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Spring Budget 2021 Pre-Budget Briefings

Health inequalities and Covid-19

Health Inequalities and Covid-19

Pre Budget briefing from the UK Women's Budget Group

Key points

- *The healthcare sector has been at the forefront of the fight against Covid-19. The pressures on the NHS have been immense and issues around funding and staff shortages have come to the fore.*
- ***The pandemic hit after a decade with the longest spending squeeze in the history of the NHS**: growth in spending was 1.6% during 2010-2019 (annual average), down from a 3.7% each year since it began in 1948.*
- *The health, social care and social work sectors are large employment sectors within the UK economy, employing around 4.4 million people in 2019. The workforce is predominantly female**: 78% (3.45 million) employees in these sectors are women.** However, these sectors are **hierarchically structured by gender**.*
- *The NHS currently has a **shortage of 106,000 staff (9% of all posts**) and it is estimated to need an **additional 5,000 internationally recruited nurses every year** to preventing worsening staff shortages. The pandemic has increased the pressures on existing staff, exacerbating long-standing issues of chronic excessive workloads and burnout.*
- ***Staff shortages are likely to worsen with Brexit and the end of the EU freedom of movement.** 71% of EU migrants who are 'key workers' would not be eligible for a UK work visa under the new immigration system. This includes essential non-medical NHS staff and social care workers.*
- ***All minority ethnic groups other than Chinese women have been at higher risk of Covid-19 mortality than the White ethnic population.***
- *During the coronavirus pandemic in England, Covid-19 mortality levels were **3.8 times higher for Black African men, and 2.9 times higher for Black African women** than the White ethnic population.*

The healthcare sector has been at the forefront of the fight against the new coronavirus pandemic. The pressures on the NHS have been immense in the past year and issues around funding, preparedness and staff shortages have come to the fore.

Women comprise three-quarters of the healthcare workforce, which means women have been at the frontline of the health crisis facing the associated excessive workload, stress and burnout that the pandemic has brought to healthcare staff.

Gender is an important driver of health inequality. Often it intersects with other inequalities based on class, ethnicity, disability, gender identity and/or sexual orientation and other characteristics to present a widely uneven landscape of access, treatment and health outcomes. However, despite these inequalities, data on women's use of health and social care services is relatively poor.

This briefing looks at long-standing issues in the health service, in terms of structuring, funding and inequalities in health outcomes, and how Covid-19 has exacerbated these and created new problems.

Health Funding

Following the longest funding squeeze in its history over the past decade, the NHS has seen spending growth slow from 3.7% each year since 1948 to 1.6% between 2010/11 and 2018/19 (yearly average).[1]

Under austerity measures, NHS providers moved from an aggregate £2bn surplus in 2010 to a £2.5bn deficit in 2015/16. While deficits have fallen since then, NHS providers ended 2018/19 with a £571

[1] The King's Fund (2019) *NHS Funding: our position* (https://bit.ly/2EHgf3B)

million deficit. Clinical Commissioning Groups (CCGs) overspent by £155 million.[2]

The 2019 Spending Review pledged increased spending of £33.9bn for the NHS by 2023-24 in addition to the £20bn by 2023/4 announced in June 2018, leading to the 'NHS Long-Term Plan' (see next section). This committed a 3.4% annual increase for NHS England (in average real-terms) between 2019/20 and 2023/24, totalling £20.5 billion.[3] However, this is less than long-term historical growth of 3.7% and less than the Kings Fund has estimated is needed to improve services (4%).[4]

The Autumn 2020 Spending Review, initially planned to provide public spending certainty until 2023/24, was narrowed down to a spending commitment for 2021/22 only. The Chancellor committed a total of £26.2bn for direct spending on tackling Covid-19, including £15bn for test and trace, £2.1bn for PPE and £0.9bn for vaccines.[5] This is on top of the £51.6bn in 2020/21 directly spent on Covid-19. A further £3bn has been set aside in 2021/22 for an 'NHS recovery package' to tackle waiting lists for planned care, relieve pressure on the NHS and for mental health services.[6]

Spending on the NHS has risen from £150bn in 2019/20 to more than £200bn just a year later. Whilst this colossal rise has been mostly due to the pandemic, there have also been smaller commitments to improve mental health services, mothers' and infants' safety, and investment in the NHS physical infrastructure. However, the uncertainty over public health funding in the midst of a pandemic, as well as an absence of a multi-year commitment to workforce funding in the context of a workforce crisis were big omissions.[7]

NHS Long-Term Plan

The NHS Long-Term Plan was announced in 2018 and seeks to strengthen the NHS contribution to prevention, population health and health inequalities as part of an overarching plan including social care and public health. It has several clinical priorities; cancer, cardiovascular disease, maternity and neonatal health, mental health, stroke, diabetes, respiratory care and children and young people's health.[8]

Improving primary and community services are also central to the plan, with a pledge to create multidisciplinary 'fully integrated community-based health care' teams. By 2023/4 funding for this will be £4.5 billion more than in 2019/20.[9]

Under new NHS plans, a ring-fenced investment fund will be provided to improve mental health services for adults, children and young people, with a commitment to spend an increase of £2.3 billion in real terms over the next 5 years.

