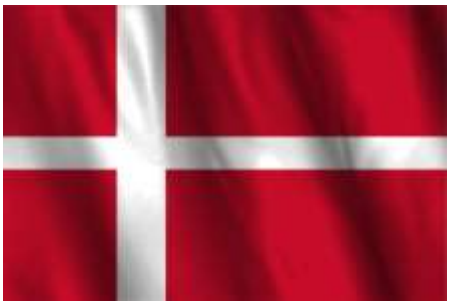
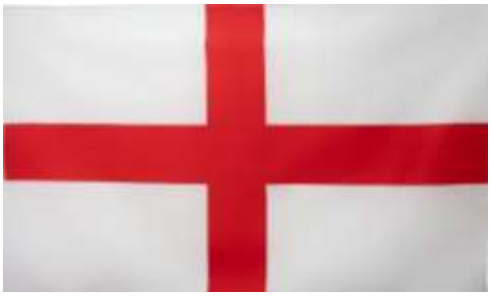
Addressing the Inverse Care Law in Scotland

Learning from Scotland, Denmark and England





Report on a meeting held on the 1st September 2025 at the Dovecot Studios in Edinburgh

David Blane, University of Glasgow

Carey Lunan, University of Edinburgh

Stewart Mercer, University of Edinburgh

Executive summary

A meeting was held on the 1st September 2025 at the Dovecot Studios in Edinburgh to discuss the inverse care law in Scottish General Practice. Research funded by The Health Foundation was presented, and speakers from Denmark and England presented recent developments in their countries. This was then followed by break-out groups to discuss key learning and next steps.

Summary of speakers talks:

- Mogens Vestergaard presented recent developments from Denmark, where planned reforms to general practice funding aim to directly tackle the inverse care law. He described how GP shortages are concentrated in low-income areas with higher levels of illness and ageing populations, a challenge expected to worsen by 2050. The **Deep End Denmark Initiative**, inspired by Scotland's model, has provided professional support, training, and advocacy for GPs in deprived areas, helping secure national attention, including from the Prime Minister, who has called for action on unequal doctor distribution. In response, Denmark's new **national health plan** proposes aligning GP list sizes with patient complexity, redistributing resources based on population needs, expanding medical training capacity, and incentivising GPs to work in underserved areas.

- John Ford outlined how the inverse care law continues to shape English general practice, with practices in deprived areas receiving less funding per patient, struggling to recruit and retain staff, and achieving poorer outcomes—creating a self-reinforcing cycle of disadvantage. Current reforms include a political commitment to renegotiate the GP contract and review the **Carr Hill formula**, with proposals to add greater deprivation weighting and integrate all funding streams into a more equitable, needs-based model. Additional measures under consideration include **Quality and Outcomes Framework (QoF) reform**, new equity-focused indicators, and enhanced services targeting under-served areas. Workforce initiatives, such as the **Targeted Enhanced Recruitment Scheme** and redistribution of medical training places, aim to strengthen provision where need is greatest.

- David Blane presented findings from Health Foundation–funded research combining a systematic scoping review, stakeholder interviews, and new data analysis, showing that despite longstanding policy ambition, the **inverse care law persists** in Scotland, with fewer GPs and less funding in deprived areas. While the **2018 GP contract** expanded the multidisciplinary workforce, it failed to address underlying inequalities. The **Scottish Deep End Project** continues to play a key advocacy role, giving voice to GPs serving the most disadvantaged communities. The report's recommendations called for substantial, transparent **investment in general practice**, fairer **distribution of funding and workforce based on need**, and a **long-term workforce plan** promoting generalist, equity-focused training and trauma-informed care. It also urged sustained funding for **effective community interventions**, such as Link Workers and Welfare Advice Partnerships, alongside routine **monitoring and evaluation of inequality impacts**, stronger **GP cluster support**, and enhanced **primary care research capacity** to ensure future policy is grounded in robust evidence and meaningful action on health equity.

Summary of key themes from discussants:

1. Fair and transparent funding aligned with need

Scotland's current resource allocation model for core general practice funding does not adequately reflect the scale or complexity of need in deprived communities, as it relies too heavily on age rather than factors such as multimorbidity, deprivation, and early onset of illness. A more equitable, needs-based or life-expectancy–adjusted approach – similar to Denmark's model, which aligns funding with health burden and lifetime healthcare use – is required.

2. Building data, evidence and accountability

There is an urgent need to improve the quality, integration, and use of data to understand and address health inequalities in Scotland. Inconsistent primary care coding, fragmented social care data, and limited data sharing across sectors hinder equitable resource allocation and informed policy-making. Better data would support clearer mechanisms for financial transparency and accountability to ensure that additional investment in deprived areas delivers measurable improvements in care and outcomes.

