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MEDICINE

Community for Health Equity

Session 7 report

‘Health equity through regulations,
education and funding’

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Executive summary

This report captures learning from the seventh session of the [Community for Health Equity programme](#), which explored how regulation, funding and research practice can help embed health equity across healthcare and clinical research.

The session brought together perspectives from regulation, industry, research funders, pharmaceutical medicine and community organisations. Across these perspectives, a common message emerged: equity is shaped by the rules, incentives and infrastructure that determine how healthcare products are developed, evaluated and used.

Professor Bola Owolabi opened the session by making the wider case for sustained action on health inequalities. She argued that worsening health and economic inequalities require organisations across healthcare and industry to use the influence they already hold, including as employers, procurers, asset holders and partners. She also highlighted the role of regulation in requiring medicines and medical devices to work effectively across the populations expected to use them.

The Medicines and Healthcare products Regulatory Agency (MHRA) demonstrated how this principle is beginning to be applied across the product lifecycle. Its priorities include improving representation in clinical research, supporting innovation for underserved populations and applying an equity lens across regulatory activity. Health Research Authority and MHRA guidance on

inclusion and diversity plans asks researchers to consider who experiences the condition being studied, whether study findings will apply to that population and how underserved groups will be recruited and retained.

Other speakers showed that regulation is only one lever. Research funders can influence priorities, study design and participation through their funding criteria. Industry partnerships can provide expertise and capacity where they operate with clear governance and transparency. Professional bodies can establish expectations for inclusive research practice. Community organisations can bring relationships, cultural understanding and delivery capability that enable research to reach populations traditional models often miss.

The session also challenged a narrow focus on recruitment. Participation is affected by trial eligibility, location, travel costs, caring responsibilities, language, trust and the practical burden placed on participants. These factors need to be considered throughout study design and delivery.

Taken together, the session suggested that progress now depends on making equity part of routine decision-making. Regulatory requirements, funding criteria, research design, community partnership and data need to reinforce each other so that inclusion becomes a feature of how research and innovation are delivered

Programme overview

The Royal Society of Medicine (RSM) and the NHS have a shared commitment to reducing health inequalities, as outlined in the [NHS Core20PLUS5](#) initiative and the [NHS 10 Year Plan](#). The Community for Health Equity (CHE) Programme builds on this partnership, recognising that healthcare industry professionals (pharmaceutical, biotechnology and medical technology companies) possess unique resources and expertise that can support NHS goals. This includes supporting the adoption and spread of innovation, and improving how equity considerations are built into value propositions, evidence generation and implementation. This includes supporting the adoption and spread of innovation, and improving how equity considerations are built into value propositions, evidence generation and implementation.

By engaging industry, patients, clinicians and other stakeholders this programme aims to bridge gaps between commercial innovation and public health NHS needs. The RSM, as an independent professional body, provides a neutral convener platform where industry, NHS leaders and other stakeholders can dialogue and co-create solutions. This alignment ensures that NHS leader's priorities – such as equitable access to medicines and advancing national strategic goals – are informed by industry insights, while industry is guided toward addressing unmet needs in underserved communities.

Ultimately, the initiative seeks to deliver tangible health improvements on the ground through a series of targeted engagements and outputs.

Co-development and status

This report has been co-developed with programme members. It reflects perspectives shared during the session and does not represent formal policy positions of the Royal Society of Medicine or participating organisations.

Financial contributions and independence

We would like to thank our Industry Members [Boehringer Ingelheim, Gilead, Merck Group, Novartis and Pfizer] for their financial support of this event.

We would like to thank Bayer plc, which has financially supported the delivery of this programme through a sponsorship agreement. Bayer plc provided insights to inform the initial scope of the programme, with no further involvement in the content, programme, or organisation of this meeting.

