HFMA briefing
May 2023

Health inequalities

Establishing the case for change

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Introduction

Inequalities in health can drive demand for NHS services. Avoidable differences between population groups can impact the prevalence of conditions, and the ability and willingness of people to seek treatment prior to crisis. At a time of intense demand on the NHS, significant financial pressure, and critical workforce shortages, all efforts should be made to address the avoidable factors that contribute to ill health.

This briefing will support NHS finance staff to make the case for change within their organisation and local system. It not only covers the financial and economic cases for change, it also considers moral and social issues and their significance to different population groups. Throughout the briefing, relevant research is highlighted to understand the potential impact of inequality and disparities in health on the NHS. While the focus is mainly on England, the information in this document can be used more widely and is also relevant for NHS finance staff working in Scotland, Wales and Northern Ireland.

The HFMA is working on a range of briefings and online learning modules to enable NHS finance staff to support their organisation to tackle health inequalities. This work builds on existing HFMA resources including *The role of the NHS finance function in addressing health inequalities*[1] and a *Health inequalities data sources map*[2].

This briefing is part of a series of publications focusing on the finance role in reducing health inequalities. Future briefings will cover the inclusion of health inequalities funding in the allocation of resources, business cases aimed at health inequalities improvement, and examples of how finance teams are supporting their organisations to address health inequalities. There will also be a series of detailed case studies providing insight into some of the challenges faced by organisations, how they overcame these challenges, and how others can learn from them.

What are health inequalities?

Health inequalities are often thought to relate to levels of deprivation. While socio-economic status can be a key driver, inequalities in health and access to, and experience of, care can occur for many reasons. NHS England has described health inequalities as unfair and avoidable differences in health across the population and between different groups within society[3]. Health inequalities arise because of the conditions in which we are born, grow, live, work and age. These conditions influence our opportunities for good health, and how we think, feel and act. This shapes our mental health, physical health and wellbeing.

Health inequalities are often analysed and addressed by considering the four types of factors set out below.

Socio-economic factors

Socio-economic factors are frequently referred to as the wider determinants of health. These are the conditions that shape people's lives through their education, employment, housing and a multitude of other factors.

People's lives are multi-faceted and these factors cannot be considered in isolation, indeed it is essential that the cumulative impact is recognised. For example, the level of education received can impact a person's employment, which in turn drives the income that can be received, which determines where they are able to live. The circumstances in which a person lives can dictate the shops that they can access, and hence their diet, and the green spaces that are available for

[1] HFMA, *The role of the finance function in addressing health inequalities*, June 2021
[2] HFMA, *Health inequalities data sources map*, November 2022
[3] NHS England, *What are healthcare inequalities?* January 2021

recreation and exercise. People's children will then be born into these circumstances, which are likely to have an impact on the future that they can expect.

Research by The King's Fund[4] considers the health impact for a number of these factors, set out in table 1, below.

Table 1: Selected impacts of wider determinants on health inequalities

Sector	Examples
Income	• Income determines people's ability to buy health-improving goods, from food to gym memberships. Living on a low income is a source of stress and emerging neurological evidence suggests that being on a low income affects the way people make choices concerning health-affecting behaviours. • Children from households in the bottom fifth of income distribution are over four times more likely to experience severe mental health problems than those in the highest fifth.
Housing	• Poor-quality and overcrowded housing conditions are associated with increased risk of cardiovascular and respiratory diseases, depression, and anxiety. • Households from minority ethnic groups are more likely than white households to live in overcrowded homes and to experience fuel poverty.
Environment	• Access to good-quality green space is linked to improvements in physical and mental health, and lower levels of obesity. Access to green spaces is lower on average for people from ethnic minority communities and people living in areas with lower average incomes. • Exposure to air pollutants is estimated to cut short 28,000–36,000 lives a year in the United Kingdom. Differential levels of exposure are associated with both deprivation and ethnicity.
Transport	• Those living in the most deprived areas have a 50% greater risk of dying in a road accident compared with those in the least deprived areas. Children and young adults in the most deprived areas are more likely to be killed or injured on the road than those in wealthier areas.
Education	• On average among 26 Organisation for Economic Co-operation and Development countries, people at age 30 can expect to live over five years longer than people with lower levels of education.
Work	• Unemployment is associated with lower life expectancy and poorer physical and mental health, both for unemployed individuals and their households. In 2019/20, employment rates in the least deprived decile were 81.5%, compared to 68.4% in the most deprived decile. • The quality of work, including exposure to hazards and job security, determines the impact that work has on health. People from minority ethnic backgrounds experience higher levels of work stress than those from white groups.