3. Workforce distribution, development, and wellbeing

The inequitable distribution of workforce and training opportunities remains a major driver of the inverse care law in Scotland. Deprived areas have fewer GP training practices and less access to mentorship, highlighting the need for expanded training placements and a long-term national workforce strategy that aligns recruitment, retention, and skills with the principle of proportionate universalism. Sustained workforce investment is also essential to address unsustainable workloads, rising complexity, and staff vulnerability. Supporting the wellbeing and stability of the wider multidisciplinary team – including community link workers, district nurses, and health visitors – through secure, long-term funding is critical to maintaining equitable and resilient primary care.

4. Community engagement and cross-sector collaboration

Addressing the inverse care law requires genuine partnership with communities, moving beyond consultation toward empowerment and co-production. People with lived experience of disadvantage must be supported to shape services and hold systems accountable through inclusive, representative engagement and improved health literacy. More broadly, lasting progress depends on tackling the social determinants of health – poverty, housing, employment, and education – through collaboration across sectors. Sustained investment in the third sector and social care, alongside coherent social policy, is vital to strengthen community partnerships and build a more equitable, community-oriented model of primary care.

Addressing the inverse care law in Scottish General Practice - Full Report

Background

The inverse care law (ICL) was first defined by the GP Julian Tudor Hart in 1971 to describe how people who most need health care are least likely to receive it (1). In previous research, the ICL has been shown to manifest in general practice in Scotland both in relation to the distribution of resources (fewer GPs and less funding in more socioeconomically deprived areas)(2) and within consultations (higher GP stress, lower patient enablement and worse outcomes in practices in disadvantaged areas)(3, 4).

Since Scottish devolution in 1999, there have been numerous policy commitments to strengthening general practice in deprived areas, recognising the key role of GPs – as part of integrated multidisciplinary primary care teams – in reducing or mitigating health inequalities (5-7). Specific strategies have included changes to general practice funding, contracts, premises and wider team staffing, as well as a range of targeted interventions. However, there remains a major implementation gap between Scotland's policy ambitions to address health inequalities and sustainable delivery on the ground (8).

Building on similar work in England (9), The Health Foundation funded a team of Scottish researchers to explore the inverse care law in Scottish general practice since devolution. The research found that, of 20 different interventions aimed at strengthening general practice in deprived areas, only two have been rolled out nationally – Community Link Workers and Welfare Advice and Health Partnerships – with both facing uncertain futures beyond the short term (10).

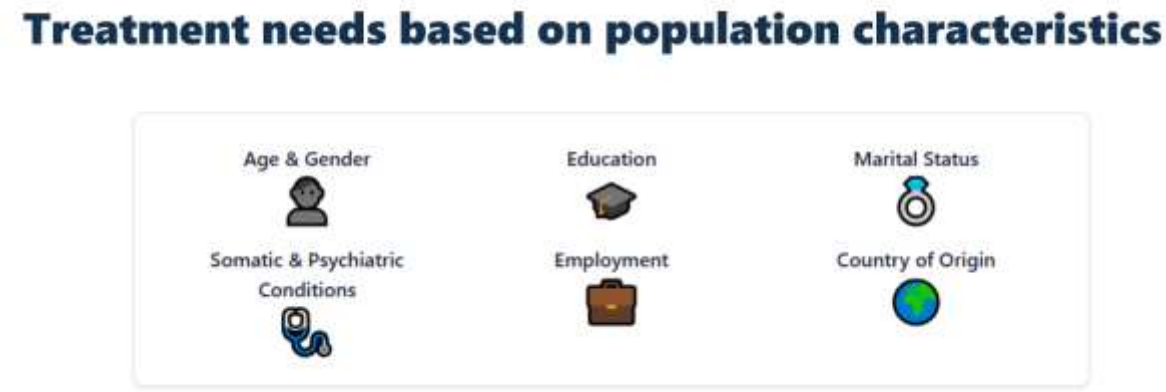
The report also found that the 2018 Scottish GMS contract has resulted in significant investment in, and growth of, the extended primary care multidisciplinary team (MDT) workforce, but it is unclear whether this new workforce has been adequately distributed according to local population need (11-14). The report made 8 recommendations (Appendix 1).

To discuss the implementation of these recommendations and gain insights from other countries, a meeting was held on the 1st September 2025 at the Dovecot Studios in Edinburgh. Findings from The Health Foundation research were presented, and speakers from Denmark and England presented recent developments in their countries. Attendance was by invitation in order to keep the meeting small and to allow in-depth discussions. A list of those who attended is shown in Appendix 2, the programme for the afternoon is shown in Appendix 3, and speakers' affiliations and biographies are shown in Appendix 4.

Participants were encouraged to speak openly and freely, with Chatham House rules being observed. Comments or views are not attributed to any individual or organisation, other than the speakers' talks which are summarised below.

