Royal College of Physicians

Supporting clinicians to address health inequalities in practice

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in health inequalities

This report was sponsored by Novartis Pharmaceuticals UK Limited by the provision of funding. Novartis Pharmaceuticals UK Limited have had no input into the report.

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Introduction

1 Health inequalities are defined as avoidable, unfair and systematic differences in health between different groups of people. A range of factors play into people's experience of health inequalities, including socio-economic issues, geographical area, belonging to a marginalised or minoritised group and belonging to a protected characteristic group.

2 Over recent years, health inequalities have been more widely discussed, both in the workplace and in mainstream media. Alongside increased awareness, there have been attempts across the country to reduce the impact of health inequalities in practice both locally and nationally.

3 This report follows the Royal College of Physicians' (RCP's) 2019 member survey about engagement with work to protect and promote population health. We found that foundation doctors, core medical trainees, higher specialist trainees and physician associates wanted to be more involved in population health work.

4 Respondents to the survey said that, as well as more time and leadership from others, they needed some additional education and training in population health. After further discussion with our members we found that while students and trainees are taught about the social determinants of health, they want to better understand health inequalities and how they can address it.

5 Following that research, in October 2020, the RCP convened the Inequalities in Health Alliance (IHA). This coalition of organisations primarily campaigns for a cross-government strategy to reduce healthcare inequalities on a national scale. The IHA includes many medical specialty societies, several NHS trusts and charities with an interest in health or inequalities.

6 There is little research into what clinicians are taught, on an individual and local level, about health inequalities – both in general and in relation to issues experienced by particular marginalised groups.

7 The clinical fellow in health inequalities role was created by the RCP and sponsored by Novartis. The aim of the role was to research, on an individual and local level, what education clinicians are receiving on health inequalities, and to create further educational resources to fill knowledge gaps as required.

8 This piece of work aimed to capture a snapshot of current practice in the UK and to engage clinicians in dialogue about what education they feel is needed to help reduce health inequalities in practice.

Method

9 In January 2022, the RCP conducted a survey of its members to gather information about what education is provided around health inequalities and how they can be addressed in practice. 957 people responded to this survey.

10 The aim of this survey was to understand more about the teaching and training around health inequalities that is already happening. This understanding will help us to create resources that will help clinicians reduce the impact of health inequalities in their practice.

11 Following the results of the survey, we conducted focus groups and individual interviews to further explore how health inequalities are seen and dealt with within the hospital setting and what can be done to help clinicians reduce the impact of health inequalities in their day-to-day work.

Survey findings

Respondents

Role	Respondents	%
Consultant	577	60.3%
Registrar (IMT3, ST3–8)	147	15.4%
Physician associate	95	9.9%
Other*	43	4.5%
SAS doctor	36	3.8%
Medical trainee (CT1/2, IMT1/2)	31	3.2%
Physician associate student	27	2.8%
Foundation doctor	1	0.1%
Total	**957**	

*Other: retired (9), GP (7), trust grade doctor (5), academic consultant (2), post-CCT clinical fellow (2), psychiatrist (1), chief executive (1), locum (1), locum consultant (1), medical director (1), clinical director (1), wellbeing director (1), occupational physician (1), associate specialist (1), clinical research physician (1), clinical teaching fellow (1), digital platform and health products adviser (1).

Teaching or training in health inequalities within training programmes

12 67% of respondents had not received teaching or training in health inequalities within a training programme or as part of their degree. 33% had received training in health inequalities as part of their degree. Of those, most (89%) had received teaching on the social determinants of health, with less than half receiving any other type of teaching on health inequalities.

13 58.5% of respondents had never received teaching or training on health inequalities within marginalised or protected groups during a training programme or as part of their degree. 41.5% of respondents had received such training, with the most common themes being low socio-economic position (20.5%), ethnic minorities (17.8%), people with a learning disability (17.3%), older people (16.3%) and homeless people (14.7%).

Response*	Respondents	%
None	477	58.5%
Low socio-economic position	167	20.5%
Ethnic minorities	145	17.8%
People with a learning disability	141	17.3%
Older people	133	16.3%
Homeless people	120	14.7%
Disabled people	105	12.9%
LGBTQ+ people	101	12.4%
Refugees and/or asylum seekers	84	10.3%
Women	82	10.1%
Sex workers	66	8.1%
Gypsy and Traveller community	41	5.0%
Other	11	1.3%
Total	**815**	

*Respondents were able to select more than one response.

