

# Understanding Health Inequalities

Author: Mark Wightman

Trust Board paper F1

## Purpose of report:

This paper is for:	Description	Select (X)
Decision	To formally receive a report and approve its recommendations OR a particular course of action	X
Discussion	To discuss, in depth, a report noting its implications without formally approving a recommendation or action	
Assurance	To assure the Board that systems and processes are in place, or to advise a gap along with treatment plan	
Noting	For noting without the need for discussion	

## Previous consideration:

Meeting	Date	Please clarify the purpose of the paper to that meeting using the categories above
CMG Board (specify which CMG)		
Executive Board		
Trust Board Committee		
Trust Board		

## Executive Summary

The NHS is a hallowed institution. Public satisfaction with the NHS in 2019 climbed by 7% after two years of declining satisfaction and now 60% of the public are 'quite' or 'very' satisfied with NHS services, (Social Attitudes Survey 2019). These data look at a period before the pandemic and as such it is likely that the outpouring of support for the NHS epitomised by the 'Clap for Carers', will have increased public satisfaction or at least maintained it, despite the impact on waiting lists. However, not all parts of the population are equally satisfied with NHS services, for example white British respondents are more satisfied than those identifying as Asian and significantly more satisfied than respondents identifying as black or mixed race.

Equally the fact that COVID 19 has disproportionately affected Black and Minority Ethnic citizens is well known. Anyone who has seen the composite pictures of NHS staff who have died during the pandemic cannot help but be struck by the predominance of our black and Asian colleagues. This has in turn caused the NHS nationally and locally to consider what this reveals about the virus in epidemiological terms but perhaps more importantly what it has revealed about inequity in the NHS per se.

This short paper is predominantly concerned with inequity in the NHS in the widest sense, not least because we recognise that colleagues in the University Of Leicester Centre for Ethnic Health are leading nationally on the impact of COVID on BAME citizens.

The key message of the paper is that inequality is a structural issue for the NHS and therefore our approach to tackling it has to be set deep within our structures and planning.

## Questions

1. Do the Board agree that there is a structural element to health inequalities?
2. Do the Board agree with the approach being taken to understanding and tackling inequalities?

**For Reference:**

**This report relates to the following UHL quality and supporting priorities:**

**1. Quality priorities**

Safe, surgery and procedures	[Yes /No /Not applicable]
Safely and timely discharge	[Yes /No /Not applicable]
Improved Cancer pathways	[Yes /No /Not applicable]
Streamlined emergency care	[Yes /No /Not applicable]
Better care pathways	[Yes /No /Not applicable]
Ward accreditation	[Yes /No /Not applicable]

**2. Supporting priorities:**

People strategy implementation	[Yes /No /Not applicable]
Estate investment and reconfiguration	[Yes /No /Not applicable]
e-Hospital	[Yes /No /Not applicable]
More embedded research	[Yes /No /Not applicable]
Better corporate services	[Yes /No /Not applicable]
Quality strategy development	[Yes /No /Not applicable]

**3. Equality Impact Assessment and Patient and Public Involvement considerations:**

- What was the outcome of your Equality Impact Assessment (EIA)?
- Briefly describe the Patient and Public Involvement (PPI) activities undertaken in relation to this report, or confirm that none were required
- How did the outcome of the EIA influence your Patient and Public Involvement ?
- If an EIA was not carried out, what was the rationale for this decision?

**4. Risk and Assurance**

**Risk Reference:**

Does this paper reference a risk event?	Select (X)	Risk Description:
<b>Strategic:</b> Does this link to a <i>Principal Risk</i> on the BAF?		Risk 8 RE: Recovery
<b>Organisational:</b> Does this link to an		

<b>Operational/Corporate Risk</b> on Datix Register		
<b>New Risk</b> identified in paper: What <b>type</b> and <b>description</b> ?		
<b>None</b>		

5. Scheduled date for the **next paper** on this topic: [date] or [TBC]

6. Executive Summaries should not exceed **5 sides** [My paper does comply]

“Restore NHS services inclusively, so that they are used by those in greatest need”

The Phase 3 Planning letter sets out the task for the NHS in our recovery from the first wave of the pandemic. The fact that NHS services should be used by those ‘in greatest need’ would appear obvious.