Summary of speakers talks:

Addressing the inverse care law in Denmark



Mogens Vestergaard presented an update from Denmark, where recent planned reforms to general practice funding seek to specifically address the inverse care law. He began by describing the inverse care law in Denmark, with fewer doctors working in areas with higher levels of illness and deprivation. **Official GP shortage areas** overlap with **low-income municipalities**. Demographic trends also show rising proportions of **elderly residents (80+)**, especially in smaller municipalities — a challenge that will intensify by **2050**.

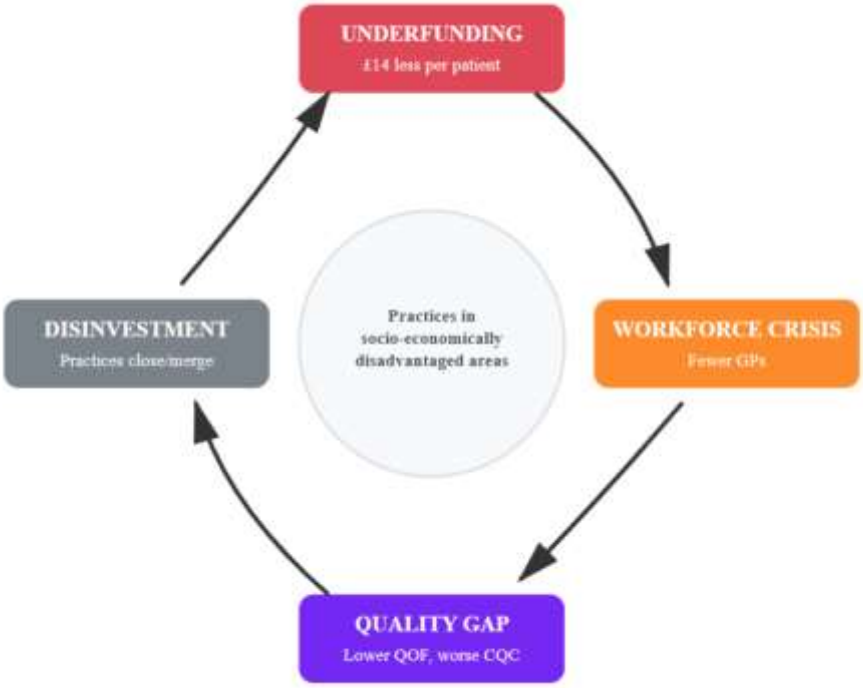
Mogens outlined the **Deep End Denmark Initiative**, inspired by the Scottish Deep End Project, which involved national and regional meetings, support for GP trainees (including case discussions and feedback and invitations to national events), a podcast series and book publication, and advocacy and media engagement giving deprived-area GPs a clear public voice.

This advocacy has attracted high-level political attention, with Prime Minister Mette Frederiksen publicly acknowledging the ICL: *"There are fewer doctors in places where there are more sick people. It's time to do something about it!"*

Recent research in Denmark has emphasised the importance of relational continuity of care (15), which is easier to achieve when practices are adequately resourced. As such, a new **national health plan** has been developed to guide resource distribution across general practice, hospitals, and regions. This proposes **weighting GP list sizes** according to patient complexity and needs, enabling fair workloads and financial parity. **Treatment needs** can be quantified using population data (e.g. age, comorbidity, education, ethnicity). Strategies to increase the GP workforce in under-served areas include additional **funding**, a **hiring freeze** on GP specialists in university hospitals to encourage community work, and a Masters degree in Medicine being expanded to seven cities to increase regional training opportunities.

Slides are available upon request.

Policies to address the ICL in English General Practice



John Ford presented an overview of how the ICL manifests in English General Practice, including evidence of **inequalities reinforcing themselves** through current funding and workforce distribution. Practices in socio-economically disadvantaged areas receive less funding per patient, which makes workforce recruitment and retention more challenging, resulting in worse outcomes (lower QOF scores and CQC ratings), leading to further disinvestment.

There is a political commitment to **renegotiate the GP contract** before the next general election, and the **Carr Hill formula** (used to allocate general practice funding) is under review, with consideration of greater deprivation weighting. Negotiations are underway between BMA, DHSC, and NHS England, with plans for **Integrated Neighbourhood Teams** to support place-based care. As well as Carr Hill reform, other policies to address funding inequalities include reform of the **Quality and Outcomes Framework (QoF)** (e.g. higher payments in deprived areas, equity-based metrics, or "equity-gap" indicators) and other funding streams such as enhanced services.

Policies to address workforce inequalities include a **Targeted Enhanced Recruitment Scheme** – a £20,000 incentive for GP trainees to work in under-doctored/deprived areas, which ends in 2025/26 – and **redistribution of Specialty Training Places**, aligning medical training locations with areas of highest need to rebalance workforce distribution.

