

SP 49

Blaenoriaethau ar gyfer y Pwyllgor Cydraddoldeb,  
Llywodraeth Leol a Chymunedau  
Priorities for the Equality,  
Local Government and Communities Committee  
Ymateb gan: Conffederasiwn GIG Cymru  
Response from: The Welsh NHS Confederation

### **Introduction**

1. The Welsh NHS Confederation represents the seven Health Boards and three NHS Trusts in Wales (our members). The Welsh NHS Confederation supports our members to improve health and well-being by working with them to deliver high standards of care for patients and best value for taxpayers' money. We act as a driving force for positive change through strong representation and our policy, influencing and engagement work.
2. We welcome the opportunity to contribute to the Equality, Local Government and Communities Committee consultation and apologies that our submission has been sent after the deadline. The Welsh NHS Confederation produced a detailed response to the Health, Social Care and Sport Committee priorities consultation and wanted to highlight some key areas that the Equality, Local Government and Communities Committee may want to also consider.

### **The role of the Welsh NHS Confederation**

3. As the biggest user of public money in Wales, it is essential that the NHS is accountable, and Assembly inquiries allow this to happen. The Welsh NHS Confederation has built a strong relationship with the clerks from a number of Committees during the Fourth Assembly and this will hopefully continue into the Fifth Assembly. These relationships have been very beneficial for Local Health Boards and NHS Trusts and also for Committee members.
4. Prior to Committee inquiries and oral evidence sessions, the Welsh NHS Confederation liaises with the clerks to ensure that the most suitable representatives from the NHS in Wales provide evidence to the Committees. We contact the Health Boards and Trusts on behalf of the Committee clerks for all inquiries to ensure that the Committees hear from representatives from across the NHS in Wales. We hope these relationships continue during the Fifth Assembly term to ensure that Committees hear from experts within the NHS and that Committees can fully understand the policies and processes of the NHS and the wider health and social care sector.

### **Priorities for the Equality, Local Government and Communities Committee**

#### **a. The impact of poverty on people's health and well-being.**

5. We would recommend that the Committee considers the impact that socio-economic deprivation has on people's health and well-being.
6. As highlighted in our briefing, "From Rhetoric to Reality – NHS Wales in 10 years' time: Socio-economic Deprivation and Health",<sup>i</sup> attached with our response, the socio-economic inequalities in life prospects and health are stark. Socio-economic deprivation has a significant impact on child development, on people's lifestyle choices, on healthy life expectancy, including living with an illness or chronic condition, and life expectancy.

7. While socio-economic deprivation and poverty have an impact on the NHS in Wales, with increased demand on services as a result, addressing these inequalities is not the sole role of the NHS. Tackling economic deprivation and poverty is a key challenge for all sectors in Wales, including the Welsh Government, public sector, third sector and the public. To address these challenges partnership working across all sectors is vital to ensure positive outcomes for people in Wales and it would be helpful if the Committee can take this work forward.
8. As part of the inquiry the Committee could consider the impact that welfare reform is having on people's health. In our briefing "The impact of welfare reform on people's health and well-being"<sup>ii</sup> we highlighted how the changes to welfare benefits are having a significant impact on people in Wales and have led to an increase in a wide variety of health-related conditions. Research highlights that welfare reform could include an increase in a wide variety of health-related conditions including:
  - Mental health problems;
  - Cardiovascular and respiratory illnesses;
  - Obesity-related illnesses;
  - Substance misuse and associated alcohol and drug related harms; and
  - Suicides, homicides and domestic violence.

**b. Integration of health and social care services:**

9. The Welsh NHS Confederation would support an inquiry looking into the integration of health and local government services, especially social care services.
10. The Welsh NHS Confederation believes that Wales, given its size, structure and close links, has a golden opportunity to achieve so much when it comes to integration. The Welsh NHS Confederation works with ADSS Cymru, Wales Council for Voluntary Action, Care Forum Wales, the Welsh Local Government Association and Community Housing Cymru to support the continued implementation of the Social Services and Well-being (Wales) Act 2014. However, to provide patient centred care, collaborative working and transformational change is vital across all of the public sector.
11. Integration needs to happen, both within and outside the health service and therefore it is important to look at integration across the public sector. The NHS will not be able to rise to the challenges it faces without the help of our colleagues in other sectors, including housing, education and, in particular, those in social services.

**c. Health and Housing**

12. We would recommend that the Committee considers the impact that poor housing has on people's health.
13. While the integration process relating to health and social care will pave the way to more efficient services, we cannot fully realise the potential to do more for people without the inclusion of housing. It is well known that poor housing leads to poor health. Living in poor housing can lead to an increased risk of cardiovascular and respiratory disease as well as to anxiety and depression. Problems such as damp, mould, excess cold and structural defects which increase the risk of an accident also present hazards to health. As highlighted in our briefing, "From Rhetoric to Reality – NHS Wales in 10 years' time: Health and Housing",<sup>iii</sup> good housing provides many solutions to the dilemmas and challenges faced by the health and care sector and this could be considered further by the Committee.

