ESPN Thematic Report on Inequalities in access to healthcare

UK

2018

Jonathan Bradshaw, Karen Bloor and Tim Doran
June 2018

EUROPEAN COMMISSION

Directorate-General for Employment, Social Affairs and Inclusion
Directorate C — Social Affairs
Unit C.2 — Modernisation of social protection systems

Contact: Giulia Pagliani

E-mail: Giulia.PAGLIANI@ec.europa.eu

European Commission
B-1049 Brussels

European Social Policy Network (ESPN)

ESPN Thematic Report on Inequalities in access to healthcare

UK

2018

Jonathan Bradshaw, Karen Bloor and Tim Doran

University of York

The European Social Policy Network (ESPN) was established in July 2014 on the initiative of the European Commission to provide high-quality and timely independent information, advice, analysis and expertise on social policy issues in the European Union and neighbouring countries.

The ESPN brings together into a single network the work that used to be carried out by the European Network of Independent Experts on Social Inclusion, the Network for the Analytical Support on the Socio-Economic Impact of Social Protection Reforms (ASISP) and the MISSOC (Mutual Information Systems on Social Protection) secretariat.

The ESPN is managed by the Luxembourg Institute of Socio-Economic Research (LISER) and APPLICA, together with the European Social Observatory (OSE).

For more information on the ESPN, see: http:ec.europa.eusocialmain.jsp?catId=1135&langId=en

Contents

Summary/Highlights

The National Health Service provides health care free at the point of use. It is funded by central government primarily out of general taxation. On some measures, particularly equity of access to health care, it is amongst the highest performing health care systems in the world. Patients register with a local general practitioner who provides primary care and is the gate keeper to hospital and specialist services. Networks of general practitioners also commission local healthcare services. Equity in the distribution of healthcare services is supported by systems of spatial resource allocation that take into account age and estimated health care need characteristics. A system of targets for waiting times and an inspection regime support the quality of care. There are, however, some user charges: most working age adults have to pay a standard charge for prescriptions (except in Scotland) and most adults have to pay standard charges for dental and optical services. These may deter some poorer patients, though the poorest are exempted. The National Institute for Health and Care Excellence (NICE) aims to promote equity of access to new technology by appraising its cost-effectiveness and recommending whether or not new interventions should or should not be provided by the whole NHS in England and Wales. Advice from NICE also informs decisions in Scotland and Northern Ireland, but other agencies have formal responsibility for funding decisions in these countries (Healthcare Improvement Scotland and the Health and Social Care Board respectively). Recent expenditure constraints, in combination with longstanding trends of increasing complexity and comorbidities means that demand is generally thought to exceed supply; waiting times are increasing at present. People who are not ordinarily resident in the UK and not covered by reciprocal agreements or other exemptions are charged for their treatment (normally retrospectively, but the full estimated cost in advance for non-urgent treatment) at 150% of the standard NHS rate. There remain criticisms of the balance of spending in the NHS with acute medicine and surgery being given priority over mental health, preventative health and public health.

Despite NHS funding being fundamentally equitable, health outcomes remain unequal – spatially, by income and social class, ethnicity, age and gender. The causes of these inequalities are mainly not the direct responsibility of the health care system. Other factors, including environmental pollution, food manufactured with too much salt and sugar, health behaviour (eating, drinking, smoking and exercise), and at the heart of it inequality, poverty and deprivation - which have all been getting worse in the last ten years as a result of austerity policies. Health care institutions continue to seek to improve equity in health outcomes. Recent examples include the teenage pregnancy strategy, payments to GPs for blood pressure screening, influenza vaccination of the elderly, advice about laying babies on their backs, anti-smoking campaigns and vehicle speed regulation. More could be done if public health spending was increased and government took wider regulatory action on diet, pollution and screening. Overall, however, real health inequality reductions will only come from outside the health care system: social security, housing and environmental policies that reduce the main drivers of inequality – poverty and deprivation.

