

Policy Briefing

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How fair is your local NHS? Monitoring socioeconomic inequalities in health care for local NHS quality improvement

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The NHS inequalities duty

In 1948 the National Health Service (NHS) was founded on a principle of fairness: access to health care should be based on need, not ability to pay. The 21st century NHS retains this principle, and has a formal inequalities duty. The Health and Social Care Act 2012 gives NHS officials the duty “to have regard to the need to (a) reduce inequalities between patients with respect to their ability to access health services, and (b) reduce inequalities between patients with respect to the outcomes achieved for them by the provision of health services”.

How fair is the NHS?

The NHS is one of the fairest health systems in the world, but is not perfect. Numerous studies have documented socioeconomic inequalities in NHS services. People who are wealthier, better educated and live in less deprived neighbourhoods achieve better health care outcomes (e.g. surgical mortality, preventable hospitalisation), use more NHS preventive care, such as screening and vaccination services, are more likely to visit a medical specialist when ill, are more likely to receive a needed NHS hip or knee replacement and have shorter NHS waiting times for heart bypass and angioplasty.

The need for routine monitoring

The NHS does not yet monitor whether these health care inequalities are getting larger or smaller over time, or whether some local NHS areas are

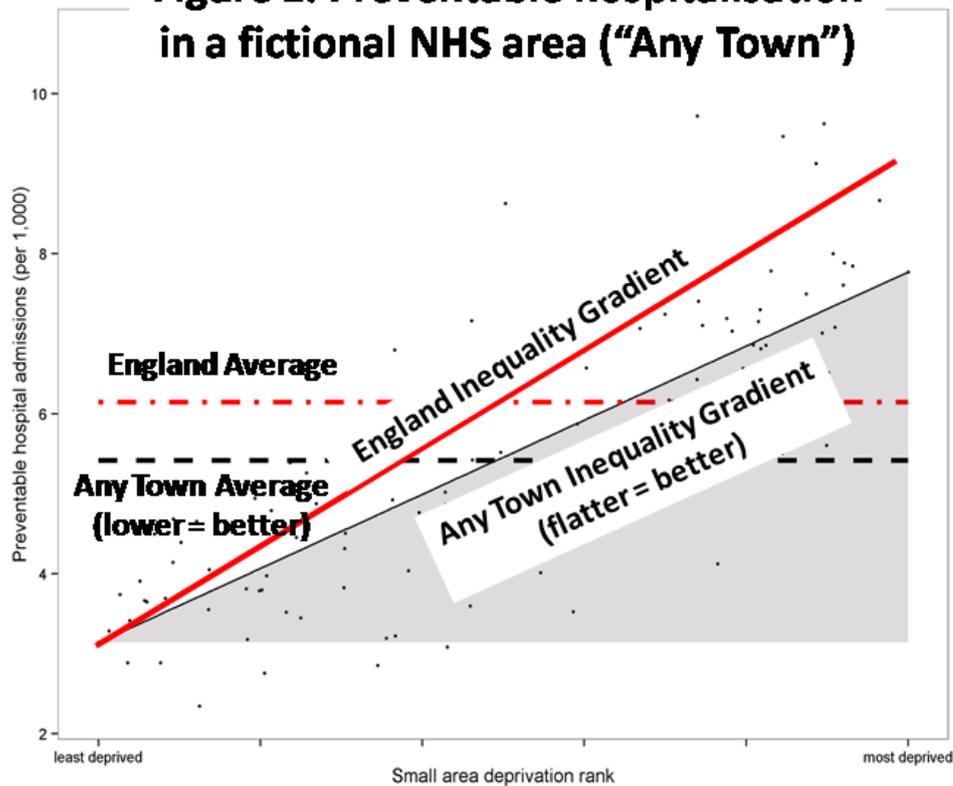
succeeding better than others at reducing them. This makes it hard to discharge the NHS inequalities duty and learn lessons about effective ways of reducing health care inequalities.

Our new inequality indicators

Our research has developed prototype NHS inequality indicators for local NHS quality improvement. Unlike the old health inequality targets in the 2000s, these indicators look at socioeconomic inequality within local NHS clinical commissioning groups. Our indicators also focus on things that NHS decision makers can do something about, rather than things that are largely beyond their control. The old health inequality targets focused on infant mortality and life expectancy. These are important for broader public health monitoring, but are less directly useful for NHS quality improvement since they are strongly influenced by non-NHS social and economic factors (e.g. living and working conditions) and related lifestyle behaviours (e.g. smoking, diet and exercise). We include indicators of inequality in NHS “inputs”, such as GP supply and primary care clinical process quality, as well as NHS “outcomes” such as preventable hospitalisation and mortality from causes considered amenable to health care.

The basic idea is illustrated in Figure 1 on the next page, which shows socioeconomic inequality in preventable hospitalisation within a fictional NHS area called “Any Town”.

Figure 1: Preventable hospitalisation in a fictional NHS area (“Any Town”)



Indicator 4. Preventable Hospitalisation: hospitalisations per 1,000 population for conditions amenable to healthcare adjusted for age and sex

Any Town has a population of about 200,000 people. Each dot represents one of the 120 neighbourhoods in Any Town, each containing about 1,500 people. Neighbourhoods are ranked by deprivation, with more deprived neighbourhoods to the right. The Any Town “inequality gradient” is simply a regression line fitted through these 120 dots. The England inequality gradient is a regression line fitted through all 32,482 neighbourhoods in England.

Any Town is doing better than England as a whole both for the average patient (a lower average line) and in terms of reducing inequality (a flatter inequality gradient). In this example, these differences are statistically significant and unlikely to be merely due to the random play of chance. The NHS may therefore be able to learn lessons from Any Town about how to tackle inequality in preventable hospitalisation.

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