#### **d. Public Engagement**

14. We recommend that the Committee considers how the Welsh Government and public bodies better engage with the public.
15. There is a need for an open and honest conversation with the public about what public bodies, including health and local government, can provide in the future. While the NHS is free at the point of contact, it is not free of obligation, and the public will need to be supported in taking more responsibility for their own health. People need to become partners in managing and improving their health, rather than passive recipients of healthcare. Communication and co-production with patients, the public, third and independent sectors will be required with more support in influencing the public message regarding co-production and self-management. Without support across all sectors for these messages, it will not succeed and the Committee has a role to consider where we are in Wales at the moment.

#### **Conclusion**

16. With the number of challenges health and care services face we recommend that future consultation or inquiries considered by the Committee assists and supports the transformation required to modernise public services in Wales, especially in relation to public health and prevention.

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<sup>i</sup> Welsh NHS Confederation, June 2015. From Rhetoric to Reality – NHS Wales in 10 years’ time: Socio-economic Deprivation and Health.

<sup>ii</sup> Welsh NHS Confederation, March 2015. The impact of welfare reform on people’s health and well-being’

<sup>iii</sup> Welsh NHS Confederation, July 2014. From Rhetoric to Reality – NHS Wales in 10 years’ time: Health and Housing.



## From Rhetoric to Reality – NHS Wales in 10 years' time

A series of briefings on the partnerships required to deliver the NHS required now and in the future...

### Socio-economic Deprivation and Health

#### Key points

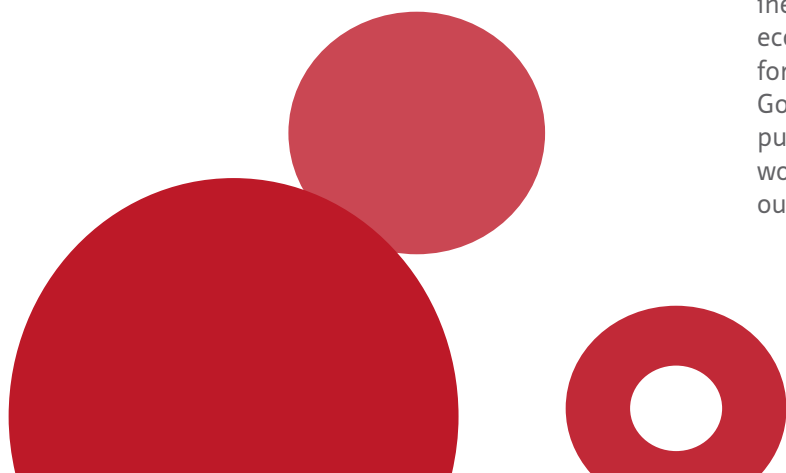
- The socio-economic inequalities in life prospects and health are stark. Socio-economic deprivation has a significant impact on child development, on people's lifestyle choices, on healthy life expectancy, including living with an illness or chronic condition, and life expectancy.
- With the introduction of the Well-being of Future Generations (Wales) Act 2015 it is imperative that all public bodies work in partnership to reduce health inequalities for people in a lower socio-economic position.
- All sectors must work together to tackle these inequalities and deliver a more preventative approach. Tackling inequality requires participation from the Government, public sector and third sector organisations that have a stake in the well-being of the population of Wales.

#### Introduction

In January 2014, the Welsh NHS Confederation launched its discussion paper entitled 'From Rhetoric to Reality – NHS Wales in 10 years' time'.<sup>1</sup> This paper sets out the ten key challenges that face the NHS in Wales, including sections on workforce, funding and integration. To keep this debate at the forefront of how we realise a shared vision for the NHS in Wales, the Welsh NHS Confederation is producing a series of briefings in the 'From Rhetoric to Reality' series.

This briefing highlights the correlation between socio-economic deprivation and people's health and well-being outcomes. Through analysing trends across socio-economic groups we highlight how deprivation has an impact on child development, people's lifestyle choices, healthy life expectancy, including living with an illness or chronic condition, and life expectancy.

While socio-economic deprivation and poverty have an impact on the NHS in Wales, with increased demand on services as a result, addressing these inequalities is not the sole role of the NHS. Tackling economic deprivation and poverty is a key challenge for all sectors in Wales, including the Welsh Government, public sector, third sector and the public. To address these challenges partnership working across all sectors is vital to ensure positive outcomes for people in Wales.



## Background

In a country where 690,000 people (23% of the population) and a third of children<sup>2</sup> are currently living in poverty,\* we must recognise the profound impact this has on the health and well-being of both current households and future generations. One of the key challenges for the NHS in Wales discussed in our 'From Rhetoric to Reality'<sup>1</sup> paper is the impact that poverty and deprivation have on people's health and well-being; *"Living in poverty continues to have profound implications for current households and future generations of children in Wales. The knock-on effect could impact on their educational performance, psychosocial development, ability to gain employment and to maintain their own health and well-being."*

There is clear evidence that people with a higher socio-economic position have a greater array of opportunities in life, including better health. The Marmot Review<sup>3</sup> into health inequalities in England found that people from different socio-economic groups experience avoidable differences in health, well-being and length of life, and that the higher a person's socio-economic position, the better their health. Marmot concluded that the two are linked, and this link is *"not a footnote to the 'real' concerns with health...it should become the main focus"*.<sup>3</sup> The patterns identified by Marmot are clearly evident in Wales.