1. Description of the functioning of the country's healthcare system for access

The core principle of the UK National Health Service (NHS) is that coverage is universal and care is provided largely free at the point of use. The NHS is complemented by local government social care,[1] which is means tested, supporting the elderly and disabled in residential and community care. Social care is not covered in this report.

Fee for service private health care is available and some firms insure their staff through private health institutions (the biggest is BUPA). There has been a recent increase in private provision, with 4 million people (10.6% of the population) having some form of private cover in 2015. Three quarters of coverage is provided through employer schemes. Private contractors can be commissioned by the NHS to provide services, indeed General Practitioners are private contractors.

For health care, citizens register with a local doctor (General Practitioner (GP)), who provides primary care and is the gate keeper to hospital and specialist services. Networks of general practitioners also commission local healthcare services. There are no charges for GP or specialist and hospital services.

The NHS is funded by central government out of general taxation. UK expenditure on health care as a percentage of GDP was 9.9% in 2015, with country-level spend in 2015-16 of £115(€131) billion in England, £12.1(€13.5) billion in Scotland, £6.6(€7.6) billion in Wales and £4.0(€3.6) billion in Northern Ireland.[2] In comparison, France spends 11.0% of its GDP on health care, and Germany 11.3%.[3] UK health spending grew rapidly in the first decade of the 21st century but since 2010 it has been relatively static in real terms. The NHS expenditure of each of the countries represents about 20 per cent of total public expenditure.[4]

There are differences between the four UK countries' national expenditure levels per capita which are a product of the Barnett formula.[5] This has governed central government allocations since 1978 and results in Scotland having a higher per capita spend (in 2014/15 £2,208(€2583) per person compared with £2,112(€2471) in England, £2,129(€2491) in Wales and £2,177(€2547) in Northern Ireland).[6] Since 1976, NHS funds have been allocated within England using a weighted capitation formula.[7]

In principle there are no major financial barriers to access. There are, however, some barriers to access due to the following:

- User charges:[8] except in Scotland there are standard charges for prescriptions for non- exempt groups (children, elderly and members of low income households are exempt, as are pregnant women and those with children up to one year, and people with certain medical conditions such as cancer, diabetes and epilepsy). There are also standard charges for dental and optical treatment for non-exempt groups (children are exempt, and older people and those on low incomes can qualify for free sight tests and subsidised optical treatment; free dental treatment is available to young people, pregnant women and those on low incomes, but not old age pensioners).

[1] But see Glendinning, C. (2018) ESPN Thematic Report on Challenges in long-term care United Kingdom ESPN TR2.
[2] HM Treasury (2017), Public Expenditure: statistical analyses 2017, London
[3] Organisation for Economic Cooperation and Development (2017), *Health expenditure and financing*: http://stats.oecd.org/Index.aspx?DataSetCode=SHA (last accessed 07/01/18)
[4] National Audit Office (2012), Healthcare across the UK: a comparison of England, Scotland, Wales and Northern Ireland, HC 192
[5] 'Barnett Formula', House of Commons Library Research Paper 01/108, 2001
[6] The Health Foundation (2016) Health and Social Care Funding Explained: http://www.health.org.uk/health-and-social-care-funding-explained (last accessed 21/02/17)
[7] Holland, W. (2013), *Information and the Resource Allocation Working Party*, Socialist Medical Association
[8] https://www.nhs.uk/NHSEngland/Healthcosts/Pages/help-with-health-costs.aspx