Organisations represented across this session

Association of Medical Research Charities
Association of the British Pharmaceutical Industry
AstraZeneca
Brook
Care Quality Commission
Caribbean and African Health Network
Cheshire and Merseyside Cancer Alliance
Faculty of Pharmaceutical Medicine
Friends, Families and Travellers
Gilead Sciences UK & Ireland
Health Innovation Kent Surrey Sussex

Health Innovation Oxford & Thames Valley
Marie Curie
Medicines and Healthcare Products Regulatory Agency
North Central London Cancer Alliance
Patient Information Forum
Pfizer UK
Picker Institute Europe
Royal Society of Medicine
University College London
University College London Hospital

Context and background

Health inequalities are driven by a range of social, economic and environmental factors. Decisions about how healthcare and research are designed and delivered can also affect who is able to access and benefit from them.¹²

Where populations are underrepresented in research, two problems arise. People may have less access to the benefits of research participation and the resulting evidence may be less able to explain how medicines, devices and interventions perform across the population expected to use them. This can affect understanding of both effectiveness and safety.³

The policy and regulatory environment increasingly recognises this challenge. NIHR has developed guidance on including underserved groups in research, while HRA and MHRA have introduced work on inclusion and diversity plans for clinical trials.⁴ Professional bodies, industry and research funders are also developing recommendations, funding requirements and practical guidance intended to improve participation and representation.⁵

However, representation is shaped by more than recruitment targets. Restrictive eligibility criteria, study location, travel costs, caring responsibilities, language, trust and limited capability to engage underserved communities can all affect whether people are able or willing to take part.⁶ HRA-MHRA guidance asks researchers to consider who is affected by the condition being studied, whether the study population will support generalisable findings and how underserved groups will be recruited

and retained.⁷

Improving inclusion therefore depends on several parts of the system acting together. Regulation, funding, study design, research delivery, community partnership and data each shape different points in the research pathway.

This means responsibility is distributed across the system. Regulators influence evidence standards and approval requirements. Funders influence which research is prioritised and the conditions attached to funding. Sponsors and researchers shape study design and delivery. NHS organisations provide research infrastructure and access to patients. Patient and community organisations bring lived experience, cultural understanding and trusted relationships that can identify barriers conventional research models may miss.

The session also placed this within a wider case for action on health inequalities. Professor Bola Owolabi linked poorer health outcomes with earlier onset of long-term conditions, reduced workforce participation and weaker economic productivity, arguing that healthcare organisations and industry have influence through employment, procurement, estates and partnership as well as through research and innovation. The wider evidence base similarly shows that future increases in major illness are expected to be concentrated disproportionately in more deprived populations.⁸ Session 7 explored how regulation, funding, education and partnership can move health equity from an ambition into routine research and healthcare practice.

¹ NHS England, [Our approach to reducing healthcare inequalities](#)

² National Institute for Health and Care Research, [Improving inclusion of under-served groups in clinical research: Guidance from INCLUDE project](#)

³ Faculty of Pharmaceutical Medicine, [Advancing Clinical Trials: Making the UK a Global Leader in Inclusive Clinical Trials](#)

⁴ National Institute for Health and Care Research, [Improving inclusion of under-served groups in clinical research: Guidance from INCLUDE project](#)

⁵ Academy of Medical Research Charities and Association of the British Pharmaceutical Industry, [Achieving inclusivity in clinical research](#)

⁶ NHS England, [Increasing diversity in research participation: A good practice guide for engaging with underrepresented groups](#)

⁷ Health Research Authority, [Increasing the diversity of people taking part in research](#)

⁸ Health Foundation, [Health inequalities in 2040 - Current and projected patterns of illness by deprivation in England](#)



Presentations

This section provides a summary of presentations given during the session and key insights gained. These informed the later discussion and provided framing to think about the recommendations and action to be taken.

1. Keeping health inequalities at the forefront in times of change

Professor Bola Owolabi CBE, Chief Inspector of Primary Care and Community Services, Care Quality Commission

Overview

Professor Bola Owolabi framed health inequalities as a health, economic and societal challenge requiring sustained attention during a period of significant change across the health system.

She highlighted projections showing an increasing concentration of long-term illness within more deprived populations and drew a direct connection between poor health, economic participation and productivity.

Her presentation focused on two ways healthcare organisations and industry can contribute.