The Equality and Human Rights Commission report 'How fair is Wales? Equality, human rights and good relations'<sup>4</sup> highlighted that the levels of long-term illness and disability are higher in Wales than the rest of Britain. The report sets out an agenda for fairness for Wales and discusses the challenge in Wales to reduce health inequalities between socio-economic groups. The Bevan Foundation report, 'Rethinking poverty – implications for action',<sup>5</sup> highlights that poverty has been a high political priority in Wales for many years. Tackling poverty featured significantly in the Welsh Government's Programme for Government and this priority has been backed by the introduction of legislation, policy statements and implementation arrangements to address inequalities including; Fairer Health Outcomes for All, Tackling Poverty Action Plan 2012 – 2016, Building Resilient Communities: Taking Forward the Tackling Poverty Action Plan, Children and Family (Wales) Measure 2010 and the Child Poverty Strategy. Despite these Government initiatives there has been little change in the number of people living in poverty in Wales, with some organisations<sup>6</sup> forecasting that the poverty rate will increase by the end of this decade.

It is now the time for all public sector organisations, including the health service, to work together to tackle deprivation and inequality. Through the Well-being of Future Generations (Wales) Act it is imperative that collaboration across all public bodies improves to achieve a *"healthier Wales"* and an *"equal Wales"*.

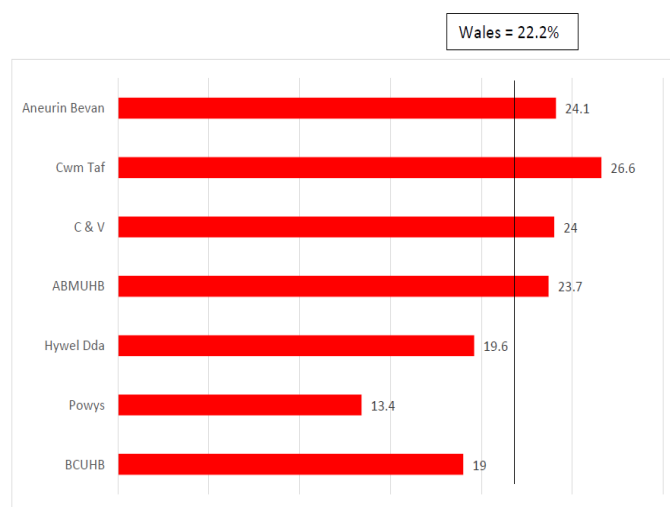
## Children

Nearly one third of children (more than 200,000) are affected by poverty in Wales.<sup>7</sup> This can mean living in cold or damp accommodation, not possessing enough warm clothing and not having enough food each day. All of these factors are likely to have a significant impact on their health and well-being as well as on the NHS in Wales.

From before birth, a range of socio-economic circumstances can impact on a child's development, future health, happiness and economic prosperity. The table (Fig 1) below highlights the number of children living in poverty is different across Health Board areas in Wales.

The table uses a measure of child poverty which is defined as children in families whose household income is less than 60% of the median UK income in 2010. In Wales more than one in five (142,595) children and young people aged under 20 live in poverty.<sup>8</sup> At the Health Board level Powys has the lowest percentage of children in poverty and Cwm Taf has the highest. In Cwm Taf University Health Board more than one in four children live in poverty (26.6%) while in Powys teaching Health Board one in eight children (13.4%) live in poverty.<sup>8</sup>

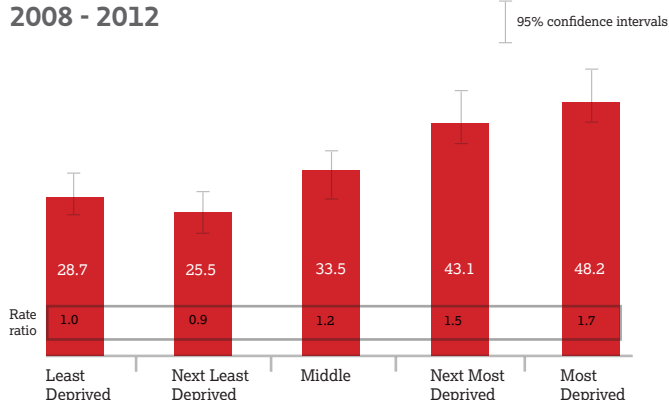
**Fig 1: % of children living in poverty, persons aged under 20, 2010<sup>8</sup>**



There are numerous research reports that highlight how poverty and social inequalities have an important bearing on a child's survival, development, future health and happiness.

