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Major conditions strategy: geography can tell you where inequality exists, but it cannot tell you why

The proposed major conditions strategy focuses on deprivation and location, but its measures of inequality are limited and, unless tackled, may risk ignoring the underlying problems, write Sam Rodger and Habib Naqvi

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The health and social care secretary for England, Steve Barclay, recently announced a new major conditions strategy, which he says will mark "a shift to integrated, whole person care."[1] Its ultimate aims are to alleviate pressure on the health system, increase healthy life expectancy, and reduce economic inactivity.

None of these ambitions are particularly notable in themselves. These have long been the aims of successive governments and, different though the packaging may be, they are aims that will be familiar to the civil servants, managers, and clinicians who will be tasked with developing and delivering this strategy.

What's more interesting about this strategy, perhaps, is what it's not. The major conditions strategy is the de facto replacement for the long awaited, but ultimately doomed, health disparities white paper, which was formally abandoned in January 2023. That policy document was to set the tone for the operation of the new Office for Health Improvement and Disparities, outlining precisely how the government would tackle long standing disparities in health. However, with the major conditions strategy purportedly covering much of the same ground, the decision was made not to publish the white paper after all.

For many with an interest in health inequalities, this was a concerning development. Scrutiny over the new major conditions strategy is understandably intense as invested parties try to understand how the new strategy will account for inequalities. The strategy is not yet written, but we are told it will focus on six conditions—cancer, cardiovascular disease, chronic respiratory disease, dementia, mental ill health, and musculoskeletal disorders.[2] These conditions represent the majority of the total disability adjusted life years in England.

By focusing on just six conditions, Steve Barclay argued, we can move away from siloed thinking about health. Some of the underlying ambitions of the strategy are sensible. It will put greater emphasis on generalist medical skills, will seek to promote early detection and treatment of disease, seek to harness innovation and technology, and it will encourage better system working.

But what about inequalities? We're told the strategy covers the same topics as the scrapped disparities paper, but from what we know so far, it will only explore "deprivation" and "place," empowering integrated care systems to "tackle clusters of disadvantage in their local areas where they exist." Geography will be the primary lens through which the strategy understands health disparities. For example, if people in a town have worse outcomes than those in the neighbouring countryside, the NHS should work with other local services to improve outcomes in the town through action such as co-location of services, or a greater skill mix for local medical professionals.

On the surface this seems reasonable enough. Inequality needs to be understood somehow, and at least there is acknowledgement of variable health outcomes. But there are some glaring omissions here, primarily what causes these inequalities in the first place. Geography can tell you where inequality exists, but it cannot tell you why. Without an understanding of why, we will struggle to meaningfully reduce these gaps.

One of these causes, not yet alluded to in the development of the strategy, is structural racism: the processes by which people of different races are disadvantaged in their access to economic, physical, and social resources.[3] Not only does structural racism influence where communities can live and where groups of migrants choose to settle, it also affects a person's ability to access healthcare, and determines their experiences of that healthcare.[4]

The major conditions strategy, by focusing its lens of inquiry on deprivation and location alone, risks failing to consider the intersection between those factors and racial disadvantage and/or other intersections between the many protected characteristics that influence a person's health and quality of life.

The strategy will put an emphasis on generalist medical skills, but it must ensure that clinical education is free of racial bias and geared towards eliminating structural inequality.[5] The strategy will seek to harness innovation and technology, but it must ensure that technology is co-designed and calibrated with diverse communities to ensure equitable results.[6] The strategy will encourage better system working, but it needs to ensure those systems have robust ethnicity-coded data with which to inform their population health decisions.[7]

Despite the strategy's intention to move away from siloed working, its focus on limited measures of disparity means it risks falling into new silos. Health inequalities cannot be separated from one another,

and identifying disadvantaged geographies can only ever locate a problem. Without understanding the causes of that problem, we will struggle to fix it.

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