John concluded by summarising the position of the Health Equity Evidence Centre, that:

- **All funding streams** need to be considered in contract reform:
    - Small tweaks won't fix inequalities.
    - **Carr Hill** should move to a **needs-based formula**, incorporating *unmet need* rather than just workload.
    - Guided by the **Advisory Committee on Resource Allocation**.
- **Capitation** remains the most equitable funding model but requires safeguards:

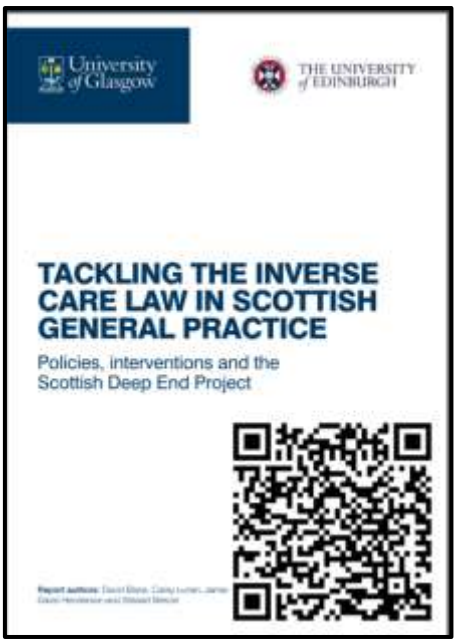
    - **Adequate investment** – underfunded capitation widens inequalities.
    - **Transparency** – GP earnings comparable to hospital consultants.
    - **Quality assurance** – based on outcomes and improvement.
    - **Stability** – predictable income, limited liability, safety netting.

The **need for transparency and accountability** around how public money is spent is particularly important, in order to build trust (among the general public and politicians) and make the case for direct investment in general practice.

- Need to align **contractual reform** with:
    - **Workforce reform** (undergraduate and postgraduate).
    - **Shifting hospital staff into community roles** to strengthen primary care capacity.

Slides are available upon request.

Recommendations from the Scottish GP report on tackling the ICL



David Blane then presented a brief overview of findings from research funded by The Health Foundation, including a systematic **scoping review**, **stakeholder interviews**, and **new analysis of routine data**. Key points included:

- Despite policy ambition to address health inequalities by strengthening general practice, the inverse care law persists, with **fewer GPs** and **less funding** in more deprived areas.
- The **2018 Scottish GP contract** expanded the multidisciplinary (MDT) workforce but **did not address the ICL**.
- The **Scottish Deep End Project** remains pivotal in advocacy and professional solidarity for GPs in the most socioeconomically deprived areas.

Recommendations from the report included:

- **Increase investment in general practice and primary care**
  - Scotland's GP funding share of NHS budget is lowest in the UK.
  - Substantial, transparent increases needed to meet the needs of complex patients.
- **Distribute funding and workforce according to need**
  - Review and update the Scottish Workload Formula to reflect unmet need and socioeconomic disadvantage.
  - Apply Proportionate Universalism (PU) principles in service design.
- **Develop a long-term workforce plan**
  - Expand generalist and equity-oriented training for GPs, nurses, and MDT members (e.g. Link Workers).
  - Embed trauma-informed, equity-based practice training.
- **Sustain effective interventions**

    - Provide long-term funding for Community Link Workers and Welfare Advice Partnerships, which directly address the ICL but remain precariously funded.
- **Monitor and evaluate inequality impacts**
    - Require Health Inequality Impact Assessments for all new policies and the 2018 GP contract.
    - Evaluate how new MDT roles (pharmacists, CTAC services, physios) affect equity.
- **Strengthen GP clusters**
    - Resource them to fulfil their remit on health inequalities, with data support, best-practice sharing, and representation in strategic groups.
- **Enhance primary care research capacity**
    - Increase funding to the Scottish School of Primary Care to enable robust evaluation of equity-oriented initiatives.

Slides are available upon request.

Key learning and next steps for addressing the ICL in Scotland – break-out group discussions

Attendees were divided into four break-out groups for discussion informed by the topics raised in the presentations and from their own knowledge and experiences of primary care. Each group had a facilitator and a scribe. The scribes then fed back the main points raised in the break-out groups to all attendees for further discussion.

Below is a summary of the four key themes that emerged from the discussions.

1. Fair and transparent funding aligned with need

- Across all groups, participants agreed that **Scotland's current resource allocation model – particularly the Scottish Workload Formula (SWF)** – fails to reflect the true scale of need in deprived areas. Because the formula heavily weights **chronological age** rather than factors such as **multimorbidity, deprivation, or early onset of illness**, it systematically underfunds communities with the poorest health. There was strong support for developing a **needs-based or life-expectancy–adjusted approach**, drawing inspiration from the Danish model, where funding is tied more closely to **health burden and expected lifetime healthcare use**.