**a) Child mortality:** There is a strong association between deprivation and the risk of child death, with child mortality rates higher in the most deprived areas than in the least deprived. The Marmot Review<sup>3</sup> highlighted how poor health is strongly linked to socio-economic status with children born into poor families more likely to be born premature, have low birth weights and die in their first year of life. Public Health Wales' Child Death Review Programme Annual Report<sup>9</sup> evidenced that most child deaths (64%) occur in the first year of life and the death rate among children living in the most deprived fifth of Wales is 70% higher than among children in the least deprived fifth of Wales.<sup>9</sup>

**Fig 2: Deaths by deprivation fifth, rate and rate ratio, children and young people aged under 18 years, Wales, 2008 - 2012**



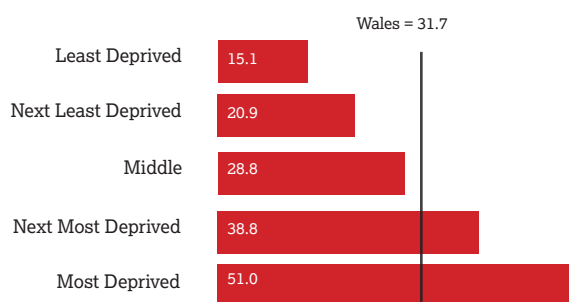
The Royal College of Paediatrics and Child Health report 'Why Children Die: Death in Infants, Children, and Young People in the UK'<sup>10</sup> discusses how reducing poverty and inequality are crucial steps towards reducing preventable child deaths.

**b) Contributes to the risk of stillbirth:** A wide deprivation gap exists in stillbirth rates, with women at higher risk of stillbirth in deprived areas. A study<sup>11</sup> from 2012 found that women from poorer socio-economic backgrounds are more likely to suffer a stillbirth than those from more affluent families. Researchers at the University of Leicester found that the total number of stillbirths in each deprivation tenth increased as deprivation increased, with approximately double the number of stillbirths in the most deprived tenth compared with the least deprived. There were 1,489 stillbirths in the least deprived tenth compared to 3,043 stillbirths in the most deprived tenth. It concludes that a better understanding of these stillbirths is necessary to reduce socio-economic inequalities.

**c) Children's development:** The early years are a critical time for a child's physical, cognitive, language, social and emotional development. Poverty begins to exert its effects from a young age.<sup>12</sup> Three-year-olds in households with incomes below £10,000 are 2.5 times more likely to suffer chronic illness than children in households with incomes above £52,000.<sup>13</sup> By age five, children from the most economically advantaged groups have been found to be more than a year ahead in vocabulary tests compared to those from disadvantaged backgrounds.<sup>12</sup> Approximately a third of pupils entitled to free school meals (just 36%) achieve five GCSEs at C or above, including English and Maths, compared to 63% of pupils who are not eligible.<sup>13</sup> Children living in low-income households are nearly three times as likely to suffer mental health problems as their more affluent peers.<sup>3</sup>

**d) Increased hospital admissions:** Children from more deprived backgrounds are at greater risk of hospital admission and are more likely to experience multiple admissions before the age of three years.<sup>14</sup> There is a higher incidence of acute illnesses among children from more deprived backgrounds, with acute infections such as pneumonia, infections, asthma and bronchiolitis, generally higher for children in the most deprived backgrounds.<sup>15</sup> As the table (Fig 3) below highlights, hospital admissions for pedestrian injuries of children from the most deprived fifth of the population is significantly higher than the least deprived.

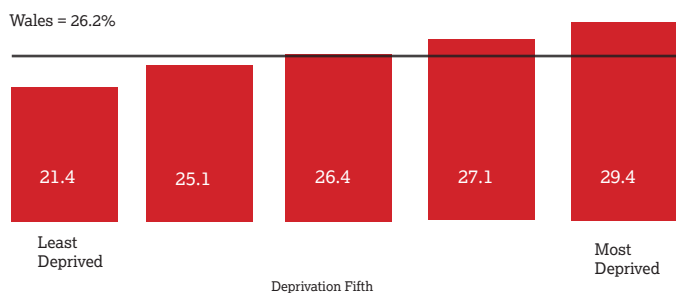
**Fig 3: Admissions for pedestrian injuries by deprivation fifth, children aged 5-14, Wales, rate per 100,000, 2006-2010<sup>16</sup>**





**e) Increased risk of unhealthy behaviour:** Children from wealthier families tend to have higher life expectancy and have healthier lives.<sup>12</sup> Deprivation plays a key role in children's obesity, as highlighted below. More than one in four (26.2%) children in Wales aged four to five-years-old are overweight or obese. However, the proportion of children from the most deprived fifth of the population who are overweight or obese is 29.4% compared with 21.4% in the least deprived fifth of the population.<sup>17</sup>

**Fig 4: Proportion of children aged four to five years who are overweight or obese for 2012 - 2013<sup>17</sup>**



As the evidence highlights, a child's development and chances of survival are heavily influenced by the social and economic circumstances into which they are born. As discussed within the Royal College of Paediatrics and Child Health's report 'Social and economic inequalities are matters of life and death for children'.<sup>10</sup> It is important that all sectors work together because children and families need to be empowered with the knowledge, skills and resources for the best start in life. We need better support for parents to adopt healthy behaviours during pregnancy and early infancy and we must design the places where children live, learn and grow to maximise their health and safety.

## Lifestyle health determinants in adults

How people live their life - whether they smoke, drink, take drugs, how they eat and whether they exercise - all impacts greatly upon their levels of health and well-being. These decisions are often perceived as solely a personal lifestyle choice but behaviour is often shaped by circumstance and socio-economic factors.

In Wales (and many other countries in the world) socio-economic factors and conditions impact on people's lifestyle choices and has a significant impact on demand for public sector services, including health. Social-economic deprivation is linked to obesity, smoking and unhealthy eating. The most recent Welsh Health Survey 2014<sup>18</sup> shows that in general adults in the least deprived areas reported healthier lifestyles in terms of smoking, obesity and fruit and vegetable consumption, however they were also more likely to drink above the recommended guidelines.

**Fig 5: Welsh Health Survey 2014: Adults who reported key health-related lifestyles by socio-demographic factors<sup>18</sup>**

	1	2	3	4
Alcohol (above guide)	45%	42%	36%	23%
Alcohol (binge)	25%	25%	23%	13%
Smoker	13%	20%	26%	36%
Fruit and veg (5 a day)	37%	32%	28%	22%
Exercise (5 per week)	28%	35%	32%	22%
Overweight	55%	60%	59%	57%
Obese	20%	21%	25%	22%

- 1 - Managerial & Professional
- 2 - Intermediate
- 3 - Routine & Manual
- 4 - Never worked

**a) Smoking:** While smoking may appear as an individual's lifestyle choice, it is possible that their decision to smoke is pushed by the effects of the context of their lives and is in effect a response to that context. In Wales a fifth (21%) of adults currently report smoking and smoking is more common among those who are not working than those in managerial and professional occupations.<sup>18</sup> The Welsh Health Survey 2014<sup>18</sup> indicates that smoking rates increased with deprivation, with 13% of adults in managerial and professional households reported smoking either daily or occasionally, compared with 36% in households headed by someone who had never worked or was long-term unemployed.

Smoking is the largest single cause of avoidable ill health and early death in Wales. Around 5,600 deaths per year in Wales are caused by smoking, which is nearly one in five of all deaths.<sup>19</sup> A similar proportion of hospital admissions can also be attributed to smoking,<sup>20</sup> with the total cost to NHS Wales estimated at £1 million every day.<sup>21</sup> Smoking is also an important risk factor for coronary heart disease, stroke, respiratory diseases, many cancers and is often related to deaths in fires. Exposure to environmental tobacco smoke is a major risk factor for conditions such as sudden infant death syndrome and respiratory childhood diseases.

**b) Obesity:** In Wales around 3 in 5 (58%) adults<sup>18</sup> are classified as being overweight or obese and this significant, and rising, number will lead to avoidable morbidity and mortality in a high proportion of the Welsh population. Obesity is an important determinant of a wide range of mortality and morbidity including diabetes, cardiovascular disease, cancer and arthritis.

The percentage of people reporting being overweight or obese increases with deprivation. The Welsh Health Survey 2014<sup>18</sup> indicated that 53% of people in the least deprived fifth reported being overweight or obese compared with 61% in the most deprived fifth. Across local authority areas, the number of people who reported being overweight or obese ranged from 51% in Monmouthshire to 64% in Rhondda Cynon Taf.

**c) Alcohol consumption:** Alcohol consumption does not follow the same pattern as obesity or smoking, with those in least deprived areas consuming more alcohol, as illustrated below. The Welsh Health Survey 2014<sup>18</sup> highlights that while adults in managerial and professional households were less likely to smoke, more likely to meet guidelines for fruit and vegetable consumption and less likely to be overweight or obese than those in routine and manual households, they were also more likely to drink above the recommended guidelines. Alcohol consumption decreased as deprivation increased, with 45% of adults in managerial and professional households reported drinking above the guidelines compared with 23% in households headed by someone who had never worked or was long-term unemployed. However the pattern in alcohol consumption is in contrast to outcomes in alcohol attributable and specific mortality.<sup>22</sup>

Alcohol is an important cause of disease and death. Recognised adverse effects include diseases of the liver and pancreas, some cancers, high blood pressure, stroke, intentional and unintentional injuries (including road traffic injury), unsafe sexual behaviour and mental disorders. Alcohol attributable mortality and specific mortality shows a strong relationship with deprivation, where rates in mortality in the most deprived areas are much higher than those in the least. Alcohol-specific mortality is 3.6 times higher for males in the most deprived areas compared with the least deprived areas and for females, there is a threefold difference in mortality.<sup>22</sup>

In summary as evidenced the potential impacts such lifestyle patterns can have on the health service should not be understated. Diet, exercise and obesity are important determinants of cardiovascular disease, type 2 diabetes, some cancers, and physical and psychological well-being.<sup>19</sup> An ageing, unhealthy population is putting unprecedented demand on our health service but we can do more to encourage people to live healthier lives and we must address the inequality that is so rife in Wales.

### Life expectancy and healthy life expectancy

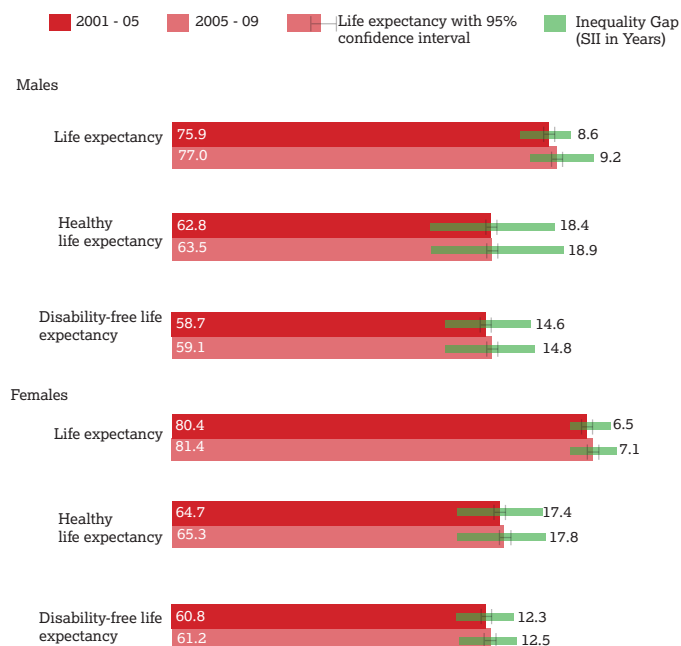
People across Wales are living longer and they are living in good health for longer. But this health gain is not distributed equally across our nation. Deprivation has a significant impact on people's healthy life expectancy and impacts on people's overall life expectancy.

Healthy life expectancy is an estimation of how long someone may live in a 'healthy' state, free from life limiting disease or serious illness. Life expectancy is the most commonly used measure to describe population health and reflects the overall mortality level of a population. Life expectancy measures how long, on average, a person is expected to live based on current age and sex-specific death rates.

While the life expectancy of both men and women has increased over time, the life expectancy gap between the most and least deprived fifth of areas in Wales has only decreased slightly. In 2011–2012 the life expectancy gap between the most and least deprived fifth of areas in Wales stood at just under six years for women and just under seven years for men.

The table (Fig 6)<sup>23</sup> below illustrates the inequality gap between life expectancy, healthy life expectancy and disability-free life expectancy.

**Fig 6: Life expectancy, healthy life expectancy and disability-free life expectancy, with inequality gap, males and females, Wales, 2001-05 and 2005-09<sup>6</sup>**



In 2005-09 life expectancy in Wales was 77.0 years for males and 81.4 for females. Males are estimated to spend 63.5 years in good health (82.4% of overall life expectancy) and 59.1 years without a limiting long-term illness or disability (76.8% of overall life expectancy). Females can expect to live 65.3 years in good health (80.2% of overall life expectancy) and 61.2 years without a limiting long-term illness or disability (75.1% of overall life expectancy). While there were increases in overall life expectancy between 2001-05 and 2005-09, there was less of an increase in the measures relating to quality of life experienced. Life expectancy has therefore improved more than quality of life and health.

The Welsh Health Survey 2013<sup>24</sup> shows that the levels of ill-health increased with levels of area deprivation. In general, those in the most deprived areas reported the worst health. The Survey found that in households headed by someone who had never worked or was long-term unemployed, 41% of adults reported that their health in general was fair or poor, compared with 13% in managerial and professional households.



**Fig 7: Welsh Health Survey 2013: Adults who reported key illnesses or health status by socio-demographic factors<sup>24</sup>**

	1	2	3	4
Currently being treated for any illness	46%	47%	54%	69%
Limited a lot by health problem or disability	11%	14%	21%	37%
Of fair or poor health	13%	17%	26%	41%

1 – Managerial & Professional  
 2 – Intermediate  
 3 – Routine & Manual  
 4 – Never worked

### Living with an illness or chronic disease.

Wales currently has the highest rates of long-term limiting illness in the UK, which is the most expensive aspect of NHS care. Between 2001-02 and 2010-11 the number of people with a chronic or long-term condition in Wales increased from 105,000 to 142,000.<sup>25</sup>

In Wales half (50%) of adults are currently being treated for a chronic illness including;<sup>24</sup>

- 20% for high blood pressure
- 14% for respiratory illness
- 12% for arthritis
- 12% for mental illness
- 8% for a heart condition
- 7% for diabetes

Socio-economic deprivation is a key factor in the prevalence of chronic illness, as highlighted within the Welsh Health Survey 2013.<sup>24</sup> In the Survey, respondents from lower socio-economic groups had a higher prevalence of chronic disease, while those in less deprived areas had lower prevalence of disease.

**Fig 8: Welsh Health Survey 2013: Adults who reported key illnesses or health status (age-standardised), by socio-demographic factors<sup>24</sup>**

	1	2	3	4
High blood pressure	18%	19%	23%	26%
Any heart condition (exc high blood pressure)	8%	8%	11%	10%
Any respiratory illness	12%	13%	16%	24%
Any mental illness	9%	11%	15%	28%
Arthritis	9%	11%	16%	24%
Diabetes	5%	6%	9%	10%

1 – Managerial & Professional  
 2 – Intermediate  
 3 – Routine & Manual  
 4 – Never worked

As highlighted in Fig 8, many diseases or health conditions become increasingly more common as socio-economic deprivation increases. Multi-morbidity (having one or more chronic conditions) is more common among deprived populations and people with these conditions often require complex care and spend more time in hospital than their counterparts. Tackling inequality could go some way to addressing the increasing number of people requiring such complex and demanding hospital care.