However, Covid-19 has caused significant ruptures to the NHS long-term plan, and the King's Fund predicts this will have to be 'recalibrated' in light of the pandemics' impact.[10]

NHS Services

Prior to the Covid-19 pandemic, NHS services were already under severe strain, which had a significant impact on service delivery as the crisis hit. Many of the standards for patient care set out in the NHS Constitution were missed. Waiting lists have grown year on year since 2009/10. By March 2019 4.3 million people were waiting for elective, consultant-led, care.[11]

Similarly, the standard that 92% of patients should start treatment within 18 weeks of referral has not

[2] The Kings Fund (2019) *How is the NHS performing? July 2019 quarterly monitoring report,* https://bit.ly/34conjB
[3] The King's Fund (2019) *The NHS long-term plan explained* (https://bit.ly/3jEecMf)
[4] The Kings Fund (6 June 2018) *'An open letter: a long-term funding settlement for the NHS'* (https://bit.ly/2ucu80v)
[5] The King's Fund (2020) What does the autumn 2020 Spending Review mean for health and care? (https://bit.ly/2VfQI5T)
[6] WBG (Nov 2020) WBG Spending Review Response, November 2020 (https://bit.ly/2NDr37b)
[7] The King's Fund (2020) What does the autumn 2020 Spending Review mean for health and care? (https://bit.ly/2VfQI5T)
[8] The King's Fund (2019) *The NHS long-term plan explained* (https://bit.ly/3jEecMf)
[9] Ibid.
[10] The King's Fund (August 2020) *Quarterly monitoring report 29: how is the NHS performing?* (https://bit.ly/3mA66qf)
[11] The Kings Fund, (2019*) The NHS misses its new target for planned elective care* https://bit.ly/2pwslER

been met since February 2016. At the end of March 2019, 86.7% of patients started treatment within 18 weeks of referral. The standard that 85% of patients should begin definitive treatment for cancer within 62 days of referral has not been met since 2013/14.[12] In 2018/19 79.1% of patients began treatment for cancer within 62 days of referral.[13]

The standard that 95% of patients at A&E should be seen within four hours was last met in 2015. The latest data for May 2019 show only 86.6% of patients were seen within four hours.[14] Bed occupancy rates for April-June 2019 were 87.9% for all beds and 90.0% for general and acute beds.[15] Occupancy above 85% is reported to compromise patient safety.[16]

Covid-19 and NHS services

In March 2020, NHS services were restructured in response to the Covid-19 pandemic. This involved discharging hospital patients, postponing non-urgent operations and block-buying capacity in independent hospitals.[17] Many consultations were moved online or over the phone. As a result, NHS activity (emergency care, planned care and diagnostic tests) fell to record lows.[18] In April 2020 there was a 36% drop on emergency admissions via A&E compared to 2019. Whilst the number increased to October 2020, the second wave in November saw numbers drop again to 19% below the 2019 level.[19]

In England there were 4.7 million fewer people referred for routine hospital care (for example hip, knee and cataract surgery) from January- August 2020 compared to the same period in 2019, a reduction of a third (34%).[20]

The number of patients waiting a year or more for an operation has increased ten-fold in the last year.[21] In July 2020, the Health Data Research Hub for Cancer modelled that limiting of normal cancer services due to Covid-19 could lead to up to 35,000 extra cancer deaths; over double the amount originally predicted in April 2020.[22] By October 2020, 47% fewer patients had started cancer treatment compared with the same month in 2019.[23]

Those in the most deprived areas have been most affected by disruptions to community services, with 46% not being able to access them (compared with 37% in least deprived areas).[24]

During the Covid-19 pandemic, Public Health England (PHE) was disbanded by government, due to perceived failings in accuracy of advice, and consistent problems with the early UK test and trace system. The November 2020 Spending Review confirmed that public health spending will be 'maintained' rather than increased once PHE is disbanded, which has received criticism for putting the impetus on funding to deal with illness rather than prevent it.[25] This will have particular impacts on women who are more likely to rely on public health services for health visitors and sexual health support.[26] Unions are also concerned this could lead to increasing NHS privatisation.[27]

[12] C. Ham and R. Murray (2018) *The NHS 10-year plan: how should the extra funding be spent* Blog for The Kings Fund, https://bit.ly/2OVpMHd
[13] NHS England (2019) *Waiting Times for Suspected and Diagnosed Cancer Patients,* 2018-19 Annual Report, https://bit.ly/2pA5cBo
[14] NHS England (2019) A*&E Attendances and Emergency Admissions May 2019 Statistical Commentary* https://bit.ly/2WwtpF5
[15] NHS England (2019) Bed *Availability and Occupancy – Quarter ending 30th June 2019* (https://bit.ly/36mnqac)
[16] Health Services Journal (2018) *NHS bed occupancy rates reach worst ