

Digital Inclusion as Health Equity: Learning from a Bevan Fellowship, Community of Practice and Rural Long-Term Condition Service

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1 Digital Inclusion as a Question of Equity

Digital health is often presented as a route to more accessible, efficient and flexible care. For people living in rural areas, this promise is real: remote appointments, online education, digital self-management resources and asynchronous communication can reduce avoidable travel and support people to engage at a time and pace that better fits their lives. However, the same digital shift can also deepen inequality if it assumes that everyone has suitable devices, stable connectivity, privacy, confidence, accessible information and the literacy needed to navigate health systems^{4,5}. **Digital inclusion therefore cannot be treated as an optional supplement to service delivery - it is part of the fairness of the service itself.**

The central argument of this paper is that digital inclusion, digital literacy and health literacy are interdependent conditions for health equity. People must be able to access services, but they must also be able to understand what is being offered, decide whether it is relevant, use it safely and continue to engage when life, symptoms or confidence fluctuate^{4,3}. This shifts attention from service availability to service usability. **A pathway can be technically open while remaining practically inaccessible** to people who lack transport, broadband, time, money, confidence, language support or trust.

2 Rurality, Long-Term Conditions and the Work of Access



Powys provides a particularly important context for this discussion. It is a large rural county with a dispersed population, limited public transport in many areas, cross-border health flows and no district general hospital within the county. **For people living with persistent pain, chronic fatigue, Long Covid or weight-related needs, the burden of access is not measured only in miles. It is also measured in planning, energy, symptom fluctuation, cost, confidence, information processing and the practical work needed to participate in care.**

Research on rural health access shows that distance interacts with deprivation, transport, workforce availability and service design. The inverse care law remains relevant: those with greatest need are often least able to secure timely and appropriate care. **Digital tools can reduce some of this burden, but only when they are designed around the realities of rural life**⁵. This links particularly to Marmot Principle 4 because digital and blended service design can reduce some of the practical costs of living with a long-term condition, including travel, time, energy and financial burden. A video appointment is not accessible if broadband is unreliable, if a person cannot use the platform, if written instructions are confusing, or if they do not have a private space in which to speak. Equally, an in-person appointment may be impossible if public transport does not align with clinic times, or if fatigue, pain or caring responsibilities make travel unrealistic.

3 Sources of Learning



- **The Bevan Fellowship being undertaken by the author, which provides the inquiry and service-design lens.** The Fellowship asks what makes a service accessible in a rural area and explores how teams can balance digital-first, digital-only and in-person provision.
- **The Digital Inclusion, Accessibility and Education Community of Practice creates a shared learning space across health, social care, local authority, education, accessibility, digital and third-sector partners.** Its value lies in turning isolated digital inclusion work into shared system capability. It allows practitioners to share examples, test assumptions, discuss barriers and build confidence in a psychologically safer environment.
- **The Powys Living Well Service (PLWS) offers a practical case study of inclusive, blended support for people living with long-term conditions in a rural area.** The service supports people with persistent pain, chronic fatigue, Long Covid and weight-related needs through multidisciplinary input, supported self-management, online learning, group programmes, one-to-one contact and digital facilitation. It demonstrates how digital access can be embedded within a wider model of care rather than treated as a separate project.



4 Digital Inclusion, Health Literacy and Digital Health Equity

The wider evidence supports this integrated view. Digital health literacy has been described as the ability to find, understand, appraise and use health information through digital technologies, and is associated with self-management, participation in decisions and quality of life^{2,3}. Reviews of digital health equity emphasise that **access to technology is only one part of the solution**. Equitable digital health also requires user-friendly design, supportive infrastructure, non-digital alternatives and educational support from professionals, peers, family members or community organisations⁵.

This evidence aligns strongly with the learning from PLWS and the Community of Practice. **Digital inclusion is not simply about enabling a person to log on to an appointment. It is about whether they can understand why the appointment matters, prepare for it, communicate effectively during it, remember or revisit what was discussed, and act on agreed next steps.** These tasks depend on digital literacy and health literacy working together^{4,3}. Where either is limited, the benefit of digital transformation is reduced and the risk of exclusion increases.

References

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5 Guided by Research: Bevan Fellowship

The **Bevan Fellowship** provides the structure for connecting practice, evidence and leadership. Its central question is deliberately practical: what makes an accessible service in a rural area? This question moves beyond whether a service exists and asks whether people can realistically use it. It invites multidisciplinary teams to examine who is reached, who struggles, who is missing from routine data and who may quietly disappear from view.

The Fellowship learning points towards a **citizen-first approach** to inclusive service design. This means **starting with people's circumstances rather than organisational pathways**. It asks teams to consider place, language, literacy, confidence, social support, transport, digital access, condition-related fluctuation and trust before assuming that a pathway is usable. Tools such as personas, user journeys, immersive simulation and reflective service review can help teams make hidden barriers visible and **test whether support feels coherent from the perspective of the person using it**.