- Non-citizens: There are also user charges for treatment of tourists and other visitors not covered by bilateral or multilateral agreements. Those seeking asylum or granted refugee status are exempt. People who are resident in the UK can access services freely, but those staying temporarily for more than six months (e.g. students) pay an immigration health surcharge (£150 (€170) per year for students, £200 (€227) for others). All visitors can be expected to obtain treatment in an emergency, though if they do not qualify for free care, efforts will be made to get them to pay retrospectively. The issue of "health tourism" has been greatly exaggerated; the cost to the NHS of treating non-residents is estimated at £1.8 (€2.05) billion a year, of which £400 (€455) million can be recouped directly from patients or through the European Health Insurance Card scheme.[9]
- Spatial inequities: there are long-standing inequities in the quality and quantity of services. The NHS attempts to reduce these by allocating resources to health care commissioners (networks of general practitioners) and consequently to hospital trusts through allocation formulae that incorporate population characteristics predictive of health care need (for example: age, health status, and area deprivation).[10] These attempts are undermined by the political need to protect areas that have historically been relatively over-funded (for example, London) from disinvestment. As a result, parts of the country – particularly in the North West and North East regions – remain underfunded relative to their population health needs.[11]
- Demand exceeding supply: The NHS is and has always been under great pressures to meet demand. Health care is rationed not by ability to pay but by other mechanisms. Access to hospital and specialist services is subject to availability and there are waiting lists. The NHS introduced waiting time targets for different hospital procedures which were effective during the 2000-2010 period but these have not been achieved in recent years and some have been relaxed or removed, partly due to unintended consequences and partly to financial constraints. Emergency Departments have targets for seeing patients within certain times but recently these have been missed – hospitals have not reached the target of 95% of patients in A&E being treated within 4 hours since summer 2015. Sometimes (particularly in the winter months), demand for hospital beds exceeds the supply resulting in patients waiting for long periods in Accident and Emergency units on 'trolleys'. Targets for GP access have been abolished, and targets for elective treatment within 18 weeks are not currently being enforced fully.[12] Mental health services are available on the NHS but are under particularly heavy pressure, particularly child and adolescent services.
- Depth: Some treatments and some drugs are not available from the NHS. For example, some cosmetic procedures are not available. Some interventions judged by NICE not to meet expected standards of cost-effectiveness are not available. Abortion is not currently available from the NHS in Northern Ireland.
- Balance of spending: There is continuous argument about the balance of spending in the NHS. In general, it is believed that acute medicine is prioritised over public health, preventative medicine and mental health.

Not all these barriers to access present serious challenges to equity in health care. Nevertheless, there are substantial inequities/inequalities in health outcomes, which have

[9] Prederi, 2013. Quantitative Assessment of Visitor and Migrant Use of the NHS in England, p.11. Available from: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/251909/Quantitative_Assessment_of_Visitor_and_Migrant_Use_of_the_NHS_in_England_-_Exploring_the_Data_-_FULL_REPORT.pdf

[10] https://www.england.nhs.uk/wp-content/uploads/2016/04/1-allctins-16-17-tech-guid-formulae.pdf

[11] Kontopantelis E, Mamas MA, van Marwijk H, Ryan AM, Bower P, Guthrie B, et al. Chronic morbidity, deprivation and primary medical care spending in England in 2015-16: a cross-sectional spatial analysis. BMC Med. 2018;16: 19.

[12] https://www.theguardian.com/society/2018/mar/23/patient-groups-criticise-hunt-ditching-nhs-waiting-time-targets

not narrowed over time, and some of which are arguably growing. These exist spatially, by social class, ethnic group and by age and gender. There is no doubt that the major drivers of these inequalities in health outcomes have little or nothing to do with equities in health care – they are mainly the consequences of social, economic, environmental and behavioural factors. This presents two main challenges to the NHS. First, residents of deprived areas place much greater demand on health services throughout their lives, despite those lives generally being shorter. Compared with the most affluent fifth of areas, hospital admission rates for people living in the most deprived fifth of areas are 20% higher for planned admissions and 71% higher for emergency admissions. The annual cost of this excess demand to secondary care services in England has been estimated at £4.8 €5.5) billion per year.[13] Second, the NHS and health care policy generally faces the challenge of addressing inequalities over which it has little direct control. Public health can influence behaviour to an extent, but responsibility for this transferred from the NHS to local government in 2013, so it is no longer under NHS control, and local authority budgets have been severely constrained over recent years. Some public health interventions continue to have major impacts on health outcomes – contraception and teenage pregnancy, Mumps, Measles and Rubella (MMR) vaccination and infectious diseases, routine testing of older people for heart disease, screening for breast and bowel cancer, and many more. But there are limits.

