Editor's Briefing

DEAD UNEQUAL

The theme of this month's *BJGP* is Inequalities. Health inequalities can take many forms, including the impact of poverty *per se* on the quality of life, life expectancy, and life chances of poor people, the health impacts of belonging to vulnerable or marginalised groups, such as the old and the mentally ill, and inequalities in care resulting from variation among practices and hospitals. As well as the corrosive effect of absolute poverty, the economic differences between the rich and the poor — the poverty gap — also contributes to differential morbidity and mortality. Figures for the impact of poverty and deprivation on mortality are stark, and are a national disgrace. Sir Michael Marmot's review in 2010[1] found that there was a difference of 7 years in life expectancy between the poorest and richest members of society, and a difference of 17 years in 'disability free life'. In Graham Watt's Deep End work in Scotland,[2] the life expectancies of men and women in the lowest socioeconomic groups were, almost unbelievably, 57 and 61 years compared with 76 and 78 years for the richest. A new Deep End initiative in Yorkshire and Humberside is described in the Journal this month.

The uneven distribution of income was of particular interest to Richard Wilkinson, the social epidemiologist, who argued in *The Spirit Level*,[3] written jointly with Kate Pickett, that countries with more equal distribution of wealth not only enjoyed better health and health outcomes, but also displayed greater social cohesion. In the light of events in Europe and North America during 2016, widening socioeconomic inequalities and the gulf between elites and the dispossessed must give us pause for very serious thought.

In 2015 the RCGP publication *Health Inequalities*[4] reviewed the extent of inequity and inequality across the health system and explored ways in which general practice can mitigate some of the worst effects of poverty on health, recognising that a properly resourced primary care workforce is a prerequisite for doing this. The commitment to better funding for general practice in the *General Practice Forward View*[5] must still be a cause for optimism, although there are concerns that Sustainability and Transformation Plans may, in some parts of the country, dilute or divert some of this new money. However, when the funding does find its way into primary care, it needs to be properly spent, and two articles

this month comment on general practice funding.

Louis Levene and colleagues conclude, from their study of population health needs and variations in NHS practice payments, that while these recognise differences in workload, they do not take into account more important variables such as deprivation and multimorbidity. In an important editorial, Mark Ashworth and Martin Gulliford look ahead to a life beyond QOF, and argue strongly for a quality framework which fully takes account of the additional demands placed on practices caring for disadvantaged and vulnerable patients with multiple chronic conditions. Any new system, they say should be *'... explicitly patient centred and aim to narrow health inequalities neglected by QOF'*. Let's hope it does.

Roger Jones,
Editor

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