-service model focuses on high volumes and is unlikely to take into account the complex needs of recent migrants, such as language barriers and past-trauma, which may require more time-intensive care.

Example 2: Mental Health Investment Standard was established in 2016/17 and mandates ICBs to increase spending on mental health at a rate that outpaces their overall budget growth. Between 2017/18 and 2023/24, spending on mental health increased from £12billion to £14.4billion and the mental health workforce increased by 22%.

Recommendations:

- The NHS should increase capitation-based funding adjusted for socioeconomic factors to support disadvantaged areas
- Investment standards should be considered to ensure increased funding to socioeconomically disadvantaged areas, underserved populations and conditions intrinsically associated with disadvantage
- Financial incentives, where used, should focus on conditions intrinsically associated with disadvantage, such as smoking, obesity, addiction or severe mental illness, or incentivise narrowing of inequalities
- Fee-for-service, where used, should include consideration of the additional resources health care organisations need to deliver care to underserved communities

Key sources: HEEC Evidence Brief Funding models to address health inequalities

Strengthening health system accountability and regulation

Evidence: Strong accountability mechanisms are key to reducing health inequalities, and while the UK leads in terms of having the most comprehensive system compared to other European countries, accountability has weakened in the last decade. The role of regulators in combating discrimination is enshrined and protected by law (as stipulated in the Equality Act 2010) and the NHS has a duty to "have regard to the need to reduce inequalities" (Health and Care Act 2022). There is no 'silver bullet' approach to improve accountability for health inequalities, however a 2022 review looking at five global strategies found it was more effective when regulators and policy-makers focused on how health systems manage to implement and evaluate broad, long-term health policies that target multiple social determinants of health. Both the Care Quality Commission (CQC) and the Institute of Health Equity provided reports on the current state of regulation and accountability both within and outside the NHS, drawing upon the current evidence base to provide several key recommendations, highlighted below. Common themes across both reports include: 1) working with partners, particularly local systems, 2) performance monitoring and assessing the impact of equity-based activity, 3) provision of funding for health inequalities that is long-term and ring-fenced, and 4) making staff at all levels within the workforce responsible and accountable for monitoring health inequalities.

Example: Brazilian Health Councils
In 1988, Brazil created Health Councils to promote community participation in the health system. Health councils are "permanent and deliberative bodies that formulate, deliberate and control the execution of health policy, including economic and financial aspects". The council consists of 50% users, 25% workers and 25% health service managers. While the Health Councils have faced difficulties in ensuring accountability, they provide a good example of social participation in health systems.

Recommendations:
- Enhance data to enable ICSs to better identify where inequalities are
- Develop targets and monitoring in partnership with local systems
- Monitor the extent to which services effectively capture and use a diverse range of service user, lived experience and/or family voice
- Continually assess the transparency of communications with providers, to ensure clear expectations relating to health inequalities are set with a view to building trust and confidence
- Make NHS inequalities dashboards visible and available to all stakeholders
- The NHS should work in partnership with the CQC to integrate actions on inequalities into their accountability mechanisms
- Continue to contribute to the evidence base around inequalities

Key sources: Rapid evidence review: Tackling inequalities through the regulation of services and organisations - Care Quality Commission, Health inequalities: Improving accountability in the NHS - IHE

Optimising the NHS as an anchor institution

Evidence: Health care systems and organisations can improve the overall wellbeing of their local communities by leveraging their resources and assets. Acting as anchor institutions, they can improve the economic, social, and environmental conditions in the areas they serve especially for disadvantaged groups. This way they can reduce inequalities in health outcomes and enable their local communities to reach their potential.

There are four main action areas through which health care organisations and systems can achieve an equitable impact as anchor institutions:

1. Working with local partners to achieve health equity.
2. Purchasing locally from a diverse supply chain.
3. Providing quality jobs and promoting workforce development and leadership.
4. Transforming organisational spaces into community assets.

Adopting a population health perspective, joining place-based networks and cultivating a culture of inclusion and respect among staff are all crucial for coordinating these action areas into a coherent and impactful anchor activity strategy.

Example Box: [Halton Health Hub: Outpatient services from a shopping centre]

Warrington and Halton Teaching Hospitals NHS Foundation Trusts have created an out-of-hospital clinical unit, Halton Health Hub, to provide outpatient services from a local shopping centre within a deprived community. Working with the Liverpool City Region Combined Authority and using Town Centre funding, the Trust contributed to the planning of the regeneration of the city centre. After undertaking public consultation, the Trust focused on the identification of opportunities to develop accessible health services along with boosting economic activity and employment rates. In the first six months since its opening the Trust served more than 3,000 appointments and is committed to continue bringing care closer to the community while supporting the sustainability of community assets and employment opportunities for the local populations.