Use the organisation's role as an anchor institution

Organisations have influence through:

- employment, including creating routes into work for people who face barriers to participation
- procurement, using social value requirements to support health and economic outcomes

- estates, using organisational assets to strengthen skills, employment and community capacity.

The central point was that organisations already control resources and decisions that influence the wider determinants of health.

Use partnership to address inequitable access and evidence

Professor Owolabi also identified opportunities for partnership between industry, the NHS, NIHR and regulators.

She argued that broader participation in clinical trials improves the validity and applicability of research, while equitable uptake of proven innovations helps ensure their benefits reach the populations who need them. She also called for regulatory frameworks that require greater consideration of how medicines and devices perform across diverse populations.

The example of pulse oximeters performing differently on darker skin highlighted the potential consequences when product development and testing fail to reflect the population expected to use them.

Key insights

- Health equity has implications for economic participation and productivity as well as health outcomes.
- Employers, procurement teams and estate owners hold practical levers that can influence health inequalities.
- Greater diversity in research strengthens the applicability of evidence.
- Regulation can create stronger expectations for inclusive development and testing.
- Partnership between industry, the NHS, research bodies and regulators can support more equitable access to innovation.

If you only read one resource: [Rapid evidence review: Tackling inequalities through the regulation of services and organisations](#)

2. Health equity in medicines and device regulation

Ms Jenn Matthissen, Head of Gastrointestinal System, Nutrition, Endocrine & Fertility & Ms Lilly Wells, Senior Benefit Risk Evaluation Assessor, Medicines and Healthcare products Regulatory Agency

Overview

The MHRA presentation examined how health equity can be embedded across the full lifecycle of medicines and medical devices.

The agency identified three priority areas:

- equitable representation in clinical research
- innovation that responds to the needs of underserved populations
- inclusive regulatory activity throughout the product lifecycle

Improving representation in research

The HRA-MHRA guidance on inclusion and diversity plans requires researchers to consider whether trial populations reflect the people expected to benefit from the research.

This includes considering who experiences the disease or condition, whether the study design will produce generalisable findings and how underserved groups will be recruited and retained.

The MHRA also highlighted opportunities to use real-world data where historic trial participation has left evidence gaps. This includes using routine healthcare data and new analytical approaches to understand

outcomes across more representative populations.

Applying equity across innovation and regulation

For medical devices and AI, representative data is important to reduce the risk of technologies performing differently across population groups. The MHRA described work examining bias within AI-enabled medical devices and the safeguards needed as technologies continue to change after deployment.

The agency is also developing a more consistent internal approach through a formal EDI framework, stronger use of equality impact assessments and an agency-wide learning programme.

Women's health

Women's health was used as an example of persistent evidence gaps across the product lifecycle, including lower representation in early development and limited evidence for pregnant and breastfeeding women.

The MHRA's Women's Health Programme is focusing on better use of data, regulatory support for innovation, improved evidence for treatment decisions and stronger engagement with women.

Key insights

- Equity needs to be considered across research, approval and post-market monitoring.
- Trial populations should reflect the people expected to use the resulting product.
- Real-world data can help address gaps created by historic underrepresentation.
- AI and medical devices require representative development data and continued monitoring for bias.
- Regulators also need consistent internal capability to apply an equity lens in practice.

If you only read one resource: [Increasing the diversity of people taking part in research](#)

3. Innovation with integrity: partnership, disclosure and equity

Dr Amit Aggarwal, Executive Director, Medical Affairs and Strategic Partnerships & Mr Matthew Rose, Medical Policy and Disclosure UK Manager & Nabil Rastani, Strategic Partnership Policy Manager, Association of the British Pharmaceutical Industry

Overview

The ABPI presentation focused on how NHS-industry partnerships are governed and how transparency supports legitimate collaboration.

Joint working focuses on direct patient benefit, while collaborative working allows broader benefit across patients, healthcare organisations and participating companies. Both operate within the ABPI Code of Practice and wider NHS, legal and regulatory requirements.

Disclosure UK provides a searchable record of relevant payments and transfers of value from pharmaceutical companies to healthcare professionals and organisations. The presentation argued that transparency serves both public accountability and confidence in partnership working.