- However, participants recognised that **no single measure captures need perfectly**. Area-level metrics like the **Scottish Index of Multiple Deprivation (SIMD)** risk missing individuals with high need in otherwise affluent areas. To mitigate this, Scotland requires **improved data infrastructure** capable of integrating individual-level information across health, social care, and socioeconomic domains. Importantly, any new system must also embed **financial transparency and accountability** – demonstrating to politicians and the public that additional funding in deprived areas translates into better services and outcomes, not higher GP profits.

2. Building data, evidence, and accountability

- A recurring theme was the urgent need for **better quality, more integrated data** to understand and respond to health inequalities. Participants highlighted inconsistent **primary care coding**, fragmented **social care data**, and a lack of shared systems as major barriers to evidence-based resource allocation. There was widespread recognition that **Scotland lags behind Denmark** in linking data across sectors – health, education, employment, and social care – to inform policy and planning. Developing **interoperable IT systems** that reduce the data-entry burden on general practice teams was seen as a critical step.

- Improving data is not only technical but also ethical and political. Participants argued that **robust evidence is essential for accountability** – both in demonstrating the impact of investment and in ensuring funds are used equitably. They also emphasised the need for new methods to capture **'unseen' or 'unmet' need**, such as patients who do not seek help or whose problems go unrecorded. Combining **quantitative metrics with qualitative approaches** – such as patient stories or participatory research – could create a more comprehensive understanding of how inequality manifests in everyday practice.

3. Workforce distribution, development, and wellbeing

- Participants across groups identified the **unequal distribution of workforce and training opportunities** as a key driver of the inverse care law. **Deep End areas** often have fewer GP training practices and limited access to mentorship and professional development. There was strong support for expanding **training rotations or placements in deprived communities**, ensuring that all GP trainees gain firsthand experience of working with populations experiencing disadvantage. In the longer term, a **national workforce strategy** is needed to align recruitment, retention, and skill mix with the principle of **proportionate universalism**.

- Workforce challenges extend beyond numbers to **team wellbeing and sustainability**. Many practices reported **unsustainable workloads**, **rising complexity**, and vulnerability to staff turnover or sickness. Participants described how the loss of even one team member can destabilise a practice. There was a clear call for **long-term, predictable investment** rather than short-term or one-off payments, which rarely deliver lasting change. Participants also emphasised the importance of supporting the **wider multi-disciplinary team (MDT)** – including community link workers, district nurses, and health visitors – whose roles are vital but often **precariously funded**.

4. Community engagement and cross-sector collaboration

- Finally, participants from all four groups agreed that addressing the ICL requires **genuine partnership with communities**, not just professional or policy-led solutions. Effective engagement must move from consultation to **empowerment**, ensuring that people with lived experience of disadvantage can help shape services and hold systems accountable. This involves **inclusive and representative engagement practices**, careful framing of questions to avoid tokenism, and providing communities with the **resources and health literacy** they need to advocate for themselves.

- Beyond healthcare, participants stressed that the ICL cannot be solved without tackling the **social determinants of health** – poverty, housing, employment, and education. Collaboration with the **third sector** and social care was seen as essential, yet many community and voluntary organisations face **insecure, short-term funding**, undermining continuity and trust. Sustained investment in these partnerships, alongside **joined-up social policy**, was viewed as critical for reducing inequalities and building the foundations of equitable, community-oriented primary care.

Summaries of the discussions in the four groups are available on request from David Blane.

Summary and Conclusions

The **Inverse Care Law (ICL)** remains deeply entrenched in Scottish general practice. Despite long-standing policy ambitions to reduce inequality, structural and systemic barriers continue to drive inequitable access, workload, and outcomes. Participants emphasised that addressing the ICL will require **sustained political commitment**, **transparent investment**, and a **whole-system approach** that links primary care reform with broader social policy.

A central conclusion was the need for **fair and transparent resource allocation** that aligns with population need. Scotland's **current workload and allocation formulas** were viewed as inadequate, perpetuating disadvantage in communities with higher levels of multimorbidity and shorter life expectancy. Participants called for a **radical revision of the Scottish Workload Formula** to reflect unmet need and socioeconomic disadvantage, drawing inspiration from international models such as Denmark's life-expectancy–adjusted approach. Any new model should be accompanied by clear **accountability mechanisms**, ensuring that additional investment in deprived areas translates directly into better care and outcomes rather than widening pay disparities or practice variation.