This is illustrated very recently in a report by the Nuffield Trust[14] that found that the health outcomes of children has stopped improving, and the UK is losing ground on child health in comparison with its comparators. Commentators blamed variously high obesity rates (behavioural and public health), low breast-feeding rates (behavioural, public health, labour market) the absence of folic acid supplementation in diets (public health), sugar (public health and commercial) and rising child poverty and inequality (social economic policy).

The creation of the NHS, tax funded and free at the point of use, resulted in a system that aims to minimise inequalities in access to health care. There are, however, systems of local decision making that can result in spatial inequalities in access, known colloquially in the UK as a 'postcode lottery' for health care. Clinical Commissioning Groups (CCGs) decide on local priorities for health care in England, and can differ in these decisions, which contributes to spatial inequalities in access to certain treatments. Administrative structures are different in other countries, with commissioning undertaken by regional Health Boards in Wales and Scotland, and by the central Health and Social Care Board in Northern Ireland.

Commissioners and providers receive guidance from the National Institute for Health and Care Excellence (NICE) in England and Wales, from Healthcare Improvement Scotland in Scotland, and from the Health and Social Care Board in Northern Ireland. One of the aims of these bodies was to remove the potential for a 'postcode lottery'. For example, if NICE recommends a new intervention (e.g. a new cancer drug) in a *technology appraisal*, it is mandatory for commissioners to fund it, and while this has promoted equitable access to technology, it has also increased NHS expenditure significantly since its creation in 1999. Clinical guidelines produced by NICE to cover whole clinical areas (e.g. obesity, or infertility); these are not mandatory, and CCGs do not necessarily implement this guidance in full (e.g. they may choose a higher than recommended body mass index (BMI) threshold for bariatric surgery, or offer one rather than three cycles of infertility treatment (IVF) to infertile women), so some geographical inequities in access may remain. NICE guidance does, however, reinforce funding pressure from patient lobbies when CCGs restrict funding. NICE also produces guidance on the cost effectiveness of public health interventions and social care. In both these areas the evidence base is weak.

Health care commissioners and providers are monitored by regulatory organisations including the Care Quality Commission (CQC). CQC licenses and inspects all public and

[13] Asaria M, Doran T, Cookson R. The costs of inequality: whole-population modelling study of lifetime inpatient hospital costs in the English National Health Service by level of neighbourhood deprivation. 2016; 1–7.
[14] https://www.nuffieldtrust.org.uk/files/2018-03/1521031084_child-health-international-comparisons-report-web.pdf

private health and social care providers in England. Its publicly accessible reports list any quality infringements and it is empowered to ensure compliance with standards of good quality care e.g. staffing levels. Failure to comply can lead to 'special measures' with additional scrutiny and sometimes replacing Boards and managers. The cost of CQC inspections is considerable, and its benefits are as yet unproven. In Scotland, Wales and Northern Ireland, slightly different systems apply (see table 1 below).

Table 1: Health and social care regulators across the UK[15]

Sector	England	Northern Ireland	Scotland	Wales
Hospitals and acute care	Care Quality Commission and NHS Improvement	Regulation and Quality Improvement Authority	Healthcare Improvement Scotland	Healthcare Inspectorate Wales
GP practices	Care Quality Commission	Health and Social Care Board	Healthcare Improvement Scotland and RCGP Scotland	Healthcare Inspectorate Wales
Mental health services	Care Quality Commission and NHS Improvement	Regulation and Quality Improvement Authority	Mental Welfare Commission for Scotland and Healthcare Improvement Scotland	Healthcare Inspectorate Wales
Social care	Care Quality Commission	Regulation and Quality Improvement Authority	The Care Inspectorate and Healthcare Improvement Scotland	Care and Social Services Inspectorate Wales

Despite strong advocacy of prevention, the public health budget was cut by £200 (€234) million in 2015, and more since (2.5% cuts are planned for 2017-18, followed by cuts of 2.6% in 2018/19 and 2019/20).[16,17] Local government budgets were cut by 23.4 per cent in real terms between 2009-10 and 2014-15, and again more are planned. Such policies have eroded local public health activity and reduced social care, which is also in the remit of local government. Social care is means tested and budget cuts have reduced its scope, affecting hospital discharge policies, reducing patient throughput, and creating 'bottlenecks' (including delayed discharges) in the NHS.

