GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Bae Abertawe
Swansea Bay University Health Board

Access to healthcare – it's contribution to inequalities

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Un Bae Ar y Cyd
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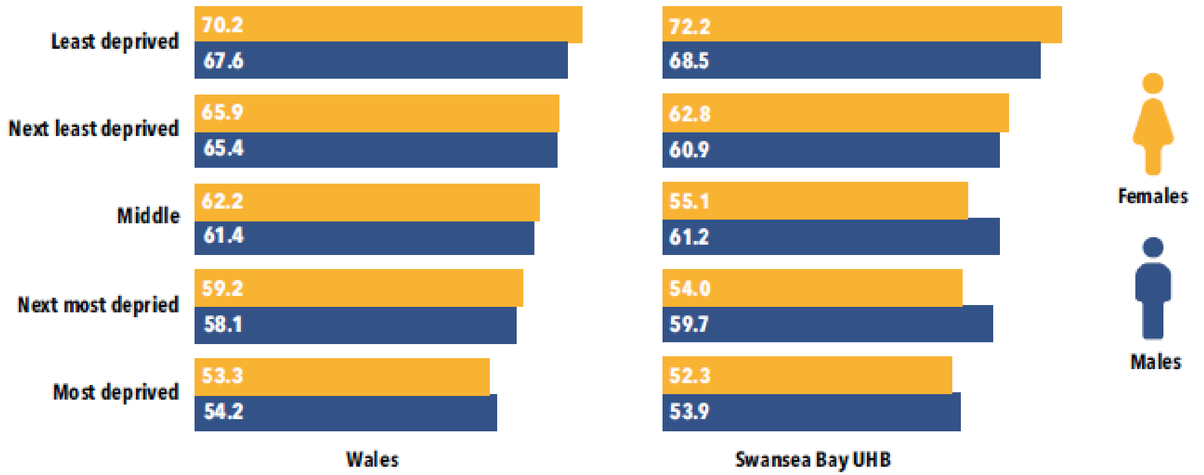
Health inequalities

Gap in life expectancy at birth – years (least to most deprived fifth) (2018-20)

Swansea	9
Neath Port Talbot	7.4
Swansea	7.1
Neath Port Talbot	5.6

Fig 5. Healthy life expectancy at birth, years, males and females, Health Board, Wales by deprivation fifth, 2018-2020

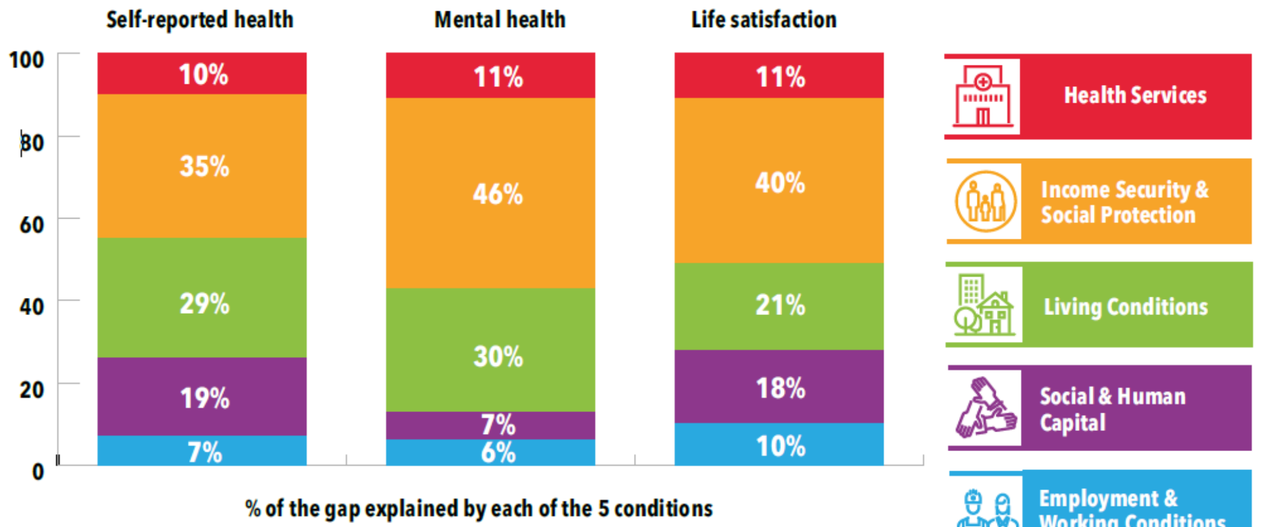
Adapted from charts produced by Public Health Wales Observatory using APS, 2011 Census, PHM, MYE (ONS) & WIMD (2019)