### Mental health

In the Welsh Health Survey 2013,<sup>24</sup> 12% of the Welsh population reported that they were currently being treated for a mental illness. The Welsh Health Survey 2013<sup>24</sup> shows a close association between poor mental health and socio-economic deprivation, with people living in the most deprived communities being more likely to be currently treated for mental illness as those in the least deprived. More than one in four (28%) people who are unemployed or who have never worked are being treated for a mental illness compared with less than one in ten (9%) people in managerial and professional occupations.

### Arthritis

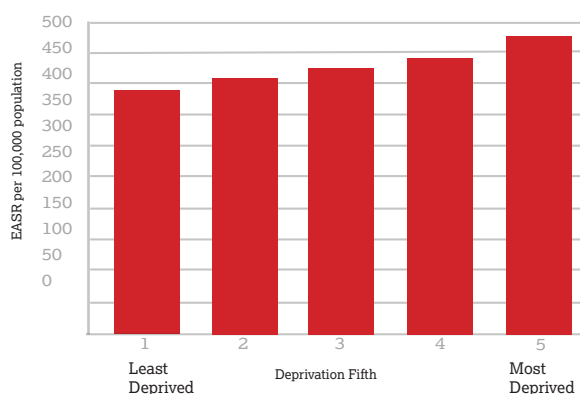
The Welsh Health Survey 2013<sup>24</sup> illustrates that people being treated with arthritis in deprived areas was higher compared with people in least deprived areas. The proportion of adults reporting being treated for arthritis in the most deprived areas was nearly one in five people (18%) compared with one in twelve people (8%) in the least deprived areas.

### Cancer

Recently published data from Welsh Cancer Intelligence and Surveillance Unit (WCISU)<sup>26</sup> considered the incidence of cancer according to the deprivation levels of neighborhoods, which revealed stark health inequalities between different Local Authorities and Health Boards areas in Wales. The results found that cancer is more common and survival rates are worse in more deprived areas.

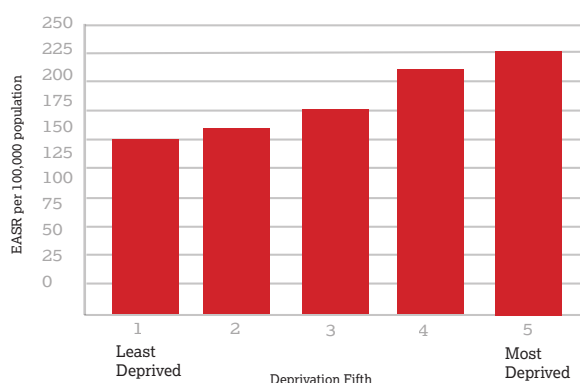
The incidence rate of cancer is 20% higher in the most deprived areas of Wales, compared to the least deprived – which is approximately 80 extra cancer cases for every 100,000 people living in the most deprived areas. WCISU report states “*The differences between local authority areas are in part due to variation in deprivation*”. Ceredigion had the lowest cancer incidence of the 22 local authority areas in Wales, while Torfaen’s rate is nearly 8% higher than the Wales average.

**Fig 9: Cancer incidence rate (EASR) for areas with increasing deprivation fifth in Wales. All persons, all ages. 2008-2012<sup>26</sup>**



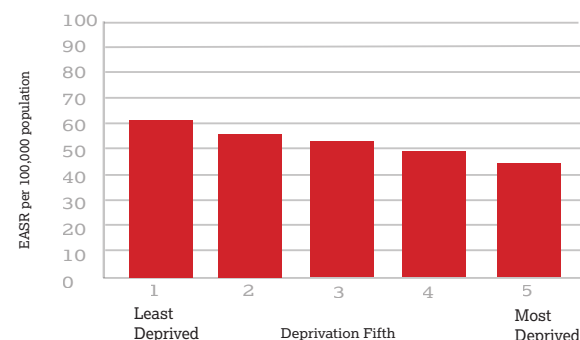
As well as cancer incidence, cancer survival rates decrease and mortality rates increase in more deprived areas. Whereas cancer incidence is 20% higher in the most deprived areas compared to the least deprived, cancer mortality rates are 50% higher.

**Fig 10: The gradient of cancer mortality rate for areas with increasing deprivation fifth. Wales, persons, all ages. 2007-2011<sup>2</sup>**



In more deprived areas the chance of survival is worse for both one year and five year relative survival. In Wales, one year survival in the most deprived areas is 17% less than in least deprived areas. For five year survival the difference is wider – the chance of survival is 28% less in the most deprived areas compared to the least deprived<sup>26</sup> as highlighted in the table below.

**Fig 11: Five year cancer survival gradient for areas with increasing deprivation fifth. Wales, persons, all ages. 2003-2007<sup>26</sup>**



## Health service use

Socio-economic deprivation and poverty have a significant impact on the NHS in Wales, with increased demand on some services as a result. The Welsh NHS Survey 2013<sup>24</sup> highlights that adults in the most deprived areas were more likely than those in the least deprived areas to report talking to a GP and attending casualty department, and less likely to report using a dentist or optician.