The infographic below speaks to the point that ‘need’ is most often determined by socioeconomic factors such that people living in deprived areas have poorer health and shorter lives.

## The National Big Picture



### Socioeconomic Status

People living in deprived areas on average have poorer health and shorter lives. Research shows that socioeconomic inequalities result in increased morbidity and decreased life expectancy. The UCL Institute of Health Equity estimates 1.3 to 2.5 million potential years of life lost annually due to inequalities.<sup>10</sup>

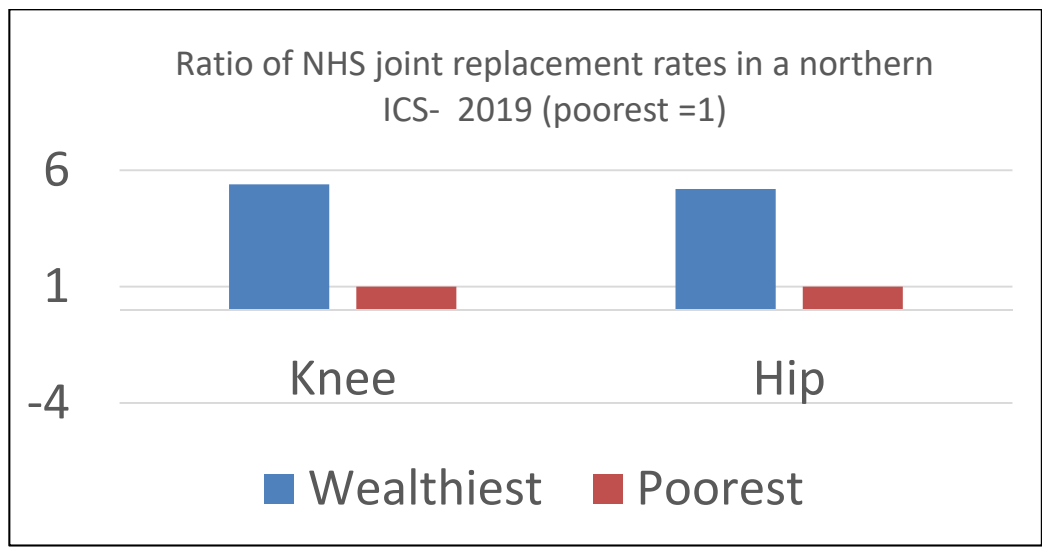
### Protected Characteristics

These are individuals’ characteristics protected by the Equality Act of 2010. Understanding these different characteristics can improve patient care in terms of health outcomes, access and experiences. There are 9 protected characteristics:

- Age
- Disability
- Gender reassignment
- Marriage and civil partnership
- Pregnancy and maternity
- Race
- Religion or belief
- Sex
- Sexual orientation

- The under 75 mortality rate from Cardiovascular Disease (CVD) is almost five times higher in the most deprived compared to the least deprived areas<sup>1</sup>
- People with learning disabilities are 4 times as likely to die of preventable causes<sup>5</sup>
- South Asians are up to 6 times more likely to develop type 2 diabetes<sup>6</sup>
- African-Caribbean and Asian females over 65 have a higher risk of cervical cancer<sup>2</sup>
- Suicide is currently the biggest killer of men under 35 in the UK<sup>7</sup>
- Lesbian and bisexual women are twice as likely to have never had a cervical smear test, compared with women in general<sup>3</sup>
- It is becoming more common for children to develop type 2 diabetes<sup>8</sup>
- Older people report receiving poorer levels of care than younger people with the same conditions<sup>4</sup>
- Muslim people report worse health on average compared to other religious groups<sup>9</sup>

That being the case there would logically be the expectation that those people living in deprived areas would be most likely to be able to access NHS services given that they are more likely to require them. However as the chart below suggests this does not appear to be the case.