Teaching or training on health inequalities outside training

14 Outside their degree course or training programmes, 55 % of respondents (459) had received teaching or training in health inequalities – mostly at conferences or online courses.

15 50.7 % had received specific training around health inequalities in marginalised and/or protected groups. The most common areas of teaching had been ethnic minorities (24.2 %), low socio-economic position (20.4 %), people with a learning disability (20.4 %), homeless people (18.7 %) and LGBTQ+ people (17.8 %).

Response*	Respondents	%
None	402	49.3 %
Ethnic minorities	197	24.2 %
Low socio-economic position	166	20.4 %
People with a learning disability	166	20.4 %
Homeless people	152	18.7 %
LGBTQ+ people	145	17.8 %
Refugees and/or asylum seekers	139	17.1 %
Disabled people	128	15.7 %
Older people	127	15.6 %
Women	104	12.8 %
Sex workers	69	8.5 %
Gypsy and Traveller community	59	7.2 %
Other	29	3.6 %
Total	**815**	

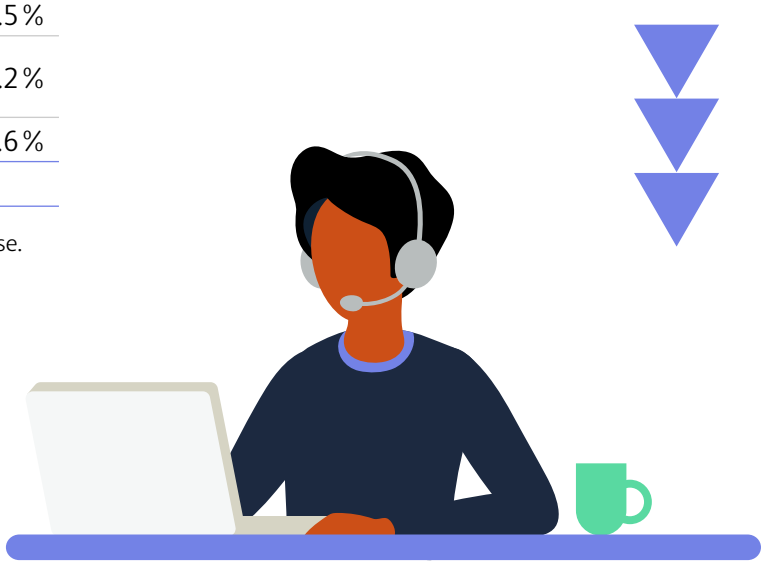
*Respondents were able to select more than one response.

Confidence in management of health inequalities in practice

16 Only 26 % of respondents felt confident in their ability to reduce the impact of health inequalities in their medical practice. 31 % of respondents felt confident in their ability to talk to patients about the impact of inequalities on their health.

17 Emergent themes when respondents were asked about areas that they felt unable to address in their practice included:

- integrating practices to minimise the impact of health inequalities
- lack of education or awareness of solutions available
- lack of time to spend with patients exploring issues
- translation and appropriate healthcare materials
- bias within medicine
- the large and multi-organisational scale of the issue
- awareness of specific issues that marginalised groups face
- understanding local issues and services.



What can the RCP do?

18 760 respondents suggested what the RCP could do to enhance practice in addressing health inequalities. The three most chosen options were e-learning (55%), workshops (28.6%) and face-to-face education (25.7%).

Response*	Respondents	%
E-learning	418	55.0%
Workshops	217	28.6%
Face-to-face education	195	25.7%
Seminars	175	23.0%
Podcast episodes	158	20.8%
Written guides	156	20.5%
Video guides	106	13.9%
Facilitating discussion with peers	71	9.3%
Other	45	5.9%
Roundtable discussions	43	5.7%
Facilitating action learning sets	36	4.7%
Blog articles	30	3.9%
Total	**760**	

*Respondents were able to select more than one response.

19 Other responses included:

- lobbying the government and pushing for legislative change
- addressing prejudice
- support in investigating health inequalities
- undergraduate education
- brief learning materials ('one side of A4')
- using RCP influence to improve care pathways
- work with other colleges to provide joint education materials
- updates on status and effect of health inequalities in different specialties
- guides on how to work with trusts/ organisations on tackling inequalities at a community level.