A second cross-cutting theme was the **need for robust data and evidence systems** to underpin equitable decision-making. Participants highlighted that Scotland's current data infrastructure is fragmented, with limited integration across health, social care, and third-sector systems. Improving **data quality, interoperability, and linkage** was seen as critical for measuring unmet need, monitoring resource distribution, and evaluating policy impact. This should include **Health Inequality Impact Assessments** for new contracts and reforms, alongside ongoing monitoring of how multidisciplinary team (MDT) roles – such as pharmacists, CTAC services, and physiotherapists – are distributed and function across socioeconomic contexts.

Workforce issues emerged as a third major theme. Participants agreed that **the distribution, training, and wellbeing of the primary care workforce** are central to tackling the ICL. Deep End areas face persistent recruitment and retention challenges, compounded by rising workload and staff burnout. Addressing these issues will require a **long-term, equity-oriented workforce plan**, expanding generalist training and ensuring all trainees gain experience in deprived settings. Embedding **trauma-informed and equity-based practice training** across the MDT – including nurses, community link workers, and other allied professionals – was viewed as essential to supporting holistic, person-centred care.

Finally, participants stressed that **community engagement and collaboration across sectors** must become integral to addressing health inequalities. Tackling the ICL cannot be achieved through clinical reform alone: it depends on empowering communities to shape services that meet their needs, strengthening partnerships with voluntary and third-sector organisations, and aligning health policy with social determinants such as housing, education, and employment. Sustaining effective, community-facing interventions – notably **Community Link Workers and Welfare Advice Partnerships** – was identified as a practical and proven step toward reducing inequalities, provided that **secure, long-term funding** is guaranteed.

In conclusion, addressing the inverse care law in Scottish general practice will demand **a combination of investment, reform, and innovation**. This means increasing the share of NHS spending directed to general practice, distributing funding and workforce according to need, and supporting GP clusters and research networks to lead local action on inequalities. It also means strengthening data systems,

evaluation capacity, and community partnerships to ensure that progress is measurable and enduring. The evidence, experience, and momentum now exist – what is needed is **sustained commitment and coordinated action** to translate these principles into lasting change for Scotland's most disadvantaged communities.

Acknowledgements

We would like to thank all speakers and attendees. Thanks also to Lauren Ng, Eddie Donaghy, James Bogie, and John Gillies for capturing the key points raised in the break-out groups and feeding this back to the whole audience. A special thanks to Jayne Richards for her hard work and expertise in helping organise the event.

Disclaimer

The views expressed in this report from the break-out group discussions were analysed and collated by the authors of this report, and do not necessarily reflect the views of all discussants. It should be noted that the two attendees from the Scottish Government did so as observers and did not contribute to the discussions. It should also be noted that Carey Lunan attended in her role as Honorary Senior Lecturer in General Practice at the University of Edinburgh.

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Appendices

Appendix 1. Recommendations from "Tackling the inverse care law in Scottish general practice" report

1. ***The Scottish Government should increase the proportion of NHS budget allocated to general practice and primary care.*** *The percentage NHS spend on general practice and primary care in Scotland is the lowest in the UK, and remains far lower than it needs to be to meet the needs of patients with complex problems. A substantial increase in funding of general practice in Scotland is urgently required and would likely need to be supported by improved financial transparency and governance arrangements.*

2. ***The Scottish Government and policymakers should ensure that GP funding (via the Global Sum) and staffing are distributed in proportion to population need, following the principle of proportionate universalism.*** *This means reviewing and updating the Scottish Workload Formula with up-to-date, reliable data and incorporating consideration of unmet need into a revised formula that more accurately captures the impact of socioeconomic disadvantage on general practice workload. Proportionate universalism is frequently cited as a fairer way of distributing resource according to need, but examples of how this can be applied in practice are lacking. There is a need to develop a framework of how proportionate universalism can be applied practically in both policymaking and service design and delivery if this approach is to be adopted meaningfully.*

3. ***The Scottish Government should work with NHS bodies and others to develop and implement a comprehensive and informed long-term workforce plan, which addresses the inverse care law in general practice.*** *We need more medical generalists who can provide holistic person-centred continuity of care, particularly for people with multiple long-term health conditions, physical and mental health co-morbidities and complex social needs. A strong workforce with generalist skills and training (which includes community nursing and newer members of the extended primary care MDT such as Community Link Workers) is needed most in areas of highest socioeconomic disadvantage. All staff should receive training in equity-orientated, trauma-informed care.*

4. ***Where interventions are working well – such as Community Link Workers and welfare advisers in general practices – the Scottish Government should ensure long-term funding.*** *Despite being the only ongoing interventions that could be said to specifically help address the inverse care law, Community Link Workers and Welfare Advice and Health Partnerships remain on a precarious financial footing, with clear negative impacts for patients, practices and the staff involved.*

5. ***The Scottish Government, NHS Scotland and Public Health Scotland should work together to ensure both rigorous health inequality impact assessments and subsequent monitoring and evaluation of the 2018 Scottish GMS contract and all new policies affecting general practice.*** *Elements of the 2018 contract, such as sustainability loans, minimum GP and practice income guarantees and the distribution*

and uptake of additional resources such as pharmacotherapy, CTAC services and physiotherapists, should be evaluated and monitored in relation to socioeconomic deprivation.