The chart shows that hip and knee joint replacements, in other words, common procedures to address issues affecting very many people annually are not distributed as we would imagine. Specifically, that if we

take deprivation to be a reasonable predictor of need, then in this example the joint replacement rates are inversely proportional to the levels of deprivation. i.e. wealthier citizens are 4 times more likely to have the procedure than their poorer neighbours.

Moreover the data (from 'Future Commissioning' NHSE/I) suggest the gap is widening and it applies equally to, Diabetes care, Access to specialists, Cataracts, Smoking cessation.

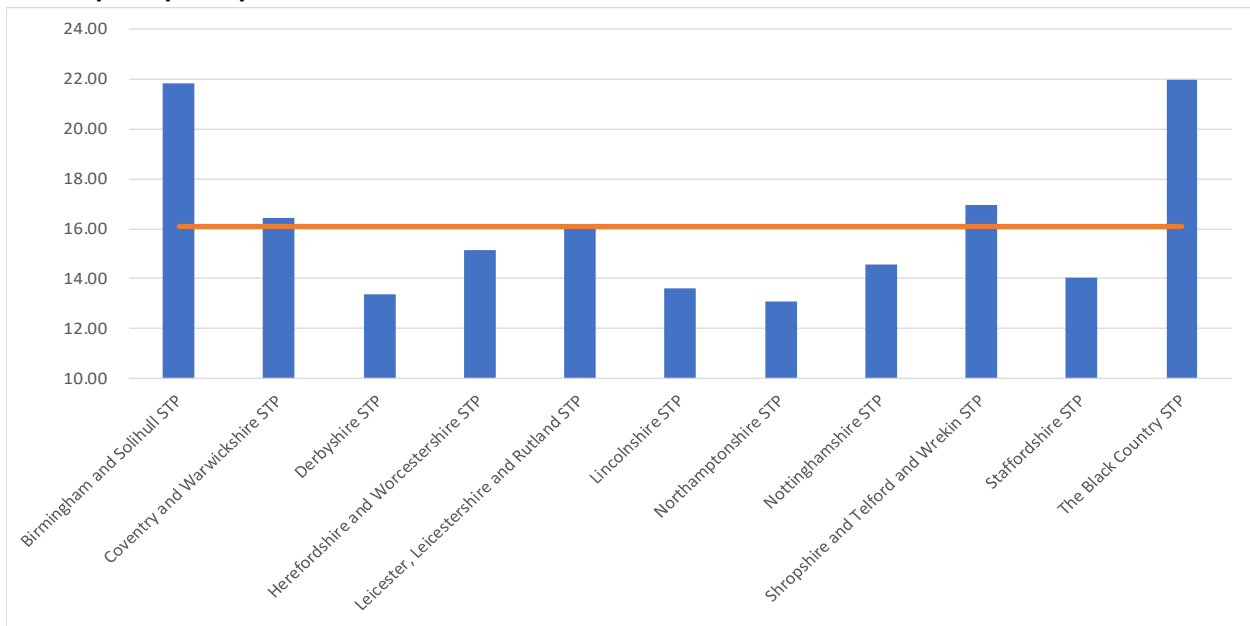
The next chart shows the difference in spend between Clinical Commissioning Groups, (CCGs) on particular diseases / procedures / treatments. The first two columns show the spend in £ millions per million of population and compares the lowest spending CCG with the highest spending. The final two columns show that the variation in spend between the financial year 2012/13 and 2017/18 rather than narrowing is actually getting wider.

2017/18	Lowest CCG spend £m/million	Highest CCG spend £m per million	Variation between highest and lowest 2017/18	Variation between highest and lowest 2012/13
Mental health disorders	97	310	3.2	1.9
Problems of the musculoskeletal system	44	153	3.5	1.9
Problems of circulation	54	117	2.2	1.6
Problems of the gastro intestinal system	61	108	1.8	1.4
Problems of the respiratory system	58	106	1.8	1.4
Problems of the genito urinary system	42	77	1.8	1.4
Problems due to trauma and injuries	23	79	3.4	1.6
Neurological	34	95	2.8	1.7
Cancers and tumours	22	93	4.2	1.9
Maternity and reproductive health	19	123	6.5	3.3
Endocrine, nutritional and metabolic problems	36	77	2.1	1.5
Problems of vision	19	63	3.3	2.1
Problems of the skin	22	47	2.1	1.6
Adverse effects and poisoning	10	27	2.7	1.6
Disorders of blood	7	19	2.7	2.2
Infectious Diseases	13	36	2.8	1.8
Healthy individuals	2	27	13.5	6.4
Problems of hearing	2	16	8.0	5.1
Conditions of neonates	1	12	12.0	12.1

