Health Inequity on the UK: Paper 1 exploring health inequality and inequity and why it is important for Practice Nurses

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Introduction

Promoting health and wellbeing is a fundamental part of every nurse's role (Nursing Midwifery Council 2018). Practice nurses are ideally placed within local communities to have a significant impact on addressing health inequities (Heaslip and Nadaf 2019). However, to achieve this they need to understand the many factors that lead to certain groups having poorer health outcomes. This, the first of two papers, begins by exploring both health and access to UK health services. It then examines the equality philosophy at the core of the National Health Service (NHS) before distinguishing between inequality, inequity and related concepts when poorer health outcomes are examined. This paper then continues to present some key governmental and professional papers driving healthcare policy. The follow-up paper then explores health experiences of certain communities such as Ethnic Minorities, Lesbian, Gay, Bisexual, Transgender and Queer (LGBTQ+) and individuals experiencing homelessness as well as the role of practice nurses in addressing their health experiences.

Health and wellbeing in the UK

The UK has an ageing population; with life expectancy at birth of around 79 years for men and 83 year for women (Office for National Statistics (ONS) 2021a). A demographic trajectory also influenced by a significant reduction in infant and child mortality, with the former the lowest on record in 2019 (ONS 2021b). Advances in longevity, do not automatically match advances in health and wellbeing across

all social groups. For example, the UK is the 22nd richest country in the world (based upon gross domestic product per capita (International Monetary Fund 2021), yet it has huge variations of wealth. The UK (UK Parliament 2021) defines poverty in two ways; relative low income (living in a household with income below 60% of the national median that year) and absolute (living in household with income below 60% of the inflation adjusted median that year). The most recent data set (2019/20) identifies there were 14.5 million (22% of the population) and 4.3 million children (31%) living in relative low income after housing costs were deducted, and 11.7 million people living in absolute low income after housing costs were deducted (UK Parliament 2021). A trend likely to have increased when the health and economic impact of the COVID-19 pandemic is considered. Poverty is important as there is a negative cycle between poverty and health (British Medical Association 2017). Indeed, the World Health Organisation (2021a) argues that poverty is the single largest determinate of health as poorer people have shorter lives and greater health and wellbeing challenges. In the UK someone living in a deprived area of England is more likely to die eight and a half years younger than someone living in a more affluent area (ONS 2021a). They will also experience more ill health and reduced wellbeing when compared to their wealthier social groups. In addition to poverty, health inequality is also monitored by geography, by specific characteristic such as sex, ethnicity, disability or by belonging to a socially excluded group (Kings Fund 2020). We need to ask ourselves why this is happening and how can it be prevented?

Access to Healthcare in the UK

The National Health Service (NHS) is free at the point of use, as set out in the seven principles of the NHS, these include providing a service based on need and not a person's ability to pay as well as providing a comprehensive service to all regardless of race, disability, age, or gender (Department of Health and Social Care, 2021). However, there are still a wide number of people who struggle to access services or become disengaged for various reasons. For some they feel discriminated against, due to race, age or sexual orientation. For others, the ability to afford appointments becomes prohibitive due to travel costs and lost time and wages. Literacy can also be an issue with people not always being able to read, easily understand and utilise information conveyed within their lived experience (NHS 2021a).

Differences between (in)equality and (in)equity and other key terms

The Kings Fund (2020) recognise that the term health inequality can have multiple meanings including differences in people's health, differences in care they receive and the opportunities they have to live

healthy lives. The key areas that are linked to inequality identified by the Kings Fund (2020) are listed below in Table 1.

Table 1 Key Areas linked to Health Inequality (Kings Fund 2020)

1. Health status, such as life expectancy and prevalence of health conditions 2. Access to care, 3. Quality and experience of care 4. Behavioural risks factors 5. Wider determinants of health

Inequalities in access to health services are preventable; those who are disadvantaged and difficult to reach are more likely to experience health inequalities and are more likely to have poor health outcomes (Hui et al. 2020). An insightful depiction of how fundamental causes and wider environmental influences can affect health inequality was created using a train station tube map showing differences in children's life expectancy in stations that are only minutes apart; for example, life expectancy of 96.4 years for those born near Oxford Circus whilst children born around Star Lane have a predicted life expectancy of 75.3 years (Cheshire 2012). The fundamental differences between these tube stops are access barriers and lifestyle risks.

