Primary care funding entrenches health inequalities:

time for a rethink

Fifty years since the term was first used to describe the mismatch between healthcare provision and healthcare need,¹ the inverse care law is alive and well. Coined by Julian Tudor Hart, a GP in a coal-mining community in south Wales, the term was a clever pun on the inverse square law. And it has stuck ever since.

Although primary care in 2021 has changed beyond recognition since 1971, one factor remains largely unchanged and it is a factor that perpetuates disparity. The funding of primary care is still largely based on capitation payments together with the more recent addition of target-based pay-for-performance rewards.

ADDRESSING AND NOT ADDRESSING HEALTH INEQUALITIES IN PRIMARY CARE

Equality of practice funding in areas of high and low social deprivation, so-called 'flat funding', simply widens healthcare inequality in the presence of unequal healthcare needs.² Marmot has advocated the principle of 'proportionate universalism', whereby universal healthcare provision is supplemented by targeted approaches related to the level of social need.³ But surely current primary care funding already invests in deprived communities?

CAPITATION FUNDING AND DEPRIVATION

Capitation funding, accounting for the majority of funding, is not linked with social deprivation, although it is linked to measures of community ill health.⁴ The Carr-Hill formula, more properly termed the global sum allocation formula, now applies to capitation calculations for both General Medical Services (GMS) and Personal Medical Services (PMS) practices, and offers an uplift based on 'additional needs of patients'.⁵ Dig a little deeper and it becomes clear that the 'additional needs' calculation is based on locality prevalence of limiting long-term illness. It takes no account of factors such as the social dimension of health nor the

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increased consultation rate seen in deprived areas.⁵ The Health Foundation estimates that unweighted capitation funding, 'flat-funding', topped up with marginal Carr-Hill weighted capitation, results in 7% less funding for practices serving more deprived populations per 'need adjusted' patient than those serving less deprived populations.⁶ Not so much flat-funding then, more like funding re-directed to more prosperous areas and perpetuating the inverse care law.

THE QUALITY AND OUTCOMES FRAMEWORK (QOF) AND DEPRIVATION

The QOF, currently accounting for less than 10% of primary care funding, is also effectively flat funded.⁴ Somehow, general practices in deprived areas have maintained their QOF income although no doubt with resultant large increases in workload compared with less deprived practices, contributing to the one-third higher consultation rates in the most deprived decile.⁷

ADDITIONAL SERVICES AND DEPRIVATION

Additional services are locally and nationally agreed 'enhanced' services, focussed on population health needs and voluntary in nature.

In other words, they directly target potential health inequalities. However, provision is likely to depend more on perceptions of practice capacity than on a sense of registered patient need. They account for 9% of funding.² Unsurprisingly, delivery of additional services is inversely related to deprivation.^{2,4} No wonder primary care is at an inherent disadvantage when

it comes to addressing health inequalities.

In the 2020 GP contract, a new additional service has appeared to ensure locally agreed action to tackle health inequalities.⁸ This sounds promising. However, it has been structured as a component of primary care networks (PCNs), is flat-funded, and unlikely to radically redirect funding into deprived communities. Instead, its focus and funding is on deprivation within each PCN, failing to divert funding to regions characterised by endemic deprivation.

MINIMUM PRACTICE INCOME GUARANTEE (MPIG)

It is ironic that just as MPIG has been phased out, this supplement to capitation budgets, designed to protect practices from historic income loss arising from the Carr-Hill formula, has historically redirected funding into deprived areas.⁹ Only awarded to a fifth of practices,¹⁰ it tended to reward practices with larger multidisciplinary teams that are likely to have delivered more consultation time for patients, particularly those in deprived areas.

MOVING TOWARD PROPORTIONATE UNIVERSALISM IN PRIMARY CARE

Our solution is for a complete re-think to the funding of primary care in high-deprivation settings based on proportionate universalism. While this may be controversial, the evidence is stark. Instead of regressive funding, we need to unpick each component of funding and weight it for high deprivation. Capitation funding needs to move away from incentivising large patient lists and offer capitation supplements, like the MPIG scheme, but focussed entirely on social deprivation.

Of all the payments to primary care, the recently withdrawn MPIG may well have been the only example of proportionate universalism in the funding of primary care. Other funding is tipped in the opposite direction. This needs to change if we are to achieve proportionate universalism.

Similarly, QOF payments should be weighted for deprivation, acknowledging

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the workload of achieving challenging clinical targets and disincentivising the current high ‘exception reporting’ rates in deprived populations. PCN funding should be allocated according to social deprivation, not flat funded.

The ‘Deep End Group’, a network of GP surgeries covering the most deprived patient populations in Scotland and more recently expanded to areas of England, Ireland, and Australia, have produced a series of recommendations for how primary care can address health needs in the most deprived communities.¹¹ Deeply practical, their recommendations are eminently suitable for funding. They emphasise a solution based on traditional primary care values such as more time with patients, greater continuity of care, protected time to support GPs, and leadership.

Addressing health inequalities requires a workforce and a workforce requires funding. We have demonstrated the importance of practice staffing as an essential requirement for the delivery of high-quality patient care, even in deprived areas.⁹

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funding allocated to the very staff, clinical and non-clinical, who could deliver Deep End care to Deep End communities.

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