20 760 respondents stated what they wanted the focus of education to be in order to enhance their practice. The top three responses were practical ideas to reduce healthcare inequalities in the workplace (69.4%), general information on health inequalities (62.6%) and health inequalities within marginalised groups (55%).

Response	Respondents*	%
Practical ideas to reduce healthcare inequalities in the workplace	528	69.4%
Health inequalities in general	476	62.6%
Health inequalities within marginalised groups	418	55.0%
The social determinants of health	410	53.9%
Conditions more often affecting the most deprived people	327	43.0%
Behaviours more likely to be exhibited by those most deprived	320	42.1%
Other	45	5.9%
Total	**760**	

*Respondents were able to select more than one response.

21 Other responses included:

- advocacy
- how to influence regional and national politics
- a collection of resources on the RCP website
- practical support for setting up outreach programmes.

Discussion

22 The main outcome that respondents desired was 'practical ideas to reduce healthcare inequalities in the workplace'. The themes that emerged when respondents were asked about areas which they felt unable to address in their practice provide direction for the next steps. We have considered them in the context of the RCP's strategic priorities and suggested actions.

Theme	Strategic priority/priorities	Suggested actions
Lack of education and awareness of solutions available	Educating	Consider creating educational materials on what solutions are available locally, regionally and nationally, as well as materials considering individual ways in which we can all help to reduce health inequalities in practice
Combating bias within medicine	Educating, improving, influencing	Raising awareness of unconscious bias training within and outside the RCP, leaders role modelling good practice, raising awareness of the issue
Lack of time to spend with patients exploring issues	Influencing	Using the RCP's standing to lobby and influence delivery of healthcare in an appropriate way
Awareness of specific issues that marginalised groups face	Educating	Creating educational tools and including experts in specific communities, as well as the communities themselves
Translation and appropriate healthcare materials	Improving, influencing	Using the RCP's influence to lobby on better provisions and to support causes that will aid this aim
Understanding local issues and services	Educating, improving, influencing	Creating educational materials, raising awareness of current projects and enabling networking
Integrating practices to minimise the impact of health inequalities	Improving	This is likely to be something that we revisit later in the project after collating current resources/ projects and expanding educational resources
Combating health inequalities on a larger scale	Improving, influencing	Continuing ongoing work with the IHA, working with NHS England and NHS Improvement, and lobbying the government

Focus group findings

23 We held two focus groups and two individual interviews to further explore education into health inequalities, experiences in the workplace and what education is needed. Participants were self-selected, registering their interest to provide further information after completing the survey. The participants were two physician associates, one internal medicine trainee, two registrars and one consultant.

Education on health inequalities

24 All participants had received education on socio-economic factors in health, but little in the way of other heath inequalities education, while at university.

25 One group and one interviewee discussed how health and illness were taught at both undergraduate degree and postgraduate level. They felt that the focus was on organic causes and pathophysiology of illness, with limited discussion of health in general and how it is impacted both by the environment that the patient lives in and by factors specific to the patient themselves, including belonging to a marginalised group. They discussed how solutions presented in education often focused on medications that may help in the pathophysiology of illness, but will not change the holistic health of the patient.

26 One group and one interviewee discussed the differences that they had experienced between working in primary and secondary care. They felt that primary care services were more geared towards dealing with the health and wellbeing of patients as a whole, rather than a specific illness.

27 One participant highlighted particularly helpful teaching on racism within medicine and health inequalities in people who experience racism. Two participants had received teaching from their local homelessness teams; they found this helpful in terms of knowing the local support available to homeless people and how to access services to help them. None of the participants had experience of formal education on health inequalities in other marginalised or minoritised communities.

28 Education about social prescribing via community-based teams had been particularly useful for two participants, who described it as helpful for viewing the patient and management of conditions in a more holistic and person-centred way.

29 One participant discussed teaching in trauma-informed care that they had received. It helped them to realise how trauma can drive addiction, increases homelessness, increases experience of health inequalities and can drive other pathology.

Experiences of health inequalities in practice

30 All focus group participants recognised instances where health inequalities had played a part in their patient's journey into and through hospital. It was clear from all focus groups that health inequalities for marginalised groups affect every aspect of healthcare from birth to death, and not just in illness but in health too. All discussed the difficulties of trying to provide services for patients to reduce health disparities without time or local funding.