Local government cuts have been unequal across the UK. In England, cuts have varied from 6.2 per cent to 46.3 per cent per capita. These differences do not reflect the equalisation policy which existed in principle until 2013-14: the most deprived areas have on average seen the largest spending cuts.[18] The chronic underfunding of social care, and its knock-on effects in terms of delayed hospital discharges, is causing considerable political agitation presently.

[15]British Medical Association. The Regulatory Systems for Healthcare Quality across the United Kingdom https://www.bma.org.uk/-/media/files/pdfs/collective%20voice/policy%20research/nhs%20structure%20and%20delivery/regulatory-systems-briefing-v5final.pdf?la=en

[16]https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/578906/LAC_DH__2016_3_v2.pdf

[17] https://www.kingsfund.org.uk/blog/2018/01/local-government-spending-public-health-cuts

[18] Innes, D and Tetlow, G, (2015) "Delivering fiscal squeeze by cutting local government expenditure". Fiscal Studies,36,3,303-325

2. Analysis of the challenges in inequalities in access to healthcare in the country and the way they are tackled

As evidence on inequalities in healthcare access and outcomes has accumulated (see Section 3), the NHS has responded with a series of initiatives to tackle the problem as part of broader governmental strategies. In 2003 reducing health inequality was made a priority for the NHS, including the setting of national targets for reducing health inequality by 2010.[19] Major investments were made in national primary care supply and quality, with targeted investment in under-doctored and deprived areas from 2008,[20] accompanied by national support for chronic conditions in disadvantaged adults from 2007.[21] There is some evidence that these initiatives had an impact on mortality amenable to healthcare, with the UK experiencing the fastest reduction in such deaths between 2004 and 2014 of the countries included in the Commonwealth Fund's 2017 report of health care system performance.[22] However, national targets on health inequalities were missed, and a legal duty for the Secretary of State to 'have regard to the need to reduce inequalities' was introduced in 2012,[23] which stimulated further initiatives including: the development of health equity indicators for use by local NHS and related agencies;[24] the introduction of a mandate for NHS England to address poor outcomes and inequalities; and the development of a comprehensive national toolkit for reducing inequalities in access to general practice services.[25]

There is some evidence for variation in access and patient experience across ethnic groups; for example, Pakistani and Bangladeshi patients rate communication more negatively, particularly women and older members of these communities.[26] There is little variation in access across socio-economic groups.[27] More significant determinants are the size of the practice and the practice location; patients attending smaller practices (composed of one or two physicians) are more satisfied on average with most aspects of care with the exception of opening hours, and patients based in London generally experience worse access than patients elsewhere in England.

Out-of-hours primary care and access to secondary care is more problematic. UK responders to the latest Commonwealth Fund survey frequently reported difficulty in obtaining out-of-hours care (49%); waiting for more than two hours in emergency rooms (32%); and facing delays in diagnosis (31%), specialist appointments (19%) and elective surgery (12% waiting longer than 4 months). There is extensive evidence that access to timely secondary care is strongly socially patterned, with more socio-economically deprived

[19] Department of Health. Tackling health inequalities: a programme for action. 2003. http://webarchive.nationalarchives.gov.uk/+/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4008268

[20] Department of Health. Equitable Access to Primary Medical Care. 2007. http://webarchive.nationalarchives.gov.uk http://webarchive.nationalarchives.gov.uk/+/http://www.dh.gov.uk/en/Aboutus/Procurementandproposals/Procurement/ProcurementatPCTs/index.htm

