The role of the NHS finance function in addressing health inequalities

July 2021

Introduction

The NHS has been legally required to tackle health inequalities since the introduction of the Health and Social Care Act 2012 but, since the Covid-19 pandemic, the focus on health inequalities has dramatically increased. The unequal impact of the pandemic across different sectors of society has highlighted existing inequalities and potentially created new ones. This is recognised in the 2021/22 planning guidance[1] which requires NHS bodies to specifically address health inequalities in elective recovery plans and accelerate preventative programmes for groups at the greatest risk of poor health outcomes.

This short paper considers what is meant by health inequalities, what causes them and the impact that they can have on people's health and the NHS. It considers the role that NHS finance staff can play in tackling inequalities and introduces a new HFMA programme of work to support members in this endeavour.

What is meant by health inequality?

The term health inequality is used to cover many different things. At its simplest level it relates to the differences between peoples' health, we do not all have the same level of health, so we are therefore unequal. However, it is more commonly used to highlight those things which cause our health not to be equal such as inconsistent access to services, lifestyle factors such as smoking, or socio-economic effects such as poor nutrition or inadequate housing.

The *NHS constitution*[2] sets out that, in order to provide a comprehensive service, available to all, the NHS has *'a wider social duty to promote equality through the services it provides and to pay particular attention to groups or sections of society where improvements in health and life expectancy are not keeping pace with the rest of the population.'*

[1] NHS, *2021/22 priorities and operational planning guidance: implementation guidance*, March 2021
[2] Department of Health and Social Care, *The NHS constitution for England'*, January 2021

It is easy to conflate health inequalities with deprivation and poverty. While these factors will often have a significant impact on people's health, it is important not to assume that these are the only drivers of health inequality. Different types of health inequality are set out below[3].

Inequalities in access

Health inequality can relate to access to services. During Covid-19, digital exclusion has come to the fore, meaning that some people cannot access virtual consultations as they may not have the appropriate technology or may be unable to use it. This could be due to a diverse range of factors such as internet availability in rural locations, a distrust of technology, as well as the more commonly accepted reason of not being able to access the appropriate equipment.

Access to services can also be limited by culture. The Covid-19 vaccination programme has highlighted the unwillingness of some groups to come forward to be vaccinated due to misconceptions around the vaccine. Language barriers can also mean that people cannot fully engage in their care as they cannot understand the information that is shared.

> ***For it to be successful, those responsible for the vaccine rollout need to ensure that the public are sufficiently capable, have sufficient opportunity, and are sufficiently motivated to take the vaccine.***
>
> ***Capability is about having the knowledge and skills to take up the vaccine. For example, some people might not have had enough information to convince them that the vaccine is safe. They may not know when, where and how to get the vaccine. Or they may not be able to make plans to have the vaccine.***
>
> ***Opportunity is about having the necessary conditions to take up the vaccine. For example, someone might not have the encouragement or social support from family and friends. Or the vaccine might not be available in their region, so they don't have the opportunity to be immunised.***
>
> ***Motivation is about having the desire to have the vaccine. For example, some people might not believe the vaccine will protect them from COVID-19, or they may not be able to overcome their fear of needles.***
>
> *COVID: The three barriers that stop people being vaccinated*
> *Tracy Epton, University of Manchester, June 2021*

Practical reasons can limit access to healthcare. For example, the times when services are open or the physical location of care, may also exclude those with unusual or erratic working patterns or in remote locations. Access can also be limited by physical disability. While the clinic itself may be fully accessible, public transport links or car parking may not be as straightforward to navigate.

Inequalities in life expectancy

Life expectancy is closely linked to deprivation. Looking at how long people live can indicate broader socio-economic inequalities, with boroughs of the same city often showing different life expectancies linked to the relative affluence of an area. This inequality is shown even more starkly if healthy life expectancy is considered, with people in more deprived areas spending a greater proportion of their life in poor health.

