Reducing Inequalities Alliance

The economic argument for tackling health inequalities

The social and moral need to reduce health inequalities is widely recognised across our health and social care system. Yet there is also a strong economic argument for tackling inequalities in health. Our analysis on data across the Bradford district showed that health inequalities added an estimated £9 million in 2022 and 2023 to the cost of hospital care. This briefing provides an outline of the financial cost of health inequalities across our district.

The extent of social deprivation in the Bradford district is significant. Deprivation affects almost half of our population (circa 260,000 of our residents) according to the 2019 Index of Multiple Deprivation.

Our residents living in many areas of Bradford, Keighley and in parts of Skipton have their health affected by poverty, as the Bradford district remains one of the fifth most deprived areas in the whole of England.

People living in high areas of deprivation are statistically more likely to have chronic illnesses (such as diabetes, arthritis, high blood pressure, epilepsy and asthma) earlier in life and are more likely to die at a younger age. Earlier ill health and premature deaths (due to health inequalities linked with deprivation) therefore affect a large proportion of our population.

Factors such as poor housing, lack of access to education and nutritious food, higher smoking rates and financial hardship are all contributing factors to health inequalities for residents living in areas of deprivation.

Deprivation is linked to increased hospital costs

Research carried out by the University of York (The costs of inequality: whole-population modelling study of lifetime inpatient hospital costs in the English National Health Service by level of neighbourhood deprivation, *Asaria M, Doran T, Cookson R., J Epidemiol Community Health 2016)* showed that over a lifetime, inpatient costs are higher for people who live in more deprived areas. This is despite

the fact people living in deprived areas generally have shorter lifespans. The amount of healthcare needed, often for multiple health conditions, contributes to higher care costs.

We analysed recent health data for Bradford district. This showed that the sheer scale of health inequalities added an estimated £9 million in 2022 and 2023 to the cost of hospital care (both inpatient and outpatient) for working aged people[1].

We estimate the cost of health inequalities on emergency hospital admissions to be in the region of £3.6 million for 2022 and 2023 for people of all ages[1]. These costs could be reduced through tackling health inequalities, by improving the risk factors for poor health (mentioned above), prevention of illness and early access to diagnosis and treatment.

Link between economic inactivity and areas of high deprivation

Our analysis showed economic inactivity (working aged people who are not in employment and are not actively job-seeking) is also greater in areas of high deprivation. In Bradford and Craven the estimated annual cost to the economy from lost earnings due to health inequalities (not just due to ill health) is at least £67 million, with £11 million lost in taxes[2].

Furthermore, we estimate that health inequalities affecting people in Bradford and Craven adds more than £82 million each year to the local cost of health-related welfare benefits.

As the Reducing Inequalities team, our efforts are concentrated on working with local partners to develop a shared strategic focus to reduce health inequalities and inequalities in the economic and social determinants of health. Initiatives to boost economic prosperity and reduce poverty for the whole district as well as improving health, are vital.

Our latest publications are available on our Reducing Inequalities Alliance website

Notes

[1] This estimate makes the assumption that the healthcare cost per head in the most deprived 40% of the population could be reduced to the healthcare costs of the middle 20% of the population in terms of deprivation.

[2] This estimate makes the assumption that long term sick levels (and resulting lost earnings) in the most deprived 40% of the population could be reduced to lost earnings of the middle 20% of the population in terms of deprivation.