6. ***The Scottish Government, health boards and integration authorities should maximise the opportunities offered within the 2018 Scottish GMS contract and its next phase of development to address the inverse care law in general practice****. Specifically, this includes matching the capacity and skills of the extended MDT workforce to local population needs, and evaluation and monitoring to better understand the impact of the new models of primary care on health inequalities, with mitigation where negative unintended consequences are revealed.*

7. ***The Scottish Government, HSCPs and health boards should provide additional support to GP clusters to enable them to realise their specific remit to address health inequalities.*** *This should include adequate data and project support, mechanisms to share best practice, development of a health inequality toolkit, and adequate representation on strategic influencing groups.*

8. ***The Scottish Government should increase funding for robust and holistic primary care research to support evaluations of new primary care policy initiatives.*** *This should include increasing funding to the Scottish School of Primary Care, bringing it proportionately closer to the level of the English School of Primary Care. Robust data collection and evaluation arrangements should be in place before implementation begins.*

Appendix 2. Attendees

Stewart Mercer	Professor of Primary Care and Multimorbidity at the University of Edinburgh	stewart.mercer@ed.ac.uk
Carey Lunan	Honorary Senior Clinical Lecturer, University of Edinburgh	clunan1@ed.ac.uk
David Blane	GP and Senior Clinical Lecturer in General Practice and Primary Care at the University of Glasgow	david.blane@glasgow.ac.uk
Eddie Donaghy	Social scientist and mixed-methods researcher at the University of Edinburgh	eddie.donaghy@ed.ac.uk
Lauren Ng	GP and Clinical PhD student, University of Edinburgh	lauren.ng@ed.ac.uk
Emilie McSwiggan	PhD student, University of Edinburgh	emilie.mcswiggan@ed.ac.uk
James Bogie	GP and research affiliate, University of Glasgow	james.bogie4@nhs.scot
Mogens Vestergaard	Professor of General Practice, Aarhus University, Denmark	mv@clin.au.dk
Katherine Checkland	GP and current Professor of Health Policy & Primary Care, University of Manchester	Katherine.H.Checkland@manchester.ac.uk
Leigh Johnston	Senior Manager, Audit Scotland	ljohnston@audit-scotland.gov.uk
Colin Angus	Patient and public Involvement Chair, ScotCh study	colin_angus@hotmail.com
Ellie Crawford (Observer)	Scottish Government, Head of Primary Care Strategy and Capability	Ellie.Crawford@gov.scot
Isla Wallace (Observer)	Scottish Government, Team Leader, General Practice Policy and Strategy	Isla.Wallace@gov.scot
Lorna Kelly	National Strategic Lead for Primary Care, Health and Social Care Scotland	lorna.kelly3@glasgow.gov.uk
Joanne Anderson	National clinical lead for Primary Care Nursing, Healthcare Improvement Scotland PCPIP	Joanne.Anderson@aapct.scot.nhs.uk
Lois Gault	General Practice Pharmacist advisor, Healthcare Improvement Scotland PCPIP	Lois.Gault2@nhs.scot
Belinda Robertson	Associate Director of Improvement, Primary Care, Healthcare Improvement Scotland	belinda.robertson3@nhs.scot
Ciara Robertson	Director of Improvement, Primary Care, Healthcare Improvement Scotland	ciara.robertson@nhs.scot
Rishma Maini	Consultant in Public Health Medicine, Public Health Scotland	rishma.maini2@phs.scot
John Gillies	Honorary Professor of General Practice, University of Edinburgh	John.Gillies@ed.ac.uk
Sian Tucker	Deputy Medical Director NHS National Services Scotland Clinical Directorate	sian.tucker2@nhs.scot
Drummond Begg	GP, Penicuik Health Centre	drummond.begg@nhs.scot
Sara Redmond	Chief Officer of Development, The Health and Social Care Alliance Scotland	Sara.Redmond@alliance-scotland.org.uk

Anne Crandles	Link Worker Network Manager, Edinburgh	Anne.Crandles@nhs.scot
Colette Mason	Link Worker Programme Manager, The Health and Social Care Alliance Scotland	colette.mason@alliance-scotland.org.uk
Marianne McCallum	Deep End GP, Glasgow	marianne.mccallum@glasgow.ac.uk
Nora Murray-Cavanagh	Deep End GP, Edinburgh	nora.murray-cavanagh@nhs.scot
Andrea Williamson	Professor of Inclusion Health, University of Glasgow	andrea.williamson@glasgow.ac.uk
Tejesh Mistry	CEO, Voluntary Health Scotland	tejesh.mistry@vhscotland.org.uk
Sarah Doyle	Chief Executive and Nurse Director, Queen's Nursing Institute Scotland	sarah.doyle@qnis.org.uk
Peter Mclean	Chair of Primary Care Managers, Scotland	peter.maclean@nhs.scot
John Ford	Public health doctor and Senior Clinical Lecturer in Health Equity, Queen Mary University London	j.a.ford@qmul.ac.uk