The discussion also recognised that

disclosure forms one part of a wider governance system, alongside regulatory approval, NICE processes, formularies and organisational conflict-of-interest arrangements

Key insights

- Cross-sector partnership can combine capabilities around defined health equity challenges.
- Clear governance should be established before delivery begins.
- Transparency helps make funding, relationships and potential conflicts visible.
- Disclosure works alongside wider safeguards and accountability mechanisms.
- Effective partnership depends on shared purpose and measurable outcomes.

If you only read one resource: [How to make sure patients get faster, more equitable access to innovative treatments](#)

4. The patient on research funding and equity

Ms Nicola Perrin, Chief Executive Officer, Association of Medical Research Charities

Overview

The Association of Medical Research Charities showed how funders can influence inclusion across the research lifecycle.

Charities are increasingly using funding criteria and assessment processes to encourage researchers to consider population diversity, focus research on underserved groups and describe how inclusion will be achieved. Some also require diversity data during project reporting.

Examples showed how this translates into practice.

Targeted investment can build research infrastructure in areas experiencing poorer health outcomes. Barts Charity, for example, is funding a new clinical research facility in Whitechapel that will bring early-phase trials into East London.

Practical changes to study delivery can also alter participation. Parkinson's UK supported research in East London using multilingual staff, translated assessment tools, community engagement and home appointments. The study recruited more Black and South Asian participants and generated findings that subsequently proved relevant to the wider Parkinson's population.

Participants reinforced this point through discussion of the cost and practical burden of travelling to research appointments.

Key insights

- Funding criteria can make inclusion part of research quality.
- Targeted funding can address specific evidence gaps and geographic inequalities.
- Practical costs such as transport and time can determine who is able to participate.
- Study design can improve both representation and the quality of resulting evidence.
- Patient involvement is most useful when it influences research upstream.

If you only read one resource: [Diversity, Inclusion, and Equity in Clinical Research Toolkit](#)

5. Equity in clinical trials

Dr Sheuli Porkess, President, Faculty of Pharmaceutical Medicine

Overview

The Faculty of Pharmaceutical Medicine presented findings from its work on making the UK a global leader in inclusive clinical trials.

The work identified continuing fragmentation despite progress, including gaps in data, system-level barriers, inconsistent leadership and the need for deeper engagement with underserved communities.

Its recommendations span the research system, including:

- regulatory support for more inclusive trials
- better demographic data
- more flexible trial design
- stronger primary care involvement
- sustained community engagement
- wider sharing of effective practice.

The presentation also described an evolution in thinking. Earlier work had focused heavily on processes and infrastructure. Subsequent discussions placed greater emphasis on understanding historical experience and working with communities as partners in research design and delivery.

Key insights

- Progress on inclusive trials remains fragmented.
- Better coordination is needed across regulators, funders, research infrastructure and sponsors.
- Demographic data is necessary to identify where participation gaps remain.
- Community engagement needs to influence research design as well as recruitment.
- Sharing practical learning can accelerate adoption of effective approaches.

If you only read one resource: [Advancing Clinical Trials: making the UK a global leader in inclusive clinical trials](#)

6. Improving diversity in clinical trials

Ms Esther Onyeka, Public Affairs & Policy Manager, Caribbean and African Health Network

Overview

The Caribbean and African Health Network (CAHN) brought a community perspective to research participation.

Its presentation highlighted how racial discrimination, limited representation in decision-making and weak investment in community engagement can influence participation in research.

CAHN argued for patient and community involvement throughout the research lifecycle, including study design, protocol development, recruitment and dissemination. Its offer to research partners includes trusted community access, culturally informed study design, recruitment and retention support, outreach and independent scrutiny of diversity plans.

This places community organisations in a broader role than recruitment alone. They can help research teams understand how culture, language, previous experience and trust affect the feasibility of a study before recruitment begins.

Key insights

- Community expertise should influence research from an early stage.
- Trusted organisations can improve access to populations conventional recruitment routes struggle to reach.
- Cultural understanding can strengthen study design as well as communication.
- Research partnerships need to recognise and resource the contribution community organisations make.