Geography

Geographical factors can have a significant impact on health inequalities and are intrinsic within the socio-economic factors described above. However, geography can create new inequalities. For example, poor transport links in rural areas can limit people's ability to attend appointments, or to have the support of their family while in hospital or after discharge. Dispersed services can reduce choice around the care available for rural communities, whereas the density of NHS provision in urban areas can allow people greater advocacy in their care.

[4] The King's Fund, *What are health inequalities?* June 2022

In 2021, the chief medical officer, published a report[5] considering the health challenges for coastal communities. He noted that this geography particularly attracted an older population which needed more care, but also had challenges around declining employment and poor housing in many cases.

Specific characteristics

Health inequalities can also be linked to specific characteristics, such as those protected in law, including sex, ethnicity, or disability.

As an example, some ethnic groups can be more prone to particular health issues, for example people from Black African, African Caribbean and South Asian backgrounds are at a higher risk of developing type 2 diabetes from an earlier age[6]. This is an unavoidable health difference. However, the inequality arises if this difference is not considered in service design and delivery, leading to an inequality of care for diabetics of this ethnicity.

In 2022, the Department of Health and Social Care (DHSC) published the first *Women's health strategy for England*[7] which states that women spend a greater proportion of their lives in ill health and disability when compared with men. It also recognises that, historically, the health system has been designed by men for men. This has led to inequalities in the effectiveness of treatments for women and a lack of research into female only health issues, such as menopause and endometriosis.

Socially excluded groups

Socially excluded groups cover people such as those experiencing homelessness, those dependent upon drugs or alcohol, sex workers, and people in contact with the justice system. People within these groups often experience significantly poorer health than the general population, which can frequently be linked to the way in which services are provided. Standard NHS services expect people to have a fixed address, to be contactable via phone or email, to be proactive in seeking care, and to be available to attend appointments during the normal working day. This creates inequality through inadvertently denying access to healthcare.

Recent challenges for health inequalities

Health inequalities have always existed, however they are worsening. In 2020, Sir Michael Marmot updated his health equity study looking at inequalities in England[8]. He found that since his work in 2010:

- people can expect to spend more of their lives in poor health
- improvements to life expectancy have stalled, and declined for women in the most deprived 10% of areas
- the health gap has grown between wealthy and deprived areas.

The Covid-19 pandemic further exacerbated inequality and highlighted the unequal impact of the disease on different population groups, some of whom were not previously thought to be an at risk group. This has led to positive developments in national policy prioritisation and local understanding of the issues for the population and the groups most impacted.

However, the recent cost-of-living crisis has further worsened the socio-economic inequalities that drive many health disparities. In Autumn 2022, NHS Providers surveyed[9] executive directors and chairs to gather their collective views on the impact of the cost-of-living crisis for the health and care