In 2017-19, males in the least deprived 10 per cent of areas in England could expect to live to 83.5 years, almost a decade longer than males in the 10 per cent most deprived areas (74.1 years)

Office for National Statistics, March 2021

[3] The King's Fund, *What are health inequalities?* February 2020

Mortality rates can also indicate inequalities. This measure of inequality is different to life expectancy as it considers rates of avoidable mortality and can indicate the inequality of access previously described, as well as other factors.

Inequalities in mental health

People who identify as LGBT+ have higher rates of common mental health problems and lower wellbeing than heterosexual people

Centre for Mental Health, November 2020

While it is known that there are inequalities in mental health, data to support this is quite patchy. Inequalities in mental health seem to relate to differences in recognition, reporting and diagnosis and appear to link to various protected characteristics such as sexuality or ethnicity.

Social exclusion for groups such as the homeless or asylum seekers, can also be linked to higher rates of mental illness.

Inequalities in long-term conditions

Inequalities in long term conditions tend to link to deprivation and lower socio-economic status. This can be a vicious circle as long-term conditions can adversely affect an individual's ability to work, which can further increase their socio-economic issues. Multiple long-term conditions are not only more likely for those in deprived groups, their onset can also occur earlier, thus reducing the healthy life years previously discussed.

Males and females living in the most deprived areas can expect to spend nearly 20 fewer years in good health compared with those in the least deprived areas: they spend nearly a third of their lives in poor health, compared with only about a sixth for those in the least deprived areas

Public Health England, 2017

Ethnicity can also cause inequalities in long-term conditions, with some ethnicities 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[4]. NHS services therefore have to recognise the different needs as offering the same approach to everybody, will create further inequalities.

The link to deprivation

Despite not all health inequalities being linked to deprivation, it is clear that these socio-economic inequalities can have a significant impact on a person's health. High health risk behaviours such as smoking, high alcohol consumption, poor diet and lack of physical activity tend to be more common in more deprived parts of the population.

When considering how to tackle these types of inequalities, it is important to consider the wider determinants of health which have an impact; a single intervention is unlikely to be effective. For example, educating people about a healthy diet will not work if their income does not allow them to purchase healthy options, or if their physical environment means that there are more takeaways nearby than grocery shops. Food deserts exist in some of England's cities where there are areas with no shops selling fresh food and the bus fare to get to a supermarket is unaffordable. Low incomes not only affect the ability to choose healthy options, they can also impact a person's metal health, creating further health issues.

Children from the poorest 20% of households are four times as likely to have serious mental health difficulties by the age of 11 as those from the wealthiest 20%

Centre for Mental Health, November 2020

[4] Diabetes UK, *Ethnicity and type 2 diabetes*, 2021

The link between good housing and good health is well known with overcrowding linked to increased risk for many conditions and lack of heating causing higher death rates in the winter months. Access to green spaces has also been shown to improve health and wellbeing.

Local authorities with a higher deprivation score (i.e. more deprived) have a greater density of fast food outlets

Public Health England, 2017

In the 2010 review[5], Sir Michael Marmot argued that it is unlikely that all socio-economic and health inequalities can be eradicated, but the gaps between the health statuses of the most affluent and the most deprived, can be narrowed. However, tackling health inequalities is not just about addressing the problems for those who are most deprived, as this just moves the inequality to a different group of people. Addressing health inequalities is a whole system approach, considering the implications across the whole population. Service transformation can create new inequalities by changing access criteria or people's ability to use services.

Integrated care systems (ICSs) where the NHS and local authorities work in partnership to address their whole population's health and wellbeing, offer an opportunity to holistically tackle some of these issues. By bringing together decision makers from health, housing, planning and others, the impact of some of the wider determinants of health can be considered and changes made.

The financial cost of health inequalities

While there is clearly a moral case for tackling health inequalities, there is also a financial imperative to do so.

In 2016, researchers at the University of York calculated that socio-economic inequalities cost the NHS acute sector £4.8 billion each year[6]. 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.

Socio-economic inequalities cost the NHS acute sector £4.8 billion each year

University of York, 2016

The wider cost of inequality is significant. In 2010, the Marmot review estimated that productivity losses totalled £31-33 billion, and lost taxes and higher welfare payments were in the range of £20-32 billion. The review also highlighted that although the pensionable age in England was expected to move to 68, more than three quarters of the population would have a health issue that impacted their work, by that point.