If you only read one resource: [Increasing diversity in research participation: A good practice guide for engaging with underrepresented groups](#)



Discussion

Equity needs to move upstream

Across regulation, funding and research delivery, the session repeatedly returned to the same issue: many barriers to participation are created before recruitment starts.

Eligibility criteria, research priorities, trial locations, funding decisions and protocol design can all determine who has a realistic opportunity to participate.

The strongest opportunity is therefore to build equity into these earlier decisions. HRA-MHRA inclusion and diversity plans provide one regulatory mechanism. Funding criteria provide another. Patient and community involvement can test assumptions during study development.

Participation is a pathway

Participants challenged the tendency to treat recruitment as the main measure of inclusion.

A representative recruitment target has limited value if people face financial, practical or communication barriers once they enter a study. Participants discussed travel costs, mobility, caring responsibilities and language, alongside the importance of supporting people throughout the trial.

This suggests research teams should consider the whole participant pathway, from awareness and consent through to completion and dissemination.

Trusted community partnership need to be built into research infrastructure

The examples shared during the session showed that trusted community relationships can materially change participation.

Effective approaches included multilingual teams, home visits, peer educators and community organisations involved in study design.

For example, a Kidney Research UK initiative using trusted peer educators increased Black and South Asian participation by working through people with shared cultural understanding and experience.

The implication is that community engagement needs appropriate time, funding and status within research delivery.

Different levers need to reinforce each other

A consistent message across the presentations was that inclusive research depends on alignment across the system. Regulation, funding, study design, research delivery, community partnership and data each influence different points in the pathway, but their impact is limited when they operate in isolation.

For example, stronger expectations on representation need to be matched by funding for practical participation costs, study designs that remove avoidable barriers and community partnerships established early enough to influence delivery. Data then needs to show where representation gaps remain and whether participation is becoming more inclusive over time.

The opportunity is to create greater coherence between these levers, so that equity requirements are supported by the resources, delivery models and accountability mechanisms needed to make them achievable in practice.



Recommendations and Actions

The actions below reflect where participants identified the greatest opportunity to improve equity of access through practical, collaborative change. They are intended to support collaboration, knowledge sharing, capacity building and co-creation across the stakeholder group.

1. Create a shared equity standard for research and innovation

Different parts of the system are already introducing equity requirements through regulation, funding, research design and community engagement. A common standard would help connect these approaches and create greater consistency across the research lifecycle.

Action

- Develop a cross-sector equity standard covering study design, population representation, participant access, community involvement and use of demographic data.
- Align the standard with existing HRA-MHRA inclusion and diversity requirements and relevant funder expectations, so organisations can work from a consistent set of principles.
- Use the standard at key decision points, including funding, protocol development, regulatory submission and evaluation, to identify where equity considerations need strengthening.

2. Build participation support into research funding and design

Travel costs, caring responsibilities, language, mobility and time can determine who is realistically able to participate in research. These should be planned for as part of delivery rather than addressed case by case once recruitment begins.

Action

- Build an expected participation-support allowance into research budgets, covering areas such as travel, interpretation, accessibility and caring costs where relevant.
- Ask funders and sponsors to identify likely participation barriers during study development and show how they will be addressed.
- Test alternative delivery routes, including home, community and local healthcare settings, where these could widen participation without compromising study quality.

3. Develop community research partnerships that can be used across studies

Community organisations can contribute trusted relationships, cultural understanding and practical insight that research teams may lack. Building these relationships repeatedly for individual studies is inefficient and limits the opportunity for communities to influence research at an earlier stage.

Action

- Develop longer-term partnerships between research organisations, funders and trusted community organisations in populations that remain consistently underrepresented.
- Fund community partners to contribute to research prioritisation, study design, recruitment, retention and dissemination, with their role agreed before individual trials begin.
- Capture and share which community partnership models improve representation and participant experience so successful approaches can be adapted elsewhere.

Additional resources

NHS England – tackling health inequalities

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Clinical trial diversity and inclusion

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