Invited but unable to attend:

Iain Morrison	Chair, Scottish General Practice Committee, BMA
Chris Black	Deputy Chair, SGPC, BMA
Alan Miles	Deputy Chair, SGPC, BMA
Chris Provan	Chair, RCGP Scotland
Caroline Hickling	Policy and Public Affairs Manager, RCGP Scotland
Paul Baughan	Clinical Lead Healthcare Improvement Scotland
Dianne Stockton	Director of Public Health for Public Health Scotland
Peter Cawston	Commissioner, Poverty and Inequalities Commission
Irene Oldfather	Director, The Health and Social Care Alliance Scotland
Mary Hemphill	PPI Member, ScotCh Study
David Henderson	Research Fellow, University of Edinburgh
Margaret McCartney	Senior Lecturer, University of St Andrews
Lindsay Pope	Professor of Medical Education, University of Glasgow
Nitin Gambhir	Lead Dean Director for NHS Education for Scotland, Honorary Professor, University of Glasgow
Adrian Baker	GP Partner, Nairn Healthcare Group

Appendix 3. Programme

2:00: Welcome – Dr Carey Lunan

2.00-2.20: Addressing the inverse care law in Denmark – Professor Mogens Vestergaard

2.20-2.35: Policies to address the inverse care law in English General Practice – Dr John Ford

2.35-3.00: Recommendations from the Scottish General Practice report on tackling the inverse care law – Dr David Blane

3.00-3.50: Break-out session 2: Key learning and next steps for addressing the inverse care law in Scotland

3.50-4.20: Feedback and discussion

4.20-4.30: Summary and wrap-up – Dr Carey Lunan

Appendix 4. Speakers Biographies

Mogens Vestergaard mv@clin.au.dk

Mogens is a Danish general practitioner and Professor of Clinical Epidemiology at Aarhus University, with research focusing on family medicine, social inequality, multimorbidity, and mental health. As founder and chair of the Danish Deep End group, he has been a leading voice in reducing the impact of the inverse care law and promoting better healthcare in socioeconomically challenged communities in Denmark. Mogens served on Denmark's Health Structure Commission and has advised the government on preparing the healthcare system for future challenges. He now works as an expert ambassador for the Ministry of Health to implement the national health reform and strengthen collaboration between authorities and general practitioners. He was awarded the Honorary Award of the Danish Medical Association in 2025.

John Ford j.a.ford@qmul.ac.uk

John is an academic public health doctor and Senior Clinical Lecturer in Health Equity in the Wolfson Institute, Queen Mary University London where he leads the Health Equity Evidence Centre. He is also Honorary Public Health Consultant within the national team of NHS England. He is the Director of the Health Equity Evidence Centre which focuses on building the evidence base of what works to address health and care inequalities and leads a programme of research focused on addressing the structural determinants of health and care inequalities, such as funding, workforce and workload.

Carey Lunan clunan1@exseed.ed.ac.uk

Carey is a GP and Chair of the Scottish Deep End Group. She is also Honorary Senior Clinical Lecturer at the University of Edinburgh. There are the roles in which she will be chairing the event. Carey also has a role as a senior medical advisor on health inequalities to the Scottish Government.

She is a passionate advocate of the role of general practice in addressing health inequalities. In 2020, when she was Chair of the RCGP in Scotland, she was awarded an MBE for services to healthcare during the Covid19 pandemic.

David Blane David.Blane@glasgow.ac.uk

David is a GP and Senior Clinical Lecturer at the University of Glasgow and the Academic Lead for the Scottish Deep End GP Group. He has been involved in research, teaching and advocacy related to the social determinants of health and health inequalities since 2010 and was awarded the RCGP John Fry Award in 2024.

Stewart Mercer stewart.mercer@ed.ac.uk

Stewart is a former GP and current Professor of Primary Care and Multimorbidity at the University of Edinburgh. Over the last 25 years he has extensively researched the needs of patients with complex multimorbidity, and how health and social care systems need to adapt and respond to ageing populations and health inequalities. As Director of Scottish School of Primary Care from 2014 to 2020) he led the New Models Evaluation of Primary Care in Scotland (2016-2018). He led the ScotCh study - an independent evaluation of the new GP contract in Scotland funded by the Economic and Social Research Council (2020-2024).