Oxford

helen.salisbury@phc.ox.ac.uk Follow

Helen on Twitter: @HelenRSalisbury

Cite this as: *BMJ* 2021;375:n2795<http://dx.doi.org/10.1136/bmj.n2795>

Published: 16 November 2021

PRIMARY COLOUR

Helen Salisbury: To level up, we need to top up GPs

Helen Salisbury *GP*

Poverty is a deadly condition. We don't need to look to faraway countries ravaged by war, climate disaster, and famine to know this—it stares us in the face here at home. A rich man in England can expect to live nearly a decade longer than a poor man and to spend 19 more years in good health. In women the gap in life expectancy is slightly less, but disadvantaged women spend even more of their lives in poor health.¹

Many factors contribute to health and longevity, but access to medical care is one. Doctors cannot prevent or cure all illness, but we can and do make a difference. In theory, everyone in the UK has an equal right to access a GP; in practice, there are too few GPs to meet demand, and they're distributed in a way that favours the rich. This neatly illustrates the persistence of Julian Tudor Hart's inverse care law, which states that people most in need of medical care are the least likely to receive it.^{2 3}

If we—the profession, the government, and NHS England—are intent on levelling up and improving health in the poorest people to match the most affluent, we need to put more GPs into the communities most in need. Last week a think tank suggested that a new body should regulate where GPs are employed,⁴ to prevent them joining already over-doctored areas. While this is interesting, it misses the point. Very few areas have an oversupply of doctors, and we should instead ask why so few GPs are working in areas of deprivation—and what can we do to incentivise more of them.

The answer, in part at least, is money. The formula for calculating practice payments puts a heavy weighting on age, as the need for care generally increases as people get older. However, my affluent area has many sprightly 85 year olds, who attract more money but need less care than patients in their 60s with multiple health problems on the other side of the city, where many don't make it to 80. We're all working hard, but GPs at the deep end are working harder. We should recognise this and remunerate practices on the assumption that they'll always need more doctors for a given list size in deprived areas.

There are too few GPs, but we need to inspire those currently in training to take on the challenge of working in communities with high needs—and the job needs to be not just possible but attractive. We must also ensure that the allied health professionals who have recently joined our teams are equitably distributed, which means investment in premises to make room for them.

Levelling up requires additional resources, and the solution is not to take medical services away from the better served to give to the least well served.

Instead, commissioners need to channel extra investment to the communities that need it most.

Competing interests: See www.bmj.com/about-bmj/freelance-contributors.

Provenance and peer review: Commissioned; not externally peer reviewed.

- Office for National Statistics. Health state life expectancies by national deprivation deciles, England: 2017 to 2019. 22 Mar 2021. <https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthinequalities/bulletins/healthstatelifeexpectanciesbyindexofmultipledeprivationimd/2017to2019>
- Fisher R, Dunn P, Asaria M, Thorlby R. Level or not? Comparing general practice in areas of high and low socioeconomic deprivation in England. Health Foundation. Sep 2020. <http://www.health.org.uk/publications/reports/level-or-not>
- Tudor Hart J. The inverse care law. *Lancet* 1971;1:405-12. doi: 10.1016/S0140-6736(71)92410-X, pmid: 4100731
- Social Market Foundation. GPs must be pushed to work in poorest areas and "level up" health—think-tank. 8 Nov 2021. <https://www.smf.co.uk/gps-must-be-pushed-to-work-in-poorest-areas-and-level-up-health-think-tank/>