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The NHS crisis is not an equal crisis

The NHS crisis is hitting people in more deprived areas the hardest, write Simon Williams and Christina Pagel

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The NHS is in crisis.[1] Primary care is creaking at the seams.[2] More patients are on NHS waiting lists than ever before in England and Wales.[3 4] Compared with August 2019, average waiting times have almost doubled, and the number of people waiting at least a year is around 300 times higher.[3] As we head towards winter, another concern is a repeat of last year's emergency care crisis.[5] In December 2022, the average ambulance response time for category 2 calls (which include chest pain and suspected stroke) was 1 hour 32 minutes across England—more than five times the target of 18 minutes.[6] The president of the Royal College of Emergency Medicine estimated that there were 500 excess deaths a week last December because of delays in emergency care.[7]

However, the NHS crisis is not an equal crisis. People from deprived communities are generally in poorer health, and therefore require more access to health and social care services.[8] For example, admissions related to cardiovascular disease, coronary heart disease, respiratory disease, and mental health are substantially more common among people from more deprived communities compared with people from the least deprived communities.[9] As such, an overburdened NHS and any associated healthcare delays will disproportionately affect people who need access to healthcare more. The demand for emergency care is also spread unequally, with emergency department attendances for people in the most deprived areas of England twice as high as for people in the least deprived areas,[10] meaning that people from deprived communities are more affected by any breakdown in emergency services.

However, there are inequalities beyond the demand for care. For example, people living in the most deprived communities are twice as likely as people in the least deprived communities to wait at least a year for treatment.[8] Patients from more deprived areas are more likely to need to re-attend the emergency department for the same problem within a week.[11] Since 2015, a small but growing gap has also been emerging in terms of how long people have to wait for emergency care, with people in the most deprived areas attending the emergency department in England less likely to be seen within the four hour target.[12] Most concerningly, the likelihood of dying owing to delays in emergency care is higher for people from more deprived backgrounds.[13]

Furthermore, inequalities by ethnicity in emergency care may be exacerbated by the crisis, since people from ethnic minority backgrounds have higher attendance rates at emergency departments compared with people from white backgrounds.[14] Of course, this is partly owing to the fact that individuals from many ethnic minority backgrounds are also more likely to live in more deprived neighbourhoods.[15] In routine care, more operations, tests, and consultations were "lost" for people in the most deprived groups since the start of the covid-19 pandemic, and the same applies for some ethnic minority groups for certain procedures (for example, Black patients have higher than expected rates of access to and use of cardiovascular care).[16]

In the absence of a change in policy, the ongoing NHS crisis will keep hitting people in more deprived areas the hardest, exacerbating the widening health inequalities worsened by the pandemic and over a decade of austerity.[17] An increasing number of people able to afford private healthcare are doing so, something that only serves to widen health inequalities further.[18]

We are trapped in a vicious circle. If people from more deprived backgrounds have a greater need for emergency care, and if they have to wait longer to receive that care, then they are more likely to have poorer outcomes post-care (in terms of disability or recovery), are more likely to need emergency care in the future, and more likely to experience negative socioeconomic outcomes (like unemployment or work absenteeism).[13] On the other hand, unless we can tackle socioeconomic inequalities more broadly, pressure on the NHS will only accelerate over the coming years.[19]

To escape this vicious circle requires a complex, coordinated effort at a number of levels. There are some specific and short term interventions that can help as we head into winter—for example, reducing the incidence of respiratory diseases (particularly among people caught in healthcare settings). These can help reduce winter pressure by lowering demand for respiratory illness-related healthcare, rates of which are higher among people from more deprived communities.[20 21] Such interventions could include requiring well fitting FFP2 masks to be worn in healthcare settings by staff, visitors and outpatients; supporting staff to test for covid and stay home if ill with covid, flu, or other respiratory viruses; and investing in adequate ventilation in health and social care settings to reduce spread of airborne respiratory illnesses.[22]

At a more fundamental level, we cannot escape the fact that the NHS is severely underfunded and under-resourced. Analysis suggests that the UK has fewer doctors and nurses, less medical equipment and fewer beds per capita, and higher preventable avoidable mortality rates than comparable countries.[23] As well as adding capacity to the NHS (both in workforce and infrastructure), we need to

reduce demand, which requires long term investment in public health and improving housing, sick pay, education, and local environments to tackle the social determinants of health.

The NHS crisis affects us all, but some are suffering far more than others.

Competing interests: CP is a member of Independent SAGE. SW is also a consultant for the World Health Organization, but writes here in a personal capacity as an academic lecturer, and his views are independent of WHO.

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