[21] Office NA. Tackling inequalities in life expectancy in areas with the worst health and deprivation. Prim Care 2010. https://www.nao.org.uk/report/tackling-inequalities-in-life-expectancy-in-areas-with-the-worst-health-and-deprivation/

[22] Commonwealth Fund (2017). Mirror, Mirror 2017: international comparison reflects flaws and opportunities for better US health care. http://www.commonwealthfund.org/interactives/2017/july/mirror-mirror/

[23] Gov.uk. *Health and Social Care Act 2012.*

[24] Cookson R, Asaria M, Ali S, Shaw R, Doran T, Goldblatt P. Health equity monitoring for healthcare quality assurance. Soc Sci Med. 2018/2;198: 148–156.

[25] NHS England. *Improving Access for All: Reducing Inequalities in Access to General Practice Services.* London, NHS England, 2018. Available from: https://www.england.nhs.uk/wp-content/uploads/2018/03/inequalities-resource-march18.pdf Accessed 3 May 2018.

[26] Burt J, Lloyd C, Campbell J, Roland M, Abel G. Variations in GP-patient communication by ethnicity, age, and gender: evidence from a national primary care patient survey. *British Journal of General Practice* 2016;66:e47-52.

[27] Kontopantelis E, Roland M, Reeves D. Patient experience of access to primary care: identification of predictors in a national patient survey. *BMC Family Practice* 2010;11:61.

patients waiting longer for treatment. Differences in education appear to be more important than differences in income; for example, the least educationally deprived fifth of patients wait 9-14% less than other patients for hip replacement surgery at the same hospitals.[28] Wealthier patients are more likely to achieve better health outcomes from care (for example, lower rates of surgical mortality and readmission) and to consume more preventative care (for example, screening and vaccination services).[29]

Given the universality of the NHS and the apparent equitability of primary care in the UK, these inequities in secondary care access have been explained by more educated patients having greater health literacy and being better able to articulate their needs and priorities, navigate the system, and to communicate with physicians closer to their own social status.[30] The effects of this unequal access are compounded by the UK's long-standing wider socio-economic inequalities, which have profound impacts on health outcomes. Despite the UK's high placing in the Commonwealth Fund's 2017 report on health system performance, it ranked 10th, ahead only of the US, on health outcomes.

After nearly 70 years of equitable access to health care in the UK, inequalities in health remain considerable e.g. life expectancy in deprived Eastern Glasgow is over a decade less than citizens in affluent Dorset.[31] The NHS has limited control over the underlying causes of these health inequalities, and is itself heavily impacted: the annual cost to the NHS of excess hospital admissions attributable to socio-economic inequality has been estimated at almost £5 billion.[32] Recent changes to the structure, organisation and regulation of the NHS, particularly in England, have not affected patients' access to health care services in England, which remain free at the point of use, tax financed and based on need, not ability to pay. The NHS and social care services have, however, been frugally funded since 2010, which has led to the erosion of performance targets and workforce problems in some sectors and regions, attributed to pay constraint and pressures on NHS staff.

3. Discussion of the measurement of inequalities in access to healthcare in the country

The Commonwealth Fund's 2017 report of health care system performance ranked the UK health care system first (of 11 developed countries) overall, first on equity, and third on access (including affordability and timeliness of care).[33] Of patients in the UK surveyed, only 1% reported facing serious problems paying medical bills, 4% faced out-of-pocket expenses of more than $1,000 (€847) per year, and 7% had any kind of cost-related problem with access to medical care. However, 11% reported forgoing dental care for reasons of cost (free dental care is only available for children, pregnant women and people on income support).