Within healthcare, the terms (in)equality and (in)equity are often used interchangeably yet there is a nuanced difference needed to understand how groups of people in society access and experience healthcare. According to Global Health Europe (2009) inequality is denoted as not having *sameness* and is described as the uneven distribution of health or healthcare resources. Inequity is denoted as *unfairness* and is described as people not being able to access the same healthcare opportunities because of corruption, poor governance, and cultural disparities. In terms of healthcare, Table 2 presents a definition of key terms including health equity, health inequality, health inequities and health disparities.

Table 2 Defining health inequalities and inequities (Braveman 2014 and Marmot 2013 cited Wilson et al. 2018)

Health inequalities	Differences that exist between groups in health service access, health status and outcomes—sometimes inequalities are acceptable, for example breast screening programmes for men and women are not equal.
Health equity	Achieving equity requires the provision of different attention to groups adversely Affected so equality in access, status and outcomes can be achieved
Health inequities	Underpinned by social justice, health inequities refer to the unjust or unfair differences in health access, status and outcomes that exist between groups of people
Health disparities	Absolute and relative differences in health status and outcomes between groups and is used to evidence of health inequities. For instance, differences in access to determinants of health and health services and quality of health care

Marmot Review

In 2008, Professor Michael Marmot was asked to chair an independent review to identify effective evidence-based strategies to address health inequalities in England with the findings published in 2010 (Marmot Review 2010). The report identified a social gradient in health, that is, the lower an individual's social position in society then the worse their health experience/outcomes and conversely the higher their social position the better their health. Marmot (2010) argued that social policy and actions should focus on addressing this social gradient, calling for a multi-agency approach recognising the wider social determinates of health. There are numerous modes exploring the wider social determinates of health however the most commonly used is that of Dahlgren and Whitehead 1991 (Public Health England, 2017) (see figure 1 Heaslip 2020). As part of the holistic assessment nurses should be considering these wider bio-psycho-social factors as part of their role in health improvement and promotion. Marmot (2010) argued against focussing solely on those experiencing disadvantage but advocated those actions to address the social gradient needed to be universal (i.e., equality) but the scale and intensity of action had to reflect the levels of disadvantage (equity).

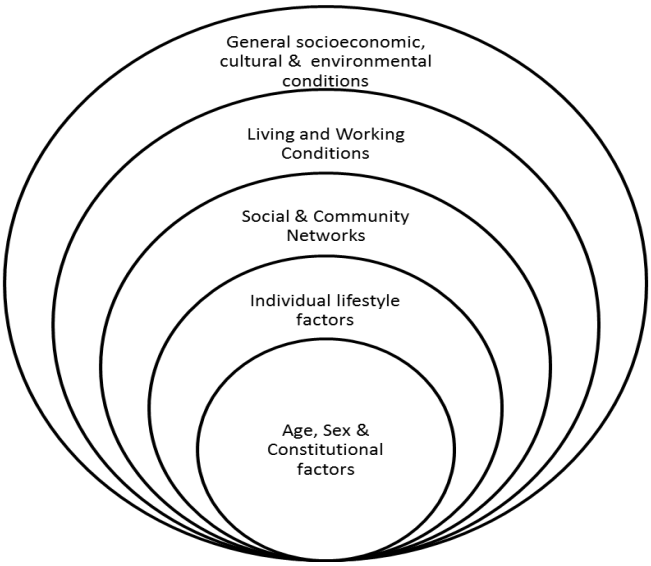

Figure 1 Wider Determinants of Health

Despite widespread agreement and recognition of the need to implement the recommendations of the review at the time, a subsequent report (Marmot et al. 2020) examining progress 10 years on identified that since 2010 there has been a widening of health inequalities in England, most notably for women. Although for both men and women, the perpetuation of the social gradient continues to

correlate with the fact that those living in more deprived areas spend more of their shorter lives living in poor health. Given we have since experienced the Covid pandemic then these costs may be even higher and more complex.