Drivers / causes of health inequities

- Evidence has consistently shown that to achieve equity in terms of health outcomes, requires all sectors of society to take bold, collective and collaborative action.
- Health care provision contributes approx. 10% to overall health outcomes.
- NHS has a significant contribution to make beyond health care provision.
- To drive down health inequalities, we need to take action on the building blocks of what determines our health.

Fig 12. The five conditions' contributions to inequities in self-reported health, mental health and life satisfaction (EU countries)

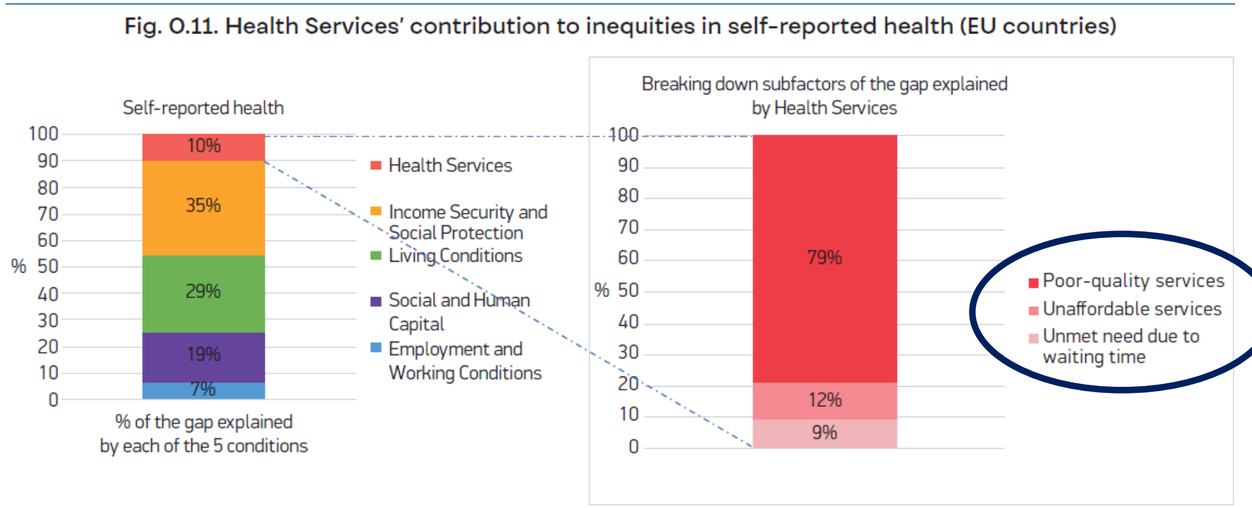


Note: Analysis controls for age and sex of individuals
Source: based on 2003-2016 data from the EQLS

Adapted from 'WHO Europe Five Essential Conditions Underlying Health Inequities' https://www.who.int/europe/publications/i/item/9789289054256

Health service provision – contribution & impact

- Three key elements of importance – access is an aspect of all three.
- Some groups of the population face barriers to accessing healthcare compared to others.
- These populations are often those living in areas of deprivation but also have other protected characteristics e.g. age, gender, ethnicity, where they reside.
- Quality of the service / provision is also important and is different for different population groups. By quality, this means considering services in terms of:
  - Equity
  - Person-centred
  - Effectiveness
  - Safety
  - Timely
  - Efficiency