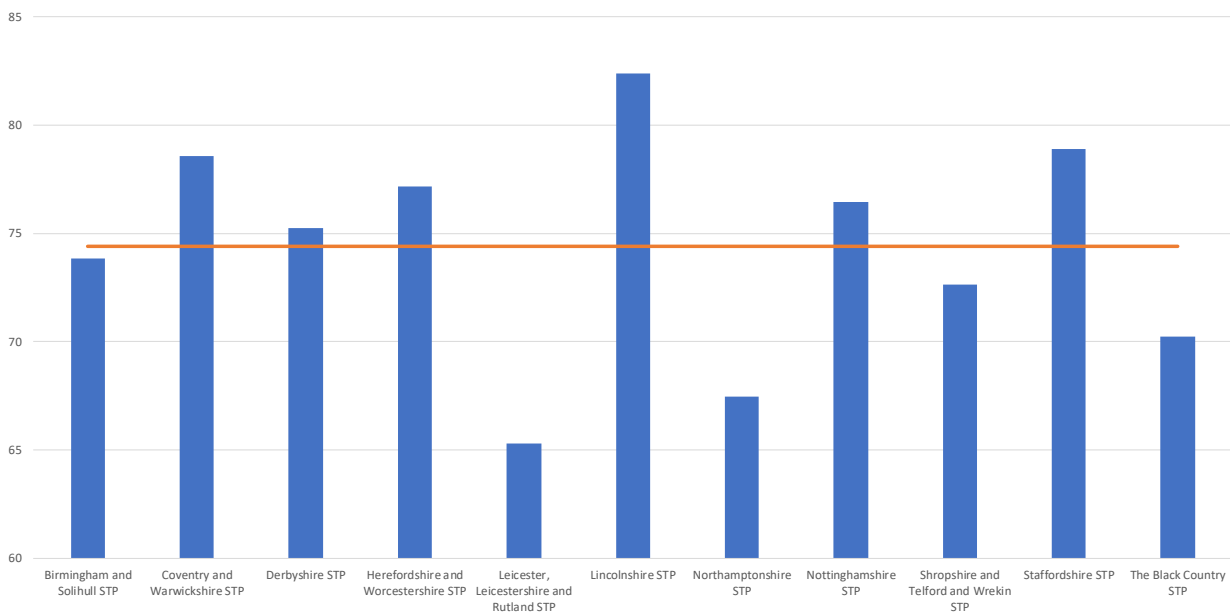
There are of course many factors in play here and the weighted capitation formulas that determine the funding for CCGs are designed to reflect CCG demographics; nonetheless the stark differences between highest and lowest spend and the widening gap suggest that something else is happening.

The next two charts compare the per capita spend (spend per head of population) *in our* neighbouring STP footprints on first renal and then cancer services.

