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- The richest fifth of people in England live at least 12 more years of life in full health than the poorest fifth.
- Nearly half of emergency admissions arise from social inequality.
- Social inequality is associated with more than 158,000 preventable emergency hospitalisations in England and nearly 38,000 deaths from treatable conditions.
- Our new NHS indicators could be produced routinely to help managers tackle the problem.

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Health Inequality and the A&E Crisis

The current A&E crisis in England is inextricably linked to health inequality. This link is rarely mentioned in media coverage, but needs to be better understood if the NHS is to survive as a universal and comprehensive health service in the coming decades. The richest fifth of people in England can expect to live at least 12 years longer in full health than the poorest fifth. Despite their shorter lives, poorer people make more use of NHS services – especially emergency services. Many emergency admissions affect people with existing long-term conditions – such as dementia, diabetes, respiratory and cardiovascular diseases – and could be prevented by more effective primary care or outpatient care.

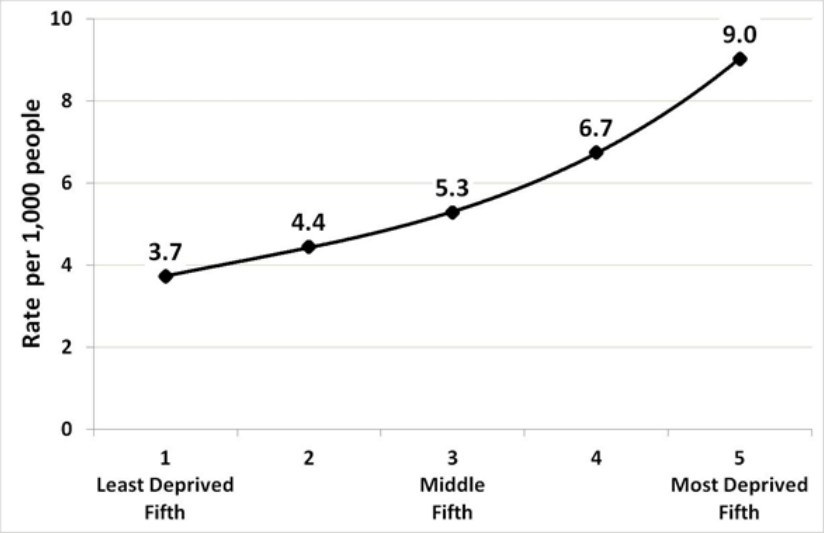
The social gradient in emergency admissions

People living in the most deprived fifth of neighbourhoods in England suffer nearly two and a half times as many preventable emergency hospitalisations as people living in the least deprived fifth, allowing for age and sex. This is a problem affecting everyone in society, not just the poorest. There is a "social gradient" in A&E admissions, whereby the further down the social spectrum you go, the greater your chances of suffering an emergency hospitalisation.

As the graph below shows, preventable emergency admissions would be nearly halved if everyone had the same rate of A&E admissions as the least deprived in society. In other words, nearly half of emergency hospital admissions arise from social inequality.

Pressure on the NHS

In our recent research on NHS inequalities, my colleagues and I at the University of York and elsewhere estimated that social inequality was associated with more than 158,000 preventable emergency hospitalisations in England in 2011/12 and nearly 38,000 deaths from treatable conditions.



Social gradient in preventable emergency hospitalisation

Preventable emergencies are putting huge pressure on the NHS. The pressures are likely to increase in future decades, as health and social care continue to absorb an ever larger share of public expenditure due to cost-increasing medical innovation, people living longer with multiple illnesses, and wage inflation in a labour-intensive industry. The rise in A&E admissions can be seen as a side-effect of medical and social progress – when in previous decades people would simply have died, they are now able to live longer, accumulate chronic illnesses, and keep returning to hospital. But it is also inextricably linked to social inequality, which may increase if recent trends towards greater wealth inequality continue.

What can be done?

The NHS is good at providing equal access to reactive GP or hospital care when people suffer a health emergency. But it needs to get better at providing proactive care to people before they suffer an emergency. One sensible approach, favoured by successive governments, is for NHS and local authorities to improve the co-ordination of care between specialties, between primary and hospital settings, and between health and social care. For example, patients at risk of repeated hospital admissions for breathing difficulties may need follow-up care in the community to check they are taking their medicines. But to co-ordinate care effectively, managers need better information about healthcare inequalities within their local area.

To help provide this information, we have developed health equity indicators for the NHS. We applied these indicators retrospectively to the NHS under the Blair/Brown government in the 2000s. We found that substantial historic investments in GP services led to improved healthcare across all socio-economic groups, particularly among the poorest, between 2004 and 2011. There was, however, only a modest reduction in inequality in preventable deaths and admissions through A&E. Routine production of our indicators by NHS England would help managers learn how to address this problem more effectively. It would also help monitor the healthcare inequality duties in the Health and Social Care Act 2012, and inform the public about healthcare inequalities within their local area.

Of course, the NHS cannot solve the problem on its own. Wider action is needed by social services, education services and other public services that impact on people's health. Action is also needed to change people's health behaviour – for example, through taxation, regulation and "nudges" to reduce consumption of tobacco, alcohol and sugar and to encourage healthy habits such as physical activity. More fundamentally, action is needed to reduce the inequalities in childhood circumstances that help to generate lifelong inequalities in health. 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 health inequality, however, should not be used as an excuse for inaction by the NHS on healthcare inequality.

Reducing healthcare inequality is a matter of social justice. It is also a matter of common sense, when the NHS is under such severe pressure from preventable emergencies arising from social inequality.

References:

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Author affilliations and further project details can be found at:

http://www.york.ac.uk/che/research/equity/monitoring/

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