1 Working with local partners to achieve health equity

2 Purchasing locally from a diverse supply chain

3 Providing quality jobs and promoting workforce development and leadership

4 Transforming organisational spaces into community assets

Optimising the NHS as an anchor institution (continued)

Example Box: The NHS Greater Glasgow and Clyde (NHSGGC) works with the Supplier Development programme to diversify its supply chain

The Supplier Development Programme in Glasgow delivers free tender training webinars, and provides guidance, tools and expert resources to businesses to enable them to work with the public sector and expand their economic activity. The NHSGGC worked with the Programme to diversify its supply chain and enable business owned or led by individuals by women, minority, disabled, and LGBTQ+ individuals to work with them. Almost 64% of the small and medium enterprises (SMEs) that attended the engagement and training events identified as being 50% or more owned or led by individuals with protected characteristics. Among the people who gave feedback on the project, 81% said they were more likely to bid for future public contracts as a direct result of participating in the programme.

Example Box: Manchester University NHS Foundation Trust (MFT) increases access to its career opportunities for local people

The Trust works closely with local schools, colleges and other local anchors to raise awareness about the career prospects within its organisations and increase the participation of local communities in its workforce. The initiatives employed to achieve these goals include:

- Tailored support to young people under 30 in terms of job searching, applications, insight days and short training.
- Accredited training for unemployed people with additional work-based training at the Trust, with shadowing and work experience.
- Supported internship programmes for people with learning disabilities.

Example Box: Bon Secours Hospital's Affordable Housing Program

Bon Secours has invested in 801 affordable housing units across 12 West Baltimore properties which are provided to low-income residents, including families, seniors, and people with disabilities. An analysis of the investment's social returns showed that the affordable housing program generates between $1.30 and $1.92 of social return in the community for every dollar in yearly operating costs.

Recommendations:

- Increase the organisation's participation in place-based partnerships and collaboratives and engage in mutually respectful, reciprocal relationships with communities
- Ask employees who live in the local area to identify trusted and proactive anchor activity partners
- Increase the organisation's knowledge about local markets and work with the voluntary and community sector to identify needs and economic opportunities
- Advertise the diversity of available roles in the organisation through job fairs, community events, ambassador schemes and collaboration with schools and higher education institutions
- Organise flexible, in-person recruitment events in community venues where recruiters can directly meet with candidates

Key sources: HEEC Evidence brief, How health care organisations can reduce inequalities in social determinants of health in their role as anchor institutions; The Health Foundation, Anchors in a storm- Lessons from anchor action during COVID-19; Taking one step further: five equity principles for hospitals to increase their value as anchor institutions (Allen et. Al, 2022)

Designing healthcare inclusive of people with low incomes

Evidence: About 250,000 people are supported each year through the NHS Low Income Scheme, but we do not know how many people are eligible who do not access support. There is much evidence describing the problems that people with low incomes face accessing healthcare. However, there is little research describing how to ensure people on low incomes are not inadvertently excluded from health care services. Improving flexibility of timing and style of health consultation (face-to-face vs telehealth), community outreach activities, and co-locating welfare advisors would be beneficial to people with low incomes, as it addresses constraints around time and resources. Food prescriptions may help people on low incomes who require costly diets.

Example: 'Poverty Proofing'

Children North East, a charity based in Newcastle-upon-Tyne, devised a programme called 'Poverty Proofing'. It helps organisations remove the financial barriers those living on low incomes face when accessing key organisations and services, and the programme to has also extended to schools and nurseries. They poverty proof health services by training staff to have an awareness about poverty and low incomes and improve the service through continuous consultation and feedback from families living in poverty.

Example: Food prescribing

The Alexandra Rose Charity, in consultation with GPs, launched a pilot in 2022 in Bromley by Bow and Lambeth to provide people with food insecurity with a food voucher for fruit and vegetables. Participants of the scheme are given up to £8 per week and an additional £2 per household member to spend in several fruit and veg shops, mostly in local markets to support the local economy. They found on average that users were eating 3.2 more portions of fruit and veg per day and there was a 40% reduction in GP visits over 8 months in a population of users that predominantly suffered from multiple long-term health conditions (91%) and being unemployed due to such conditions (85%).

Recommendations:

- Review the NHS Low Income Scheme to ensure that adequate support can be easily accessed
- Raise awareness amongst NHS staff of impact of poverty
- Co-locate welfare advisors, and ensure flexibility in consultation and appointment styles
- Review NHS services to understand the barriers people on low incomes face

Key sources: HEEC evidence brief – Designing healthcare inclusive of people with low incomes

Addressing inequalities across the workforce

Evidence: Uneven distribution of staff has led to unmet need in more deprived areas, rural communities, and people living with disabilities. More deprived areas have fewer GPs per head, rural areas have less nurses, and coastal communities have fewer healthcare staff compared to the national average. Full-time equivalent nurses in learning disability and community care dropped by 45% and 4% respectively last year, despite increases in other nursing specialties. This represents a double burden of inequity as people with learning disabilities also are likely to suffer socioeconomic disadvantage. Furthermore, NHS staff from minority ethnic groups face more workplace disadvantage in the form of bullying, poor job satisfaction and difficulty in career progression, which also means representation in health and care leadership is not proportional to the general population. A study found that minority doctors had lower 1-year retention rates in acute care in England compared to white doctors. 32 to 35% of LGBTQ+ NHS staff also reported experiencing bullying and harassment at work, with one in five reported physical violence at work too. There is mixed evidence around financially incentivising healthcare workers to work rurally, and better evidence to highlight that hiring locally and upskilling communities to become their health workforce is more sustainable and equitable.

