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Tackling health inequalities must be a fundamental priority for the NHS

In recent years, tackling health inequalities – both in terms of equitable access to health services and avoidable differences in people's health outcomes – has become a central organising principle for the NHS. COVID-19 has made clear just how much ground we have to make up in addressing this issue, with those who were most disadvantaged in society hit the hardest by the pandemic and the measures taken to control it.

National public health reform

Earlier this year, Public Health England was officially disbanded, and its health improvement responsibilities split several ways. From 1 October, core public health work will be led by a new body, the Office for Health Improvement and Disparities (OHID) – previously branded the Office for Health Promotion. The change in name signals a clear statement of intent to broadening the new body's focus on tackling population health issues, including inequalities.

OHID will work across government departments, from employment to housing, education, and the environment, to reduce disparities in health. This includes access to health services and providing an insight into the 'big picture' of the inequality that exists across the country. It will examine the wider factors that influence an individual's health, such as where they live, where they work, and how much money they make. Its launch comes at a critical time for the NHS as it continues to grapple with huge backlogs brought about by the COVID-19 pandemic, which also exacerbated the levels of unmet need. A strong partnership between the health and care system and the organisations responsible for wider determinants of health will be critical.

Embedding the issue of health inequalities into COVID-19 recovery plans

By July 2021, 5.6 million people were waiting to begin hospital treatment – the highest since records began. Against this backdrop we see a stark picture of inequality between those living in the most and least deprived areas. The health and social care secretary, Sajid Javid, has said the "disease of disparity" has resulted in people from deprived communities being hit hardest by the pandemic.

COVID-19 admission rates were 2.9 times higher in the most deprived areas compared to the least deprived, while mortality rates were 2.4 times higher. Black, Asian, and ethnic minority groups made up a third of the critical care admissions for COVID-19, even though they make up less than 14% of the UK population.

It will take concerted effort to remedy these stark inequalities in people's experience of the pandemic. Since the virus took hold, national leaders have taken a series of steps to put health inequalities front and centre as the NHS tackles its waiting lists and addresses unmet need. This includes, NHS England and NHS Improvement's 2021/22 priorities and operational planning guidance, which put in place financial incentives for trusts to prioritise addressing inequalities as they develop plans to tackle care backlogs. It is also being woven into the new legislation as part of the Health and Care Bill and forms a key focus for integrated care systems (ICSs) as they become statutory bodies.

Making progress

While there is now a real opportunity to make tackling health inequalities a fundamental priority for the NHS, there remain challenges, particularly in terms of identifying disparities and their causes. Trusts all over the country are grappling with this. Just one example is Calderdale and Huddersfield NHS Foundation Trust, which has reviewed its waiting lists and identified a need to prioritise patients waiting for surgery who have a learning disability regardless of their clinical need in order to offer an equitable service. Only when a trust is able to identify whether structural factors are influencing inequality among their patients can it take steps to address them.

It is also crucial to recognise that building health inequalities into how a trust prioritises its waiting lists may not always result in the fastest possible reduction in waiting lists. When public perception of the NHS' performance is a key concern, it will require dedication and courage from trust leaders, national bodies such as NHS England and NHS Improvement, and politicians to fulfil the commitment to reducing health inequalities and balance it with the desire to restore performance against operational targets as soon as possible.

The role of OHID

OHID will have an important role to play, working with ICSs and providing cross-government support to the health inequalities agenda. It will also provide expert advice and bring data and evidence together to help to ensure decisions to improve health are more informed, effective and joined up, reflecting the wide array of factors which affect people's health. This will be useful for trusts.

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This timely launch of OHID signals a chance to refresh the government's approach to inequalities, and trust leaders are keen to sustain the momentum gained on this issue because of the pandemic. This is now underpinned by a national policy framework which will be central to enabling trusts, and systems, to prioritise health inequalities both in terms of the immediate task ahead and in the years to come. OHID is an important new organisation, which will help the government make good on its commitments to tackle health inequalities and to improve people's lives.

What does it mean for governors?

Your trust has responsibility for reducing health inequalities as part of its system and will be held accountable for this via financial measures and NHS England’s system oversight framework.
It might be helpful to ask your non-executive directors how much data the trust has access to on health inequalities, both of its own patients and within the community it serves, and how the trust is acting on it. It would be useful to know how the trust is assuring itself of the quality of this data, as an accurate picture is essential if trusts are to act effectively.

You could also ask why are non executive directors confident that waiting lists or care backlogs are being prioritised to ensure they do not reinforce or exacerbate health inequalities.

A version of this blog was first published by HSJ.