**Renal Spend per capita:**



**Cancer Spend Per Capita:**



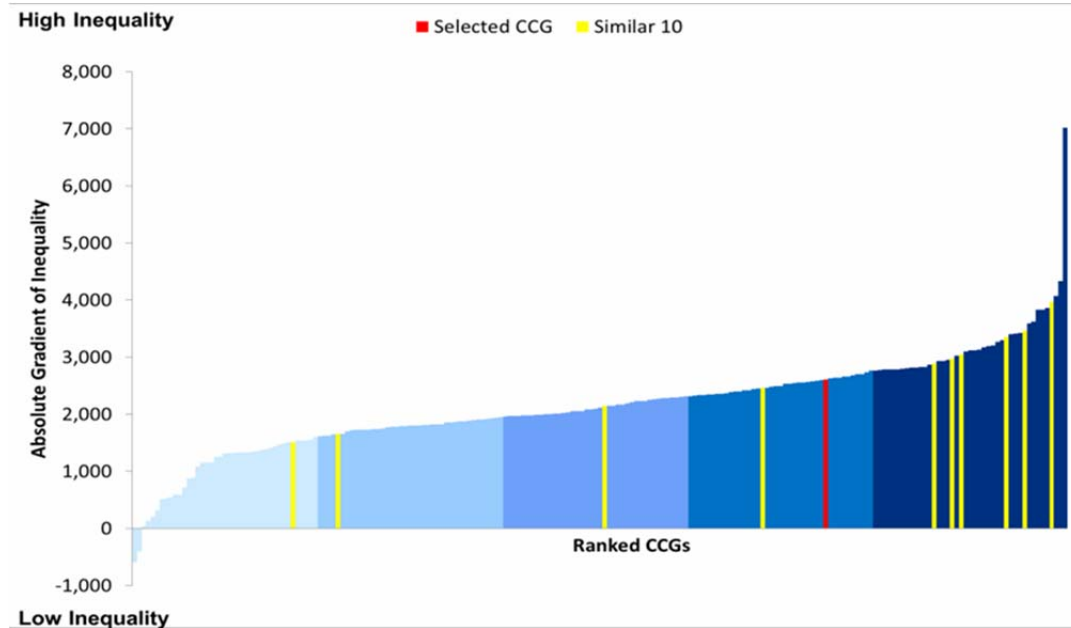
As before there will be many factors influencing the comparative spends in neighbouring STPs however whether that sufficiently explains the wide differences between economies is an interesting question.

The last two graphs in this section show the inequality in Leicester City CCG area in comparison to other CCGs nationally.

The method used to compare inequality is called 'The Absolute Gradient of Inequality', AGI. It maps a geographies population against indexes of deprivation and then compares the numbers of neighbourhoods that are considered deprived against, for example, the number of unplanned hospital admissions. As we

might expect the rate of unplanned admissions increases for each neighbourhood in line with relative levels of deprivation.

**Leicester City CCG AGI in comparison to peers:**



The chart shows that the City overall is in the top third of CCGs when the Absolute Gradient of Inequality is taken into account. And though at the start of this paper we said that the focus would be on health inequalities in the round rather than those which have become obvious as a result of COVID, it is nonetheless interesting to note that when the City CCG is compared to peer group, the list is familiar to anyone who has kept abreast of those areas of the country with higher rates of COVID and subject to interventions / enhanced support.

Rank	CCG Name	AGI
1	NHS Redbridge CCG	1,514
2	NHS Hillingdon CCG	1,657
3	NHS Sandwell and West Birmingham CCG	2,145
4	NHS Coventry and Rugby CCG	2,461
5	NHS Leicester City CCG	2,604
6	NHS Luton CCG	2,887
7	NHS Birmingham Crosscity CCG	2,973
8	NHS Bradford Districts CCG	3,046
9	NHS Blackburn with Darwen CCG	3,348
10	NHS Birmingham South and Central CCG	3,467
11	NHS Manchester CCG	3,972

The objective of the first part of this paper was to show that in considering health inequalities it is necessary confront the idea that there might be some fundamental and structural issues within the NHS that are perpetuating or worse still furthering the gap between the health haves and health have nots.

The second part of the paper looks at what we might do to address this.

**If inequality is at least in part structural, what are we going to do?**

There is a requirement for NHS organisations alongside other public sector bodies to carry out an Equalities Impact Assessment on any changes to policy or practice which might disadvantage certain groups.

“An Equality Impact Assessment (“EIA”) is an analysis of a proposed organisational policy, or a change to an existing one, which assesses whether the policy has a disparate impact on persons with protected characteristics.” (Cabinet Office 2020)

In essence the EIA is there to ask of the NHS, ‘Does the service change we are proposing disproportionately / adversely affect a certain group of our citizens?’ However, we might argue based on the data we have looked at above that this is entirely the wrong question to ask given that we have seen that the current disposition of NHS services and resource allocation already disproportionately disadvantages certain groups of our citizens. It would perhaps make more sense to invert the idea of an EIA from something that in process terms is carried out after a plan / policy has been devised (to check that no one is disadvantaged) into a proactive process that recognises that inequality exists and therefore expects planning and policy making to address the reasons.