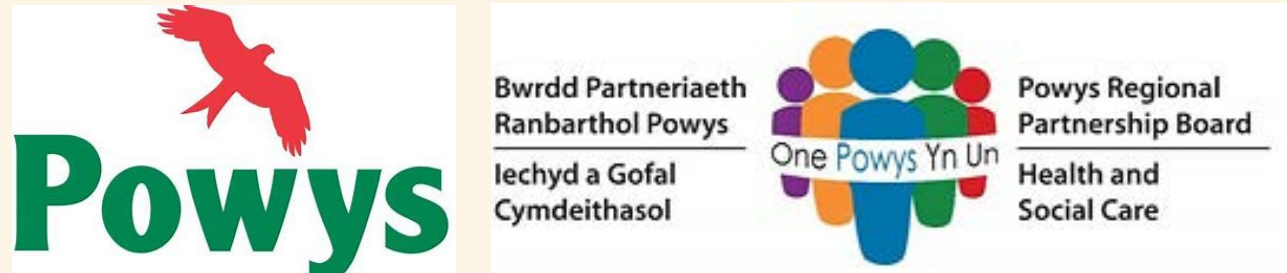
6 Powys Living Well Service: Citizen First

PLWS shows how a **citizen-first model** can be used to improve access while retaining the flexibility needed for equity. The service supports people with long-term conditions to live the lives they want by helping them manage their condition better, with a focus on persistent pain, chronic fatigue, ME/CFS, long COVID and weight issues. The multidisciplinary team includes physiotherapy, psychology, medicine, nursing, dietetics and occupational therapy, reflecting the reality that long-term conditions affect movement, mood, confidence, relationships and everyday participation as well as symptoms.

Digital facilitator roles are central to this approach. They help people build confidence to access virtual consultations, use platforms such as Attend Anywhere and engage with online resources before clinical contact.



Partnership working with libraries, local authority colleagues, accessibility organisations and third-sector partners extends this support beyond the clinical team, helping people access devices, connectivity, skills and confidence in ways that reduce stigma. This is important because **people often need practical support before they can benefit from clinical expertise delivered through a digital route**⁵.



The aim is not to replace human relationship or remove in-person care. Rather, it is to use digital tools where they reduce burden and support autonomy, while preserving telephone, face-to-face, facilitated and community-based options where those are needed. **This blended approach treats flexibility as an equity mechanism.**

7 From Isolated Effort to Shared Capability

The **Community of Practice** extends the learning beyond PLWS. **Digital inclusion barriers rarely sit within the control of a single service**. Connectivity, device access, accessibility, confidence, language, transport, trust and local support are distributed across different organisations and roles. A Community of Practice is therefore well suited to this work because it creates a relational infrastructure for shared problem-solving. It allows ideas to move between settings and helps practitioners recognise that similar barriers are being encountered elsewhere.

The Community also contributes to workforce development and psychologically safer learning. Digital inclusion work can feel uncertain because it asks staff to confront what they do not know, where their assumptions may be wrong and where standard pathways may unintentionally exclude people. **A regular cross-sector forum makes it easier to discuss these issues without locating responsibility in one profession or team - it strengthens shared capability, supports staff confidence and enables partners to work together on barriers that no single organisation can resolve alone.**⁴

8 Learning for Health Equity

- 1 **Digital inclusion is more than access to technology.** Devices and connectivity matter, but inclusion also depends on confidence, usability, accessibility, motivation, trust and support^{1,5}.
- 2 **Digital literacy and health literacy should be treated together.** People need to use digital tools in order to access health information, but they also need to understand and apply that information in their own lives^{2,3}.
- 3 **Blended care is not a compromise; it is a design principle for equity.** Digital options can reduce travel and increase flexibility, while non-digital options protect against exclusion.
- 4 **Inclusive digital transformation requires workforce confidence and shared learning.** Staff need opportunities to explore uncertainty, learn from others and understand the wider social determinants that shape access.
- 5 **Partnerships extend reach.** No single service controls the full set of barriers that determine whether people can use digital health support. Libraries, local authorities, accessibility organisations, voluntary groups and community networks can all help create the conditions in which digital health becomes usable rather than merely available, reducing practical barriers that affect everyday living and wellbeing.

9 Implications for Service Design

Services applying this learning should ask practical access questions: who is least likely to use the pathway, what assumptions it makes about literacy, transport, digital confidence, privacy, language, time and energy, and what support is offered before and after appointments. This reflects evidence that **equitable digital health depends on design, support and implementation, not technology alone**⁵, and translates Marmot Principle 4 into service-design terms by considering whether care reduces or increases the everyday burden of managing health.

Inclusive changes may be simple but deliberate: clearer letters, proactive calls, flexible appointments, transport checks, digital practice sessions, accessible bilingual information and referral routes into community digital support. **The key shift is cultural as well as technical: services should design and test access, rather than assume it exists once an appointment or webpage is available.**