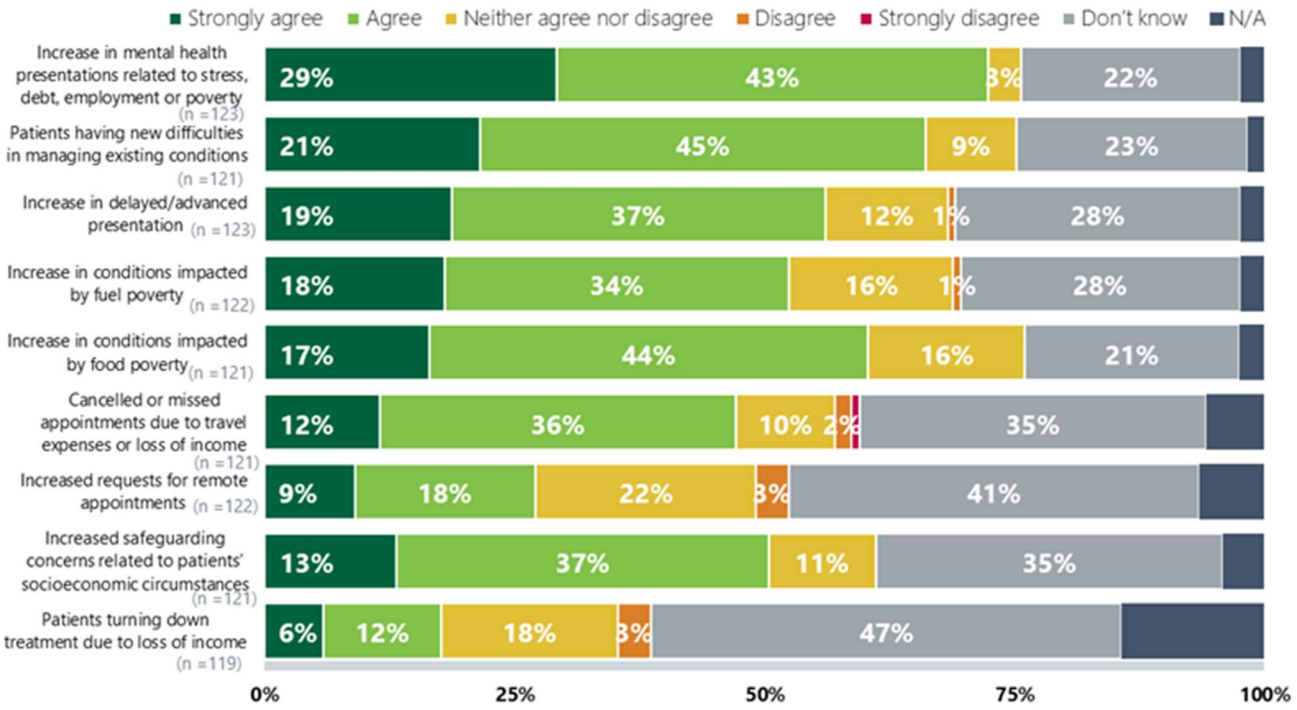
[5] Department of Health and Social Care, *Chief medical officer's annual report 2021: health in coastal communities,* July 2021
[6] Diabetes UK, *Ethnicity and type 2 diabetes,* 2021
[7] Department of Health and Social Care, *Women's health strategy for England,* August 2022
[8] Institute of Health Equity, *Health equity in England: the Marmot review 10 years on,* February 2020
[9] NHS Providers, *Rising living costs: the impact on NHS, staff and patients,* September 2022

sector. Some 95% of trust leaders stated that the rising cost-of-living had significantly, or severely, worsened health inequalities in their local area.

Figure 1, below, shows the impact on service access that was noted by the survey respondents, due to the rising cost-of-living. This is a stark demonstration of the multiple impacts of inequalities on demand for healthcare and the inter-relatedness of many disparate factors.

The effects seen suggest that the severity of conditions is likely to increase as circumstances cause them to worsen, but people are unable to attend appointments or afford the related prescriptions. This has a direct impact on people's quality of life, ability to attend school or work and be an active member of society. It will also create the future crises that will impact on the NHS and wider care sector.

Figure 1: Effect of the cost-of-living on how people access services



Making the case for change

'Illness is neither an indulgence for which people have to pay, nor an offence for which they should be penalised, but a misfortune, the cost of which should be shared by the community.'

