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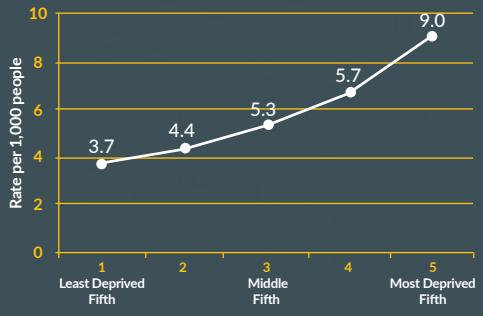
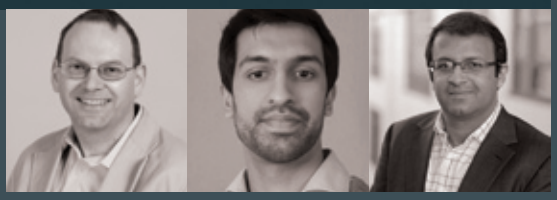


UNHEALTHY LAZARUS AND THE A&E CRISIS



Left to right: Richard Cookson, Miqdad Asaria, Shehzad Ali

After Jesus restored him to life, Lazarus enjoyed a long and healthy life as a Bishop. As far as we know, he never needed a subsequent emergency hospital visit. Modern day Lazarus is less fortunate. Social and medical advances are helping people avoid premature death. But many survivors are unhealthy – and vulnerable to health emergencies requiring A&E admission.

Rising demand for A&E services is intertwined with inequality. A poor Lazarus is more likely to visit A&E than a rich Lazarus. Poorer people tend to be unhealthier survivors, at greater risk of A&E admission for long-term conditions such as heart and lung diseases, diabetes and dementia. Allowing for age and sex, people living in the most deprived fifth of neighbourhoods suffer nearly two-and-a-half times as many of these potentially preventable emergency hospitalisations as people living in the least deprived fifth.

And it's not just the poor. The middle fifth of neighbourhoods experience 40% more preventable A&E admissions than the top fifth. There is a 'social gradient' in A&E admissions, whereby the further down the social spectrum you go, the greater your chances of emergency hospitalisation. As the graph shows, preventable emergency admissions would be nearly halved if everyone had the same rate of A&E admissions as the least deprived.

Preventable emergencies are putting huge pressure on the NHS. The pressures are likely to increase in future decades, as health and social care absorb an ever larger share of public expenditure due to costly new medical technology, people living longer with multiple illnesses, and wage inflation in the caring professions. The NHS needs to smarten up its act if it is to survive as a universal and comprehensive health system.

A&E pressures are partly a barometer of wider social ills, and cannot be dramatically reduced unless Britain becomes more equal. The need for wider action on inequality, however, should not be used as an excuse for inaction by the NHS on healthcare inequality. The NHS is good at providing equal access to reactive care when people suffer a health emergency. It needs to get smarter at providing proactive care to people before they suffer an emergency. The NHS is seeking to improve the co-ordination of care between specialties, between primary and hospital settings, and between health and social care, with initiatives such as the Better Care Fund and the Vanguard sites. But it has not yet addressed the inequality dimension of co-ordinated care. People at the top of society are good at caring for themselves – they have sharp elbows, good information, strong social networks, and pleasant home environments in which to recover from illness. Everyone else – including those in the middle – needs proportionately more help. To grasp this nettle, NHS staff will need better information about healthcare inequalities within their own local area.

To help provide this information, we have developed health equity indicators for the NHS. These include inequality gaps for GPs per head, primary care quality, waiting times, avoidable emergency hospitalisation, dying in hospital, and mortality amenable to healthcare. Using data from the 2000s, we found that some local NHS areas do significantly better than others at reducing local healthcare inequality gaps, and some show signs of sustained improvement over time. But we do not know how local NHS areas are currently performing on equity. Routine production of our indicators by the NHS could help researchers and managers find out which areas are performing the best on equity, and why, and learn lessons about the most cost-effective ways of delivering proactive co-ordinated care.

- For further information see: http://www.york.ac.uk/che/research/equity/monitoring/