There is little evidence to highlight why adults in more deprived areas are less likely to access a dentist or optician but international research highlights that people living in poverty often report that they only use health services that are low-cost or free, that they have unmet healthcare needs due to costs of transportation and medication and experience greater need for support to access preventive care.<sup>27</sup> It has been shown that dentists, as independent contractors in the NHS, choose to set up practices in more affluent areas.<sup>28</sup> To ensure effective increase in dental attendance in families from deprived areas it is important to remove barriers to care, such as travel, and ensuring health promotion and education targeting adults in locations such as shopping centres serving a deprived area to increase their knowledge and awareness.<sup>29</sup>

**Fig 12: Welsh Health Survey 2013: Adults who reported using selected health services, (age-standardised), by socio-demographic factors<sup>24</sup>**

	1	2	3	4
GP	15%	17%	19%	29%
Attended casualty dept	16%	17%	18%	20%
Outpatient Dept	33%	31%	32%	34%
In hospital as inpatient	8%	8%	10%	12%
Pharmacist	73%	70%	67%	70%
Dentist	73%	70%	67%	70%
Optician	56%	49%	47%	49%

- 1 – Managerial & Professional
- 2 – Intermediate
- 3 – Routine & Manual
- 4 – Never worked

## Meeting the challenge

If we are to meet the growing needs of the population both now and in the future, it is vital that all sectors work together. As this briefing has highlighted, social economic deprivation has a significant impact on people's health and, in turn, the health service. Despite all efforts, social inequalities in Wales still exist and the challenge that these pose cannot and must not be left to the health service alone to address.

A significant opportunity to improve the lives of the people of Wales and tackle the challenges outlined in this briefing is the introduction of the Well-being of Future Generations (Wales) Act 2015.

The Act is designed to make public bodies think more about the long-term, work better with people and communities and each other, look to prevent problems and take a more joined up approach. It is about improving the social, economic, environmental and cultural well-being of Wales. This new law will mean that, for the first time, public bodies listed in the Act must do what they do in a sustainable way, including demonstrating how they are maximising their contribution to "a healthier Wales" and "a more equal Wales". All public bodies will need to make sure that when making their decisions they take into account the impact they could have on people living in Wales in the future.

Through the Act it is imperative that all public bodies prioritise reducing health inequalities for those in a lower socio-economic position. As the Royal College of Paediatrics and Child Health Wales reports; "*policies to modify health behaviours need to address the social determinants of health, and interventions need to be proportionately targeted across the social gradient if they are to reduce health inequalities effectively*".<sup>10</sup> This groundbreaking legislation provides us with the opportunity to make a substantial difference to the future health and well-being of our population and we must seize it with both hands. We must collectively embrace the aims of the Act and work together to make them a reality. While one agency cannot do this alone, the NHS must build on how it might improve its ability to work and support partners and colleagues in other sectors to reflect the multi-disciplinary demands required to run public services in a holistic way. This will, in turn, help reduce overall demand on health and drive improvements across the NHS and for patient outcomes.

As well as statutory agencies and other relevant organisations, the public also has a key role to play to improve its own health and well-being and reducing unhealthy lifestyles. The future success of the NHS relies on us all taking a proactive approach to health and ensuring that we create the right conditions to enable

people in Wales to live active and healthy lifestyles. The sustainability of the NHS and other public services bodies is the responsibility of everyone in Wales, but do the public understand this? The recent Welsh NHS Confederation / ABPI survey<sup>30</sup> highlighted that 86% of people believe their own behaviour impacts "a great deal" or "a fair amount" on their health and well-being. People need to be educated and empowered to have the knowledge and understanding to remain in good health and receive appropriate interventions.

## Conclusion

The research and evidence illustrates that, in nearly all instances, people living in the most deprived areas have worse health than those in the most affluent areas. The challenges NHS Wales faces must be addressed and they must be addressed soon. As 'From Rhetoric to Reality'<sup>1</sup> highlights, we in Wales are on "a burning platform" and cannot stand still. Demand on health and social services is at the highest it has ever been. The way services are delivered must change and so must the way people live their lives through maintaining a healthy lifestyles. We must deliver a more preventative approach for our public's health that has maximum impact to reduce inequalities and keep people healthier for longer.

Deprived communities, however, need support. But this support must come from many organisations, not just the health service alone. We all have so much to gain from reducing the unfair inequality that is so prevalent in our Welsh society. Urgent and sustained action is needed by the Welsh Government and all public bodies if fairer health outcomes for all are to be achieved. As part of this work, it is crucial that we all realise the significance of the Well-being of Future Generations (Wales) Act 2015 and the key role it can play in our mission to tackle social inequalities and improve the health and well-being of the people of Wales.

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\* A household is considered to be in poverty if its income (after tax and adjusted for household size) is below 60% of the UK median for the year.

## Join the conversation

Please let us know how you think we can turn our much talked-about NHS of the future into a much-needed reality for the people of Wales.

Join the debate by contacting our dedicated From Rhetoric to Reality email address: [reality@welshconfed.org](mailto:reality@welshconfed.org) or write to us.


## The Welsh NHS Confederation

The Welsh NHS Confederation is a membership body representing all the organisations making up the NHS in Wales: seven Local Health Boards and three NHS Trusts.

We support our members to improve health and well-being by working with them to deliver high standards of care for patients and best value for taxpayers' money. We act as a driving force for positive change through strong representation and our policy, influencing and engagement work.

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