So, rather than an ‘Equality Impact Assessment’ an ‘Inequality Improvement Action’.

Changes to enshrined legislation are clearly for others to consider but the principle of planning for proactive improvements to inequity versus reactive checks on impact underpins the approach we intend to take as the local NHS in Leicester, Leicestershire and Rutland.

#### **Expectations and Actions:**

As the Board know (and as covered elsewhere on this Board agenda). Colleagues in the system have been working on a series of Expectations and Actions that will define how we design an integrated care system in LLR. The extract below illustrates how the expectations and actions were designed to address at a fundamental level some of the inequity described in the first part of this paper

- We will ensure that physical and mental health have parity
- **We will direct resources to where there is greatest need based on population health data by 1<sup>st</sup> April 2021.**
- We will develop and implement standardised pathways for major conditions that improve outcomes, **reduce health inequalities and reduce unwarranted variation** by 31<sup>st</sup> March 2021
- We will use **population health management approaches to risk stratify** and segment our population
- We will work with our academic and research partners to focus on the risk factors for COVID-19 and develop appropriate interventions by 30<sup>th</sup> September 2020
- We will develop innovative ways of engaging with our population and we will always **involve patients** in shaping our transformational programmes
- We will produce **‘Place Based Plan’s** for the nine ‘places’ across Leicester, Leicestershire and Rutland by December 2020

For example, ‘directing resources to where there is greatest need’ will necessarily involve looking at e.g. commissioning budgets and ensuring that despite historic allocations, in future the resources will be allocated on a need basis informed by population health data. (i.e. access to elective hips and knees will reflect deprivation rather than wealth).



Similarly, when we and health economy partners are producing 'place based plans' we will recognise that not all places and indeed neighbourhood are the same.

**The LLR Triple Aim:**

Whilst the expectations and actions set out the major themes and approaches for the LLR system as we plan recovery and beyond, the Board will also be aware that as a component of the revised system governance arrangements a number of 'Design Groups' are being established to redesign pathways and services.

The LLR Triple Aim sets out that the key focus for the design groups, which are:

- **Reducing inequalities**
- Improving outcomes and wellbeing
- Restoring the system's finances

Thus the expectation is that the design groups will develop a clear understanding of which neighbourhoods, population cohorts have poorer access and /or outcomes and how we plan to address those issues.

There is a lot of work involved in this not least because to develop a clear understanding of inequity in both *access* to services and *outcomes* post treatment / intervention, will require UHL and the wider system to either change or at the very least, enhance some of the traditional metrics we measure.

For example: (and with an acute focus)

Q. Are there differences in referral rates for elective procedures between white British and BAME / between most deprived and least deprived neighbourhoods?

Q. Are there differences in conversion rates from first outpatient appointment to treatment between neighbourhoods / ethnicities?

Q. What is the nature of a waiting list in a particular service, does it reflect the demographics of our local population?

Q. Do post-operative revision rates / complications occur more in certain demographics than others?

We do not know the answers to these questions yet and further still we do not know whether they are the right questions to ask. BUT will be working on the principle that being actively inquisitive in order to understand where inequity might exist has to form the basis of developing an approach to tackle it.

**Summary:**

Bevan's original vision for the NHS that it would meet the needs of everyone, be free at the point of delivery and be based on clinical need, not ability to pay has stood the test of time. However, it does not follow that because the NHS is freely available to all that 'all' have equal access or indeed outcomes. Access in itself is determined by amongst other things, a person's sense of right and entitlement and if that sense is diminished as a result of socioeconomic factors and lived experience then access cannot be equitable. Recognising this and

seeking to understand where inequalities exist in a planned and systematic way has to inform the planning of our services and the wider health system. That work starts now.

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