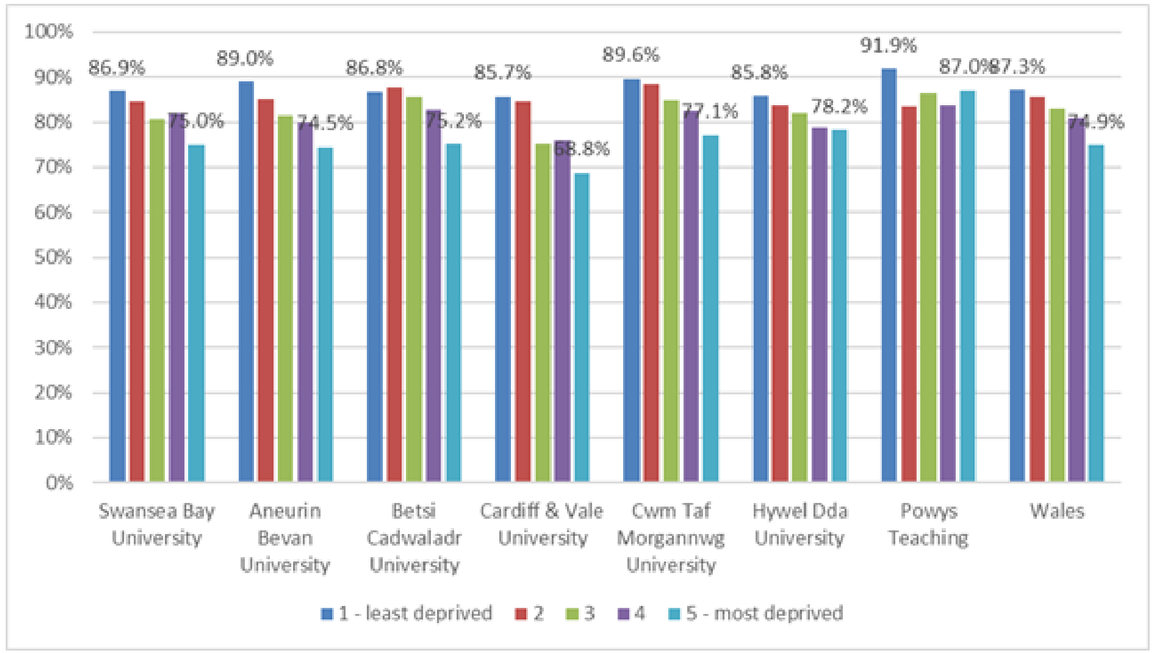
Source: Welsh Health Equity Status Report WHO Europe, 2019

What evidence do we have about equity of our current services

- Evidence shows uptake of Abdominal Aortic Aneurysm (AAA) screening goes down with deprivation (as seen here) yet the proportion of people who go on to have an aneurysm detected goes up with levels of deprivation

- Achieving more equal distribution of uptake of the screening programme will save lives and potentially save money.

Uptake of Abdominal Aortic Aneurysm (AAA) Screening by deprivation quintile by health board



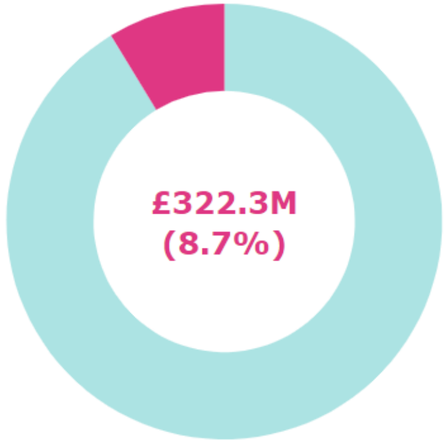
Health service differential utilisation

- People living in more deprived areas:
  - tend to consume more healthcare at any given age, in terms of volume and cost due to more adverse health conditions
  - are more likely to use unplanned care and are less likely to use specialist and prevention services

- This indicates there are cost savings to be made by identifying earlier entry points to improving health outcomes for those living in deprived areas, including access to elective care, primary care as well as upstream approaches addressing health harming behaviours and the wider determinants of health.