Example: Australian National Aboriginal and Torres Strait Islander Workforce Plan
The National Workforce Plan is an Australian initiative and framework developed in partnership with indigenous communities to achieve proportional representation within the healthcare workforce. Strategic directions include ensuring there are enough Aboriginal and Torres Strait Islander students studying and completing health qualifications to meet the future health care needs of Aboriginal and Torres Strait Islander peoples and ensuring successful transitions into the workforce and access clear career pathway options.

Recommendations:
- The NHS should implement mutual aid schemes to share staff across organisations
- Medical school should continue to provide opportunities for people from socioeconomically disadvantaged backgrounds to study medicine
- The NHS should support trusts and general practices in socioeconomically disadvantaged areas to ensure they are attractive places to work with flexible working patterns with favourable terms and conditions

Key sources: HEEC evidence briefs: Empowering health care staff to address health inequalities, Community engagement and empowerment to address health inequalities; Reshaping the workforce to deliver the care patients need, Trends and determinants of clinical staff retention in the English NHS

Key references and resources

Health Equity Evidence Centre Evidence Briefs

Evidence briefs publicly available here

- What works: Improving case finding of long-term health problems in disadvantaged communities
- What works: Finding ways to better support people who frequently attend emergency departments
- What works: Achieving equitable lipid management
- What works: Addressing inequalities in the primary and secondary outpatient interface
- What works: Health checks for patients with severe mental illness
- What works: Mitigating inequalities in telephone and digital triage for primary health care
- What works: Fostering equitable access to primary health care for asylum seekers, migrants and refugees
- What works: Addressing inequalities in the uptake of cervical screening
- What works: Mitigating inequalities in patient self-referral to specialist services
- What works: Improving access, uptake and optimisation of behavioural interventions in the health care setting to better meet the needs of disadvantaged groups
- What works: Designing health care inclusively for people with low incomes
- What works: Improving health and digital literacy in disadvantaged groups
- What works: Funding models to address health inequalities
- What works: Payment mechanisms to improve prevention spending in health care settings
- What works: Community engagement and empowerment to address health inequalities
- What works: How health care organisations can reduce inequalities in social determinants of health in their role as anchor institutions
- What works: Empowering health care staff to address health inequalities
- What works: Leveraging Quality Improvement to address health and care inequalities
- What works: Integrating health at a neighbourhood level to address health care inequalities
- What works: Co-location of general practice services to support disadvantaged groups

Key references and resources

Health Equity
Evidence Centre

Patient-led, Inclusive Culture:

- EQUALISE: Guiding principles for equitable primary care - Health Equity Evidence Centre
- EQUIP Health Care | Research to Improve Health Equity
- Creating Trauma-Informed and Responsive Change - Executive Summary
- LGBT Foundation - Experience of Maternity Services
- A practical guide for services designed for people experiencing multiple disadvantage.pdf

Enabling Partnerships:

- Consequences of how third sector organisations are commissioned in the NHS and local authorities in England: a mixed-methods study
- Neighbourhoods working to improve health inequalities - NHS North East London
- Mitigating Risks of Digital Exclusion in Health Systems | Good Things Foundation
- Commissioning Framework from Sussex VCSE

Equity-Focused Systems:

- Data-driven systems and inequalities in health and social care (Ada Lovelace Institute)
- Improving the recording of ethnicity in health datasets - Race Equality Foundation, Wellcome Trust
- A Scoping Review of Approaches to Improving Quality of Data Relating to Health Inequalities
- How to undertake equity-focused quality improvement - Health Equity Evidence Centre
- Patients in Context — EHR Capture of Social and Behavioural Determinants of Health | New England Journal of Medicine
- Social needs screening in primary care: A tool in the fight for health equity?
- NIHR Guidance on co-producing a research project

Equitable Structures:

- A Canadian study comparing funding mechanisms to address health inequalities
- Taking one step further: five equity principles for hospitals to increase their value as anchor institutions - PMC
- Reshaping the workforce to deliver the care patients need - The Nuffield Trust
- Poverty proofing | North East and North Cumbria NHS
- Health inequalities: Improving accountability in the NHS - IHE

Further information

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Health Equity
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