Aneurin Bevan

The preceding sections have set out the broad impact of health inequalities, most of which is widely known and discussed. However, making the case for longer term change during a period of extreme pressure for the NHS, with short term recovery targets, is very challenging.

The key to developing a successful case for change is to understand the local population and the groups within it, some of whom may be hidden within larger groupings that appear to have little inequality. As an example, 93.2% of people in England over the age of 70, have received at least one dose of the Covid-19 vaccine[10]; this is a significant proportion and suggests that the vaccination programme was successful for the majority of people. However, when that data is analysed further, it can be seen that it was less successful for particular ethnic groups, with only 67.2% of black African over 70s receiving the vaccine. Drilling down into local population data to understand where variation exists, is an essential part of developing the case for change.

[10] BMJ Open, *Sociodemographic inequality in COVID-19 vaccination coverage among elderly adults in England: a national linked data study,* July 2021

The moral principle of addressing avoidable differences that are largely preventable in terms of access and treatment for patients cannot be disputed. Access to healthcare and achievement of good outcomes should not be dependent upon where a person lives, their income, their ethnicity or any other factor. But, however compelling the moral case is, taking action is often hampered by financial or political constraints.

This section sets out the imperatives for change across these two key areas for NHS finance staff; policy and finance. It describes the high-level quantitative research which can support a case for change and suggests how this can be applied at a local level, linking to the short term targets that are currently driving NHS activity.

In considering these imperatives, it must be noted that doing nothing is also a choice that has consequences for all aspects of the NHS. Doing nothing does not maintain the status quo, it merely ignores the issues and associated problems.

The policy imperative

The *Health and Care Act 2022*[11] (the Act) set out a triple aim for the NHS to have regard to the wider effect of any decisions made, that could impact:

- the health and wellbeing of the people of England
- the quality of health services provided
- efficiency and sustainability across the NHS.

The first two aspects of this triple aim are also required to consider the impact on inequalities, setting a legal requirement on NHS bodies to address this area in their provision of services.

The inclusion of inequalities within the Act, gives a legislative basis and obligation to the work that has been ongoing for a number of years within the NHS to encourage and enable organisations to address inequalities. This work has become more high profile since the Covid-19 pandemic.

- The Act further introduces a range of obligations on NHS bodies in relation to health inequalities including a duty to promote integration, provide a new quality of service duty. Integrated care boards (ICBs) will also be subject to an annual assessment that will look into how well they have discharged their functions in relation to a range of matters including reducing health inequalities, improving quality of service and public involvement and consultation.
- Underpinning the national NHS objectives for 2023/24[12] is the following statement from NHS England, 'as we deliver on these objectives, we must continue to narrow health inequalities in access, outcomes, and experience, including across services for children and young people.' The objectives also include a requirement to 'continue to address health inequalities and deliver on the Core20PLUS5 approach'.

Core20PLUS5

The Core20PLUS5 approach[13], developed by NHS England, is a national approach to inform action to reduce healthcare inequalities at both national and local system level.

The approach is focused on action in the following areas:

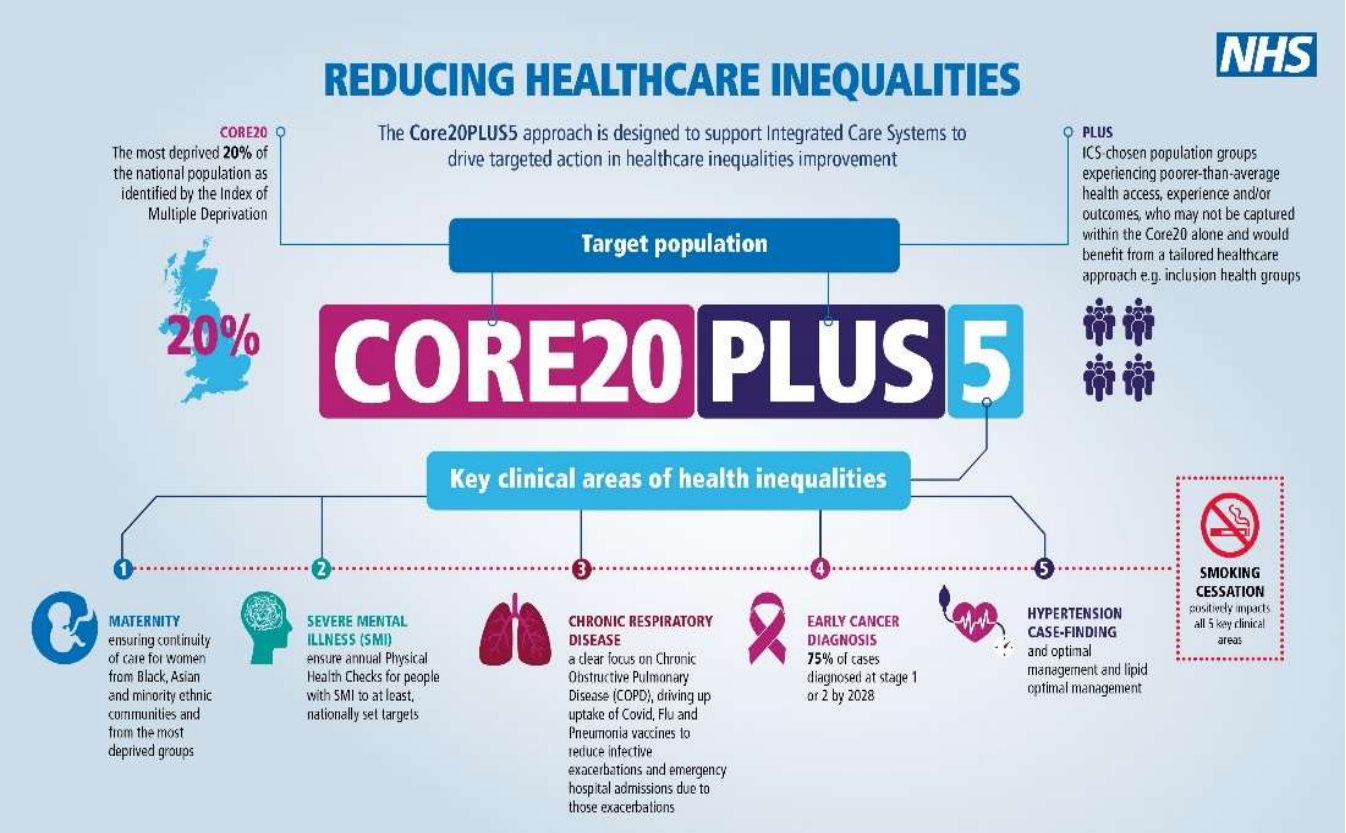
- Core20: the most deprived 20% of the national population as identified by the national *Index of multiple deprivation*[14].
- Plus: ICS-determined population groups experiencing poorer than average health access, experience, or outcomes – this area should be informed by ICS population health data and may include socially excluded groups, groups with protected characteristics, or pockets of

[11] UK Government, *Health and Care Act 2022 (part 1, section 8),* April 2022
[12] NHS, *2023/24 priorities and operational planning guidance,* January 2023
[13] NHS England, *Core20PLUS5 – an approach to reducing healthcare inequalities,* 2023
[14] Ministry of Housing, Communities and Local Government, *English indices of deprivation 2019,* September 2019

deprivation hidden within areas of relative affluence. This element allows it to be tailored to local need.
- 5: a focus on five specific clinical areas where significant improvement is needed nationally.

Figure 2 gives a graphical representation of the approach for adults. A similar model for children and young people focuses on an alternative five clinical areas: asthma, diabetes, epilepsy, oral health, and mental health.