Annual Cost of Inequality on Healthcare in Wales (2018)

Source: WHO Collaborating Centre, Public Health Wales



Select healthcare setting: Total

Select sex: Total

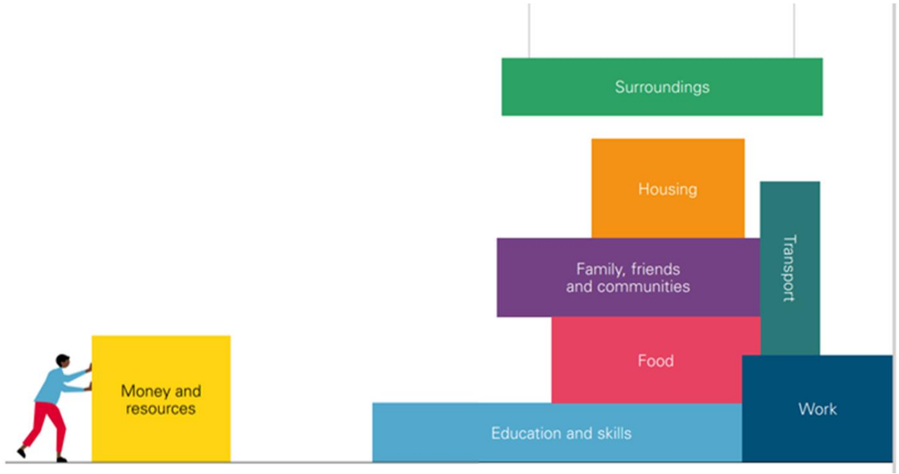
Cost Component	Cost of Inequality	Total Cost	% Attributable to Inequality
Elective	-£20,300,000	£1,616,400,000	-1.0%
Emergency	£247,400,000	£1,087,800,000	23.0%
Maternity	£1,800,000	£226,600,000	1.0%
Outpatient	£39,300,000	£601,200,000	7.0%
A&E	£54,200,000	£174,100,000	31.0%
Total	£322,300,000	£3,706,100,000	9.0%

Note: *Negative costs indicate that people living in the least deprived areas contribute most to the cost of elective admissions*

Source: Cost of Health Inequality to the NHS in Wales, WHCCC,

Waiting lists

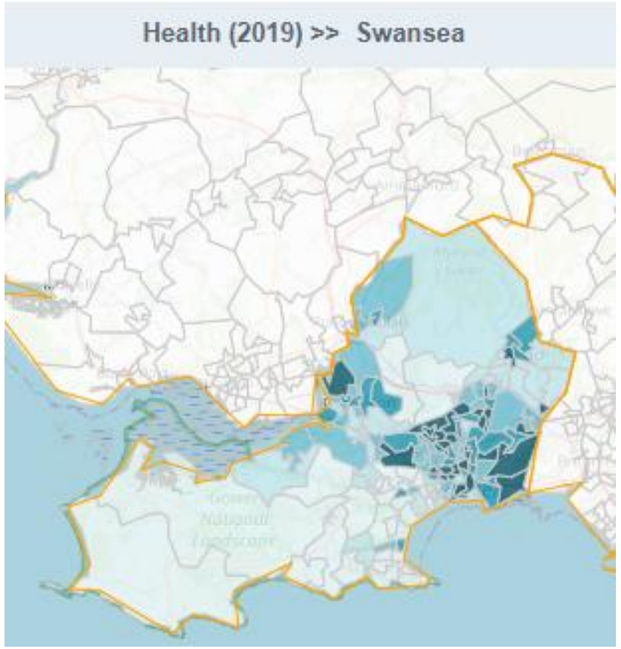
- People in more deprived areas or with particular population characteristics are twice as likely to wait longer for treatment and be more negatively affected by waiting in terms of health and quality of life.
- Reasons for this include:
  - **Appointments being difficult to attend** – e.g. someone cannot take time off work or does not have access to a car or public transport
  - **Difficulty in navigating the NHS** – e.g. some people find it harder than others to articulate their health concern and advocate for treatment (health literacy)
  - **People reach the waiting list in different health states and deteriorate at different rates** – people from more deprived areas are more likely to have multiple health conditions, deteriorate more quickly, develop complications while they wait and experience worse health outcomes
  - **Individual circumstances** affect whether a patient's condition affects their ability to work or fulfil caring responsibilities.



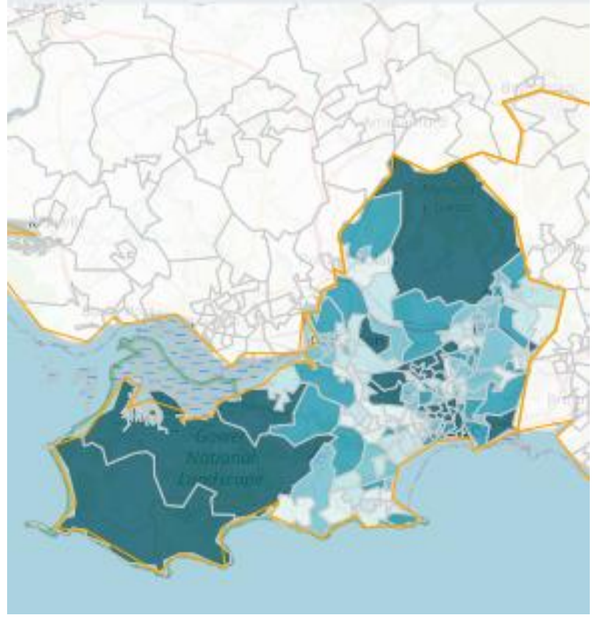
Care needed in how we understand ‘access’ and its impact on health

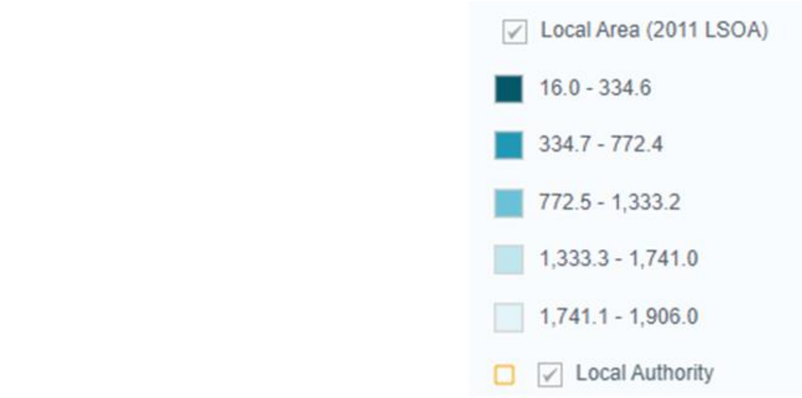
Overall rank (2019) >> Swansea

Health (2019) >> Swansea



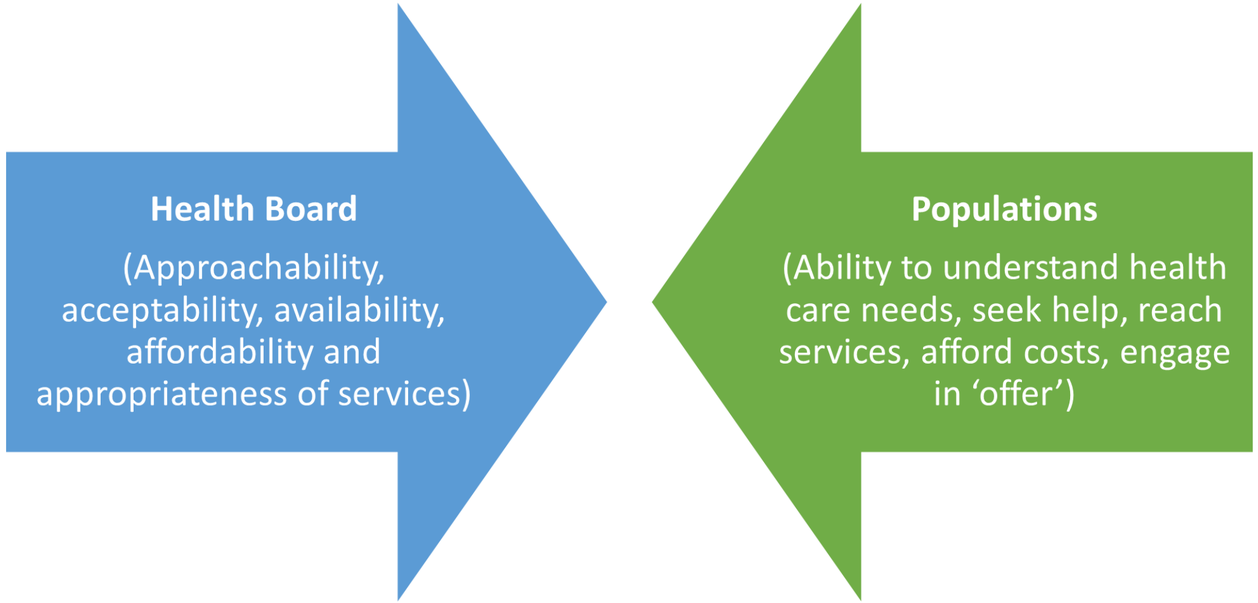
Access to Services (2019) >> Swansea





Understanding access and how it is measured

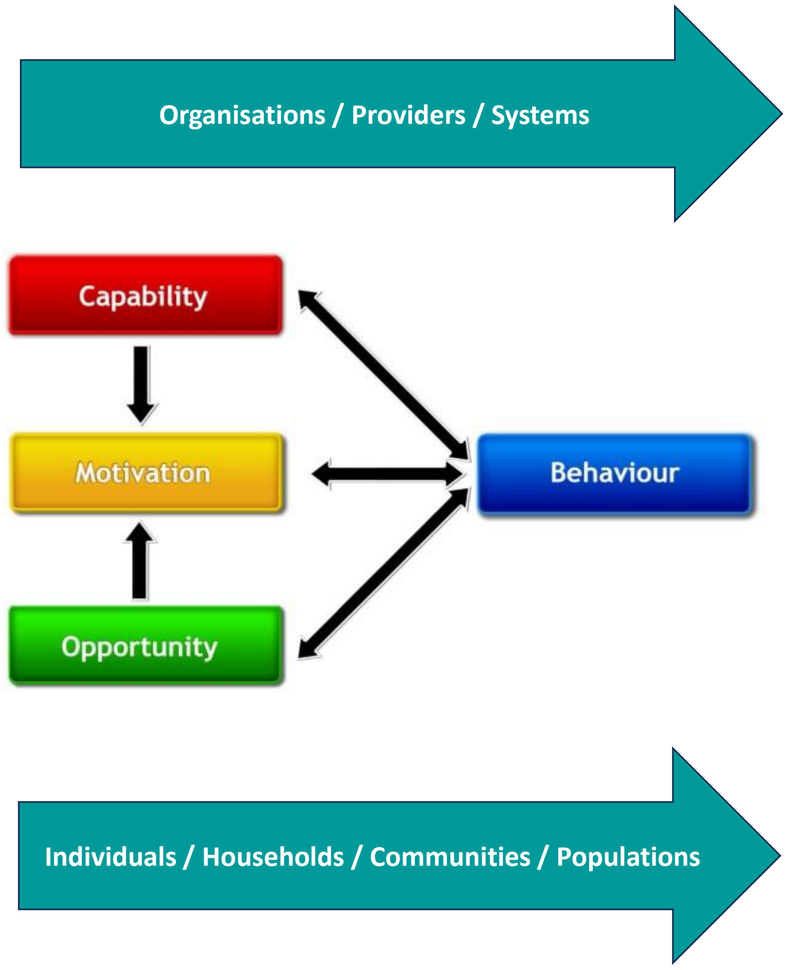
- Access is a complex concept but at its core:
  - If services are available **and** there is an adequate supply, then the **opportunity** to obtain health care exists and a population may 'have access' to services.
  - Extent to which a population **'gains access'** depends on more than proximity but includes financial, organisational and social or cultural barriers that limit the utilisation of services.