Strategic Healthcare Priorities for 2020 and Beyond

Working within a global economy with limited healthcare resources, it is imperative to be able to deliver equal and equitable care to everyone as a 20th century strategic priority. The 17 Sustainable Development Goals (SDGs) were introduced as an urgent call for all countries to address poverty and other deprivations (United Nations 2015). Of particular interest to practice nurses are SDG one (no poverty), SDG three (good health and well-being), SDG five (gender equality) and SDG 10 (reduce inequalities). Of particular note, are two recent challenges to the continued implementation of good health and wellbeing (SDG three and SDG ten) are the recent Covid pandemic which has highlighted health inequities faced by ethnic minority groups in particular (we shall address this in the next paper) and the international shortage of nurses. The most recent report from the World Health Organisation (2021b) focusses upon 'Gender and Health', recognising that healthcare access experiences can be directly linked to gender due to rigid gender norms, violence, stigma and discrimination, and poverty. Whilst we often think these issues are related to low income countries there is evidence of gender differences in the UK especially in terms of period poverty (young girls missing education due to lack of finances to purchase sanitary products) and socially excluded groups such as people who are homeless, and ethnic minority groups which we explore further in the next paper in the series.

Within the United Kingdom (UK) itself, the 2010 Equality Act confirmed a duty to non-discriminatory practice and the NHS and staff working within it as a public sector provider of care have specific duties under the Public Sector Equality Duty (Equality and Human Rights Commission 2021) to provide equal opportunities in every community, eliminate discrimination and victimisation and foster open and honest communication about equitable and equal access to healthcare (Government Equalities Office, 2015). In 2018, NHS England published its response to the specific equality duties of the Equality Act and identified 6 objectives (Table 3) to which all who work in the NHS (including practice nurses) have a responsibility to deliver.

Table 3 NHS England response to the specific equality duties of the Equality Act 2010 (NHS England 2018)

Equality Objective 1	To improve the capability of NHS England's commissioners, policy staff and others to understand and address the legal obligations under the public sector Equality Duty and duties to reduce health inequalities introduced by the Health and Social Care Act 2012.

Equality objective 2:	To improve disabled staff representation, treatment and experience in the NHS and their employment opportunities within the NHS.
Equality objective 3:	To improve the experience of LGBT patients and improve LGBT staff representation
Equality objective 4:	To reduce language barriers experienced by individuals and specific groups of people who engage with the NHS with specific reference to identifying how to address issues in relation to health inequalities and patient safety.
Equality objective 5:	To improve the mapping, quality and extent of equality information in order to better facilitate compliance with the public sector Equality Duty in relation to patients, service-users and service delivery.
Equality objective 6:	To improve the recruitment, retention, progression, development and experience of the people employed by NHS England to enable the organisation to become an inclusive employer of choice

This commitment reflects the recognition by the NHS and Public Health England (2017) that health inequalities are unfair and preventable. It also that it recognises the nurses advocacy and enabling role, and the need to move beyond direct patient care to also become involved in cultural and structural change and consciousness raising. The NHS Long-Term Plan (2021b) sets out measurable goals for reducing health inequalities, by targeting a greater share of funding to areas with higher health inequalities. These areas in turn have to clearly define how this additional funding will be utilised to reduce health inequalities and address risk factors of smoking, poor diet, high blood pressure, obesity and alcohol and drugs all of which cause the most premature deaths in the UK (NHS 2021b) all of which we argue are within the key domain of practice nurses.

Conclusions

Whilst the current focus of the NHS is on equality, it is evident that there are important nuances to consider. For example, there is a lack of equity in health services which leads to health disparities for people living in the UK linked to the wider determinates of health. Practice nurses are ideally placed to address some of these wider determinates as part of their holistic assessment and in meeting the Public Sector Equality Duties. Paper two shall build upon this to explore health inequity of three particular communities including people who are homeless and individuals from LGBTQ+ and Ethnic Minority communities as well as how practice nurses can work to address the health inequities and disparities these groups face.

Key Points

1. Understanding key terms such as health equality, equity and disparities is important for Practice nurses in order to be able to critically consider the health experiences of people they work with

2. In the holistic assessment of patients, it is fundamental that practice nurses reflect and consider how the wider determinate of health impact upon patients health and wellbeing
3. Whilst the NHS is committed to equality, practice nurses needed to understand how this could inadvertently lead to inequity unless they tailor interventions to meet individual needs

CPD Reflective Points

1. Think about the terms equality, equity and health disparities. Does the practice where you work focus on equality or equity? What are the implications of this in terms of health disparities?
2. Identify one patient you work with, considering the wider determinates of health, what issues do you think influences their health decisions or access?
3. Identify one aspect of practice that you could implement which would help address health disparities
4. What is your practice surgery doing to help address the UN Sustainable Development Goals?

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