Figure 2: Core20PLUS5 approach for adults



The Core20PLUS5 health inequalities policy expects local leaders to make choices about which areas to focus on in reducing inequality, within an overall framework set by NHS England. This ensures that a balance is achieved between national consistency and local need.

Working with local authority partners

The policy imperative to reduce health inequalities does not just sit with the NHS. Local authorities also have legal duties in this regard and form part of the wider integrated care system (ICS) to deliver them through partnership working. The public health grant specifically states that a local authority must have regard to the need to reduce inequalities between the people in its area.

The various Acts that govern the work of local authorities also add to the imperative:

- the *Health and Social Care Act 2012*[15] requires local authorities to take steps to improve the health of their population
- the *Care Act 2014*[16] states that local authorities must provide or arrange services that prevent people developing needs for care and support
- the *Social Value Act 2012*[17] requires public sector commissioners, including local authorities and the NHS, to consider economic, social, and environmental wellbeing in the procurement of services or contracts. This directly relates to addressing some of the wider determinants of health.

[15] UK Government, *Health and Social Care Act 2012,* 2012
[16] UK Government, *Care Act 2014,* 2014
[17] UK Government, *Public Services (Social Value) Act 2012,* 2012

Tackling health inequalities requires a multi-faceted approach which recognises the complex nature of people's circumstances. Making the case for change as a system to utilise multiple resources and meet the objectives of all partners, is likely to be more successful than working individually.

The financial imperative

In 2016, researchers at the University of York calculated that socio-economic inequalities cost the NHS acute sector £4.8 billion each year[18]. Data showed that people living in the most deprived fifth of neighbourhoods had 72% more emergency admissions and 20% more planned admissions, than those living in the most affluent fifth of neighbourhoods.

In 2021, the British Red Cross estimated that high intensity usage of A&E, closely associated with health inequalities, cost the NHS £2.5 billion per year[19].

These national level reports show the significant financial impact that health inequalities can have for the NHS and, in turn, suggest areas of focus for individual trusts and their systems. Many organisations are impacted by the reduction in Covid-19 funding in 2023/24 compared to 2022/23, and face growing inflationary pressures coupled with a challenging efficiency target. It is vital for NHS bodies to reduce unnecessary cost in order to continue to deliver a full range of services.

Unnecessary costs linked to health inequalities can arise in the NHS for a variety of reasons, such as:

- missed appointments due to working patterns or transport availability
- emergency admissions through a lack of preventative care
- inappropriate service usage, for example A&E attendance for minor ailments as the only option
- exacerbation of conditions due to poor living standards.

Considering these unnecessary costs, the recent Hewitt review further recommends that ICS funding going towards prevention should be increased by at least 1% over the next five years[20].

A number of NHS organisations have already begun to look at the trends in their trusts due to some of the above factors[21].

Northern Care Alliance NHS FT

Analysis of the costs of A&E attendances in Oldham in summer 2021

- average cost per head was significantly higher for patients from the two most deprived deciles
- 46% of the population live in the two most deprived deciles but account for 60% of attendances and 59% of total cost
- if cost per head was reduced to the average, potential savings of £2.2m (13% of costs)

Alder Hey Children's NHS FT

Costs of asthma

- analysis carried out for each decile of deprivation
- education, skills and training appears to have the biggest impact
- trust spent £2.17m more than expected over 5 years on patients in the bottom decile of deprivation

Leeds Teaching Hospital NHS Trust

Using patient level cost data to analyse outpatient attendances

- outpatient data interrogated to understand data such as age, deprivation, and ethnicity
- analysis of adult hepatology showed most deprived decile had a non-attendance rate of 20%
- least deprived decile had a non-attendance rate of 6%

[18] University of York, *The costs of inequality: whole-population modelling study of lifetime inpatient hospital costs in the English National Health Service by level of neighbourhood deprivation*, May 2016
[19] British Red Cross, *Nowhere else to turn,* November 2021
[20] Rt Hon Patricia Hewitt, *The Hewitt review: an independent review of integrated care systems*, April 2023
[21] HFMA, *Using cost data to address health inequalities,* April 2022 (NB for Healthcare Costing for Value members only)

Knowing that these differences exist, enables questions to be asked and action to be taken. In some cases this has been as simple as changing clinic times or locations, or providing transport to support attendance. Some of this work has also supported prediction of who is likely to miss an appointment, enabling additional reminder calls to be made and support to be offered.