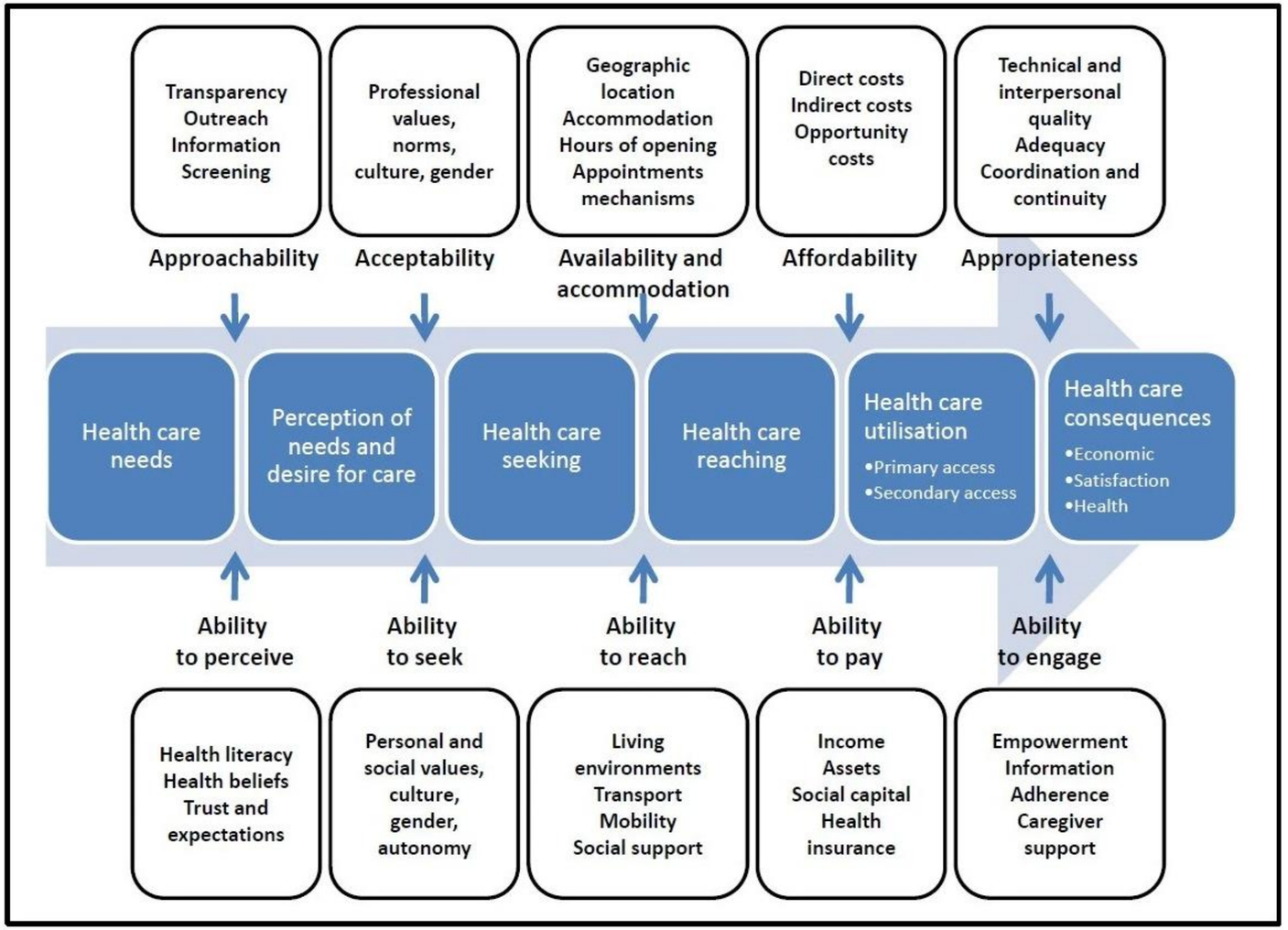


- Improving access is concerned with helping people to get the health care and resources they need in a way they can benefit from, in order to preserve or improve their health.

- Equity of access may be measured in terms of the availability, utilisation or outcomes of services.

Framework to understand access to healthcare





Source: Levesque framework for healthcare access

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Key Messages

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Purposeful action as a population health focused organisation

- Inequitable access – more deprived areas tend to have:
  - higher health needs yet have access to fewer GPs per person,
  - less engagement with secondary care,
  - less access to preventative interventions and social services,
  - report poorer experience and satisfaction of health services, and
  - have poorer health outcomes.

- Tackling inequities requires:
  - Investing in **strong data collection and analysis** to understand patient populations, gain insights to underlying factors of inequalities and tailor effective interventions
  - Embedding a **culture shift to prioritising equity** and inclusivity across service delivery with leadership that tackles inequalities at all levels of the workforce
  - **Integration** of services and interventions **with different sectors and system partners** to improve understanding, collaboration and access to services for patients
  - Engagement with patients and communities to **co-design and co-produce** services and interventions that meet specific needs
  - Recognising our responsibilities as **anchor institutions** and working **proactively** to tackle inequalities within the healthcare workforce and patient communities.

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Diolch
Thank you

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