31 One group discussed differences in end-of-life care in different patients seen in hospital. They compared the organisation and delivery of end-of-life care for a patient with a supportive family - who also worked within the medical field – and for a patient with a learning disability who had no close relatives or loved ones. They recognised how advocacy by people who know the system is important and affects the delivery of care.

32 One group discussed differences experienced in more and less wealthy areas of the same region. Their experience of seeing patients trying to navigate the same system in two very different environments was stressful. They discussed having a dedicated team for health inclusion at one hospital, which was incredibly helpful for many patients experiencing barriers to accessing healthcare and ongoing care. At another hospital there was no similar team, and they felt that it would have been very useful. They discussed not knowing how best to support these patients, as there was little involvement of third-sector and dedicated teams. This meant that they did not know what was available to support patients who were seeking asylum, homeless or had little external support.

33 This group also discussed other factors that have an impact on health, such as money, air pollution and education. We focused on air pollution and how it has a greater impact on people living in the most deprived areas, exacerbating pre-existing health problems. They discussed how difficult it was both to discuss with patients and to create an adequate treatment plan, knowing that there was little they could do to change the underlying factors in their patient's ill health. They discussed how feeling unable to deal with this complexity reduced practising medicine to the 'bare minimum' of what they felt could be done on the day.

34 One interviewee discussed the difficulties that they had seen in outpatient clinics. They discussed the challenges that patients face in attending appointments – the cost of travelling, finding the time among work and caring responsibilities, and the lack of freedom to choose a time and type of appointment. They discussed the 'digital divide' – not all patients have the equipment and internet connection needed for virtual appointments. They also discussed the difficulties of meeting communication needs, whether due to the patient being disabled, not having English as their first language or not having access to written post.

35 Participants in both groups and both interview sessions discussed their current organisation's 'did not attend' (DNA) policy for outpatients. They felt that patients who experience health inequalities were disproportionately negatively affected by the policies. Most workplaces that the participants had worked in had a 'one DNA then discharge' policy. They discussed how this is likely to further disadvantage patients who already have barriers to accessing healthcare, and that they felt powerless to do more to help.

36 All participants discussed lack of time as a barrier to addressing health inequalities. The pressure of demand for care – manifesting as waiting lists and overbooked clinics – meant that participants felt they had little time to focus on the underlying causes of their patients' ill health. They often lacked knowledge of where to refer patients for further support with things such as the cost of living, social prescribing or isolation.

37 One group discussed the barriers to communicating with patients after a clinic appointment. They included letters that did not reach the patient, and how to effectively send further advice that could help the patient become more empowered and involved in their own care.

What would be helpful in future education around health inequalities?

38 All participants were keen to access further education on health inequalities, specifically how they could help to reduce them in practice. They felt that better understanding of the needs and experiences of marginalised groups would help them in a healthcare setting. They were also interested in education on wider aspects of health and wellbeing, including the impact of sustainability and climate change on health.

39 All participants wanted teaching that focused on what could be done at the point of seeing the patient, and ideas for change individually and locally. For example, both groups said that teaching on social prescribing and how to access it would be helpful.

40 While two participants felt that talks or workshops at conferences were a good way to transmit information, they also felt that it was less accessible for many people, due to time and financial constraints.

41 One participant suggested social media videos and this was widely supported by others. All participants responded positively to the idea of video and audio education.

42 All participants preferred the idea of easily searchable 'bitesize' information over larger packages, as they could be accessed at a time and place convenient for them. They also wanted the option to study further if desired, through signposting to resources and information. Most of the participants were aware of the RCP Medicine podcast and had listened to more than one episode.

Next steps

43 We will use our insights from this work to develop bitesize audiovisual educational resources on various aspects of health inequalities. They will provide tips to help clinicians make changes to and enhance their practice to benefit patients and signpost to further learning.

44 The resources will feature experts in and communities affected by various elements of health inequalities. We will disseminate them primarily via social media, but using all RCP communication channels.

45 The resources will address the themes that we have identified through this work:

- **a** bias within medicine
- **b** addressing health inequalities with limited time
- **c** addressing specific issues that marginalised groups face
- **d** making information accessible
- **e** understanding local issues and services
- **f** how to integrate services and practices to reduce health inequalities.

Acknowledgements

Thanks to the RCP advisory group on reducing health inequality for its support and guidance.

Contact us

If you would like to discuss anything in this report, please contact us via **policy@rcp.ac.uk**

www.rcp.ac.uk