Developing a case for change to address health inequalities can appear to be a daunting prospect, however the examples above show that a significant difference can be made through small changes, once the problem is understood. Making the case specific to the local issues, makes it more compelling.

Waiting lists are a key area of focus for the NHS as the service seeks to recover to pre-Covid activity levels. When Calderdale and Huddersfield NHS Foundation Trust focused on this area[22], it found that patients from ethnic minority groups were waiting 15.2 weeks for an operation that should be performed within a month. This was 7.2 weeks longer than white patients. Work around communication, asking what support might be needed to attend an appointment, and improving staff awareness, led to a waiting time of 4.4 weeks for all groups within nine months. This demonstrates that work to improve health inequalities can lead to improvements for the whole population.

As the population ages, long term conditions become more prevalent. However, this prevalence tends to vary with levels of deprivation, with people living in less affluent areas not only being more likely to have a condition but to have problems 10-15 years earlier than people living in more affluent areas[23].

Analysis carried out by Cambridgeshire and Peterborough ICS[24] on their 65+ population, showed that there were 91,000 people living with a chronic condition in 2022. The average annual health cost for each patient was £707, the majority of which related to non-elective admissions. Population growth predictions suggest that this number will increase to 143,000 by 2041, creating an additional annual cost of just under £37 million. Based on the majority of this cost relating to non-elective admissions, it is also anticipated that a further 800 beds would be needed to meet the associated demand. This is the cost of doing nothing about a known issue that is, in part, driven by socio-economic inequalities.

Developing the local case for change

This briefing has set out a high-level overview of what health inequalities are and the impact that they can have on people's health and the care that they receive. It has shared national research giving the financial implications of doing nothing, plus local case studies of where changes have been made. Drawing these together, there are a number of steps to go through to develop an effective local case for change, as a finance professional.

1. Identify the specific financial, or performance, pressures for the organisation and work with business analytics colleagues to develop the underlying activity data.
2. Overlay deprivation, geographical, and protected characteristic data to the activity information and determine any trends and correlation.
3. Use costing data and other financial information to estimate the impact of delivering an equitable service.
4. Identify national policy drivers, or local priorities, that would support further work to be done in this area.
5. Find a clinical champion within the organisation to support the work.
6. Work with system partners to understand if they are seeing similar impacts or have related issues.

Addressing health inequalities is vital for the future sustainability of the NHS. Finance staff have a key role to play as an enabler for this, but can also be part of driving the change that is needed.

[22] HFMA, *Healthcare Finance: Our business,* March 2022
[23] The King's Fund, *Long-term conditions and multi-morbidity,* 2012
[24] Cambridgeshire and Peterborough Integrated Care System, *ICS strategy development: key areas,* 2022

About the HFMA

The Healthcare Financial Management Association (HFMA) is the professional body for finance staff in healthcare. For over 70 years, it has provided independent and objective advice to its members and the wider healthcare community. It is a charitable organisation that promotes best practice and innovation in financial management and governance across the UK health economy through its local and national networks.

The association also analyses and responds to national policy and aims to exert influence in shaping the wider healthcare agenda. It has particular interest in promoting the highest professional standards in financial management and governance and is keen to work with other organisations to promote approaches that really are 'fit for purpose' and effective.

The HFMA offers a range of qualifications in healthcare business and finance at undergraduate and postgraduate level and can provide a route to an MBA in healthcare finance. The qualifications are delivered through HFMA's Academy which was launched in 2017 and has already established strong learner and alumni networks.

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