In terms of timeliness, UK patients are generally able to see a primary care physician quickly, but this will sometimes be another member of the practice team rather than their named doctor. In the most recent annual GP Patient Survey, which covers England, 92% of patients reported securing an appointment at a convenient time but only 56% reported being able to see their preferred GP most of the time and 48% were seen the same or next

[28] Laudicella M, Siciliani L, Cookson R. Waiting times and socioeconomic status: evidence from England. *Social Science & Medicine* 2012;74(9):1331-1341.
[29] Cookson R, Propper C, Asaria M, Raine R. Socio-Economic Inequalities in Health Care in England. Fisc Stud. 2016;37: 371–403.
[30] Asaria M, Doran T, Cookson R. The costs of inequality : whole-population modelling study of lifetime inpatient hospital costs in the English National Health Service by level of neighbourhood deprivation. 2016; 1–7.
[31] Marmot M (2010) *Fair Society, Healthy Lives* http://www.instituteofhealthequity.org/resources-reports/fair-society-healthy-lives-the-marmot-review
[32] Asaria M, Doran T, Cookson R. The costs of inequality : whole-population modelling study of lifetime inpatient hospital costs in the English National Health Service by level of neighbourhood deprivation. 2016; 1–7.
[33] Commonwealth Fund (2017). Mirror, Mirror 2017: international comparison reflects flaws and opportunities for better US health care. http://www.commonwealthfund.org/interactives/2017/july/mirror-mirror/

day.[34] Experiences of primary care are generally positive, with over 80% of surveyed patients nationally reporting their overall experience and satisfaction with communication as good.

The JAF Report[35] on health care access in the UK concluded that the available indicators do not show any challenge in the access domain and in 2016, unmet need for medical care due to cost (0.1%) was better than the EU average. No health challenges are identified in the JAF Health quality domain. Screening for colorectal cancer and the influenza vaccination rate for 65 year-old and older are, respectively, better and considerably better than the EU average. In 2014, the obesity rate (especially among young) is worse than the EU average. Inequality in risk-factors by income or educational groups is an issue in the United Kingdom. Indeed, inequality in regular daily smoking, obesity (as measured by the gap between the bottom and top income quintile), vegetable consumption and physical activity (as measured by the gap between low and high educated people) are worse or considerably worse than the EU average. On the other hand, fruit and vegetable consumption among young are considerably better than the EU average. The JAF report concluded

> "In the United Kingdom health spending per capita and health outcomes are both around the EU average. However, a number of health outcomes are deteriorating compared to the EU average change in the last years, including life expectancy and potential years of life lost. With spending on prevention higher than the EU average, some indicators on prevention (in particular colorectal cancer screening and influenza vaccination for older people) are better than average. Healthcare is universal and mostly funded by government outlays. Co-payments for NHS services are limited and coverage is very comprehensive, with some variation across devolved administrations. Indicators on access to healthcare are generally better than the EU average, in particular in terms of costs. The decline in the number of nurses and midwifes in the last years, with the risk of further reductions in the next years, is a concern for the future availability of care. In terms of non-health determinants, obesity and inequality in some risk-factors are an issue in the United Kingdom. Recent initiatives focused the integration of health and social care, as well as on cost control." (Page 14)

The Report on the comparative assessment of the accessibility of healthcare services[36] was critical of the EU SILC questions on access to medical care. But the latest data for 2016 has:

- The UK 1% for three **reasons too expensive too far to travel or waiting lists** compared with the EU average of 3.1%. Overall the UK was ranked ninth equal with Malta. There was very little variation by age group, activity status, gender, income quintile or education level.
- The UK 0.1% **too expensive** compared with the EU average of 1.6%.
- The UK 0% **too far to travel** compared with the EU average of 0.1%.
- The UK 0.9% **waiting list** compared with the EU average of 0.8%. The UK did comparatively least well on this indicator.

[34] NHS England. GP Patient Survey. Available from: https://www.gp-patient.co.uk/abouthttps://www.gp-patient.co.uk/about . Accessed 10 May 2018.
[35] JAF HEALTH FIRST AND SECOND STEP ANALYSIS UNITED KINGDOM
[36] European Commission (2015) The Report on the comparative assessment of the accessibility of healthcare services: comparability of indicators on unmet needs for medical examination or treatment across EU Member States