The role of the NHS finance function in addressing health inequalities

The impact of health inequalities affects every part of the NHS. It is therefore important that NHS finance staff develop an understanding of the challenge in order to support their organisations and appreciate where their skills can make a difference.

Understanding the local population

Tackling health inequalities requires a good understanding of the population that an NHS body or an ICS is working to support. For clinical staff, their day-to-day role will probably bring them into contact with people from across the area but for those working in support functions such as finance, it can be difficult to fully appreciate the needs and diversity of the wider population. Finance staff across both provider and commissioner bodies need to be curious and gain an appreciation of the population that

[5] Institute of Health Equity, *Fair society, healthy lives*, February 2010
[6] 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

they support. Having a better understanding the range of needs will help to support better decision making. It will enable more effective use of resources and prioritisation of investment. Those working in NHS finance are unlikely to know every nuance of population need but, by being curious, better questions can be asked as business cases are developed.

Supporting the use of good quality data

Using good quality activity and cost data effectively, is essential to understanding health inequalities. This information not only shows who is accessing which services, it also shows where services are not being utilised as expected. The financial data that supports this will indicate patterns of resource usage which can highlight areas of inequality across an area. The 2021/22 NHS planning guidance highlights that accurately recording ethnicity is a key priority for systems as they attempt to tackle local inequalities.

NHS finance staff have a role to play in promoting the use of data across their organisations and systems. Linking information to understand pathway costs across the whole system is essential and can help to identify those areas where an intervention in one part of the ICS has an unexpected effect elsewhere. By demonstrating the value that can be achieved through fully understanding how a population uses their local NHS services, finance staff can support the whole system to tackle health inequalities.

Developing business cases

Addressing health inequalities will require investment. It is vital that this investment is used effectively and targeted correctly. Finance staff tend to have a wide organisational or system view and, through using data to understand population needs, can work with clinical colleagues to ensure that business cases to tackle inequality are being targeted correctly.

There is also a need to recognise where inequalities are not being considered but should be included within a business case. For example, some technologies to improve healthcare may have an extra beneficial effect for certain communities which are particularly affected by a condition.

Resource allocation

The national importance placed on tackling health inequalities in the wake of the Covid-19 pandemic has been reflected in the financial planning process. To qualify for funding through the elective recovery fund (ERF), ICSs need to demonstrate how they are addressing health inequalities through the prioritisation of waiting lists and proactive case finding of those who may benefit from services but have not yet accessed care. Income to organisations will become partially dependent upon work being done to address health inequalities and it is therefore essential that NHS finance staff have a good understanding of the challenges in their areas.

As ICSs develop place-based approaches, nationally allocated funding will need to be further split at a local level. The national resource allocation formula takes account of a number of factors that indicate inequality including deprivation and mortality. Any local resource allocation will need to be cognisant of similar factors, requiring finance staff to have a good knowledge of their population to both support funding allocation and to challenge decisions if necessary.

As ICSs work more closely together to address population health and wellbeing, NHS finance staff need to work with their colleagues in local authorities to gain awareness of the wider socio-economic inequalities in their areas. Local authority staff work closely with disadvantaged groups in the community and are likely to have a broader knowledge of where health interventions, or funding, could make a difference. ICSs offer an opportunity to address inequalities holistically, recognising that the investment and benefit may occur in different parts of the local system.

HFMA support to members

Health inequalities impact every part of the NHS and will therefore be intrinsic across all of the HFMA's work programme and committees in the coming year. Additionally, through a mix of briefings, webinars, podcasts, and conference sessions, the HFMA will cover specific areas that will support members to understand and tackle the challenge of addressing health inequalities. These will include topics such as:

- understanding health inequalities
- the financial impact of health inequalities
- investing in prevention
- using data to inform decision making
- how investing in technology can address health inequalities
- supporting population health management approaches to tackle inequalities.

If you have examples of work to tackle health inequalities that you would like to share with others, please get in touch. If there are areas where you would like support or have any suggestions about other areas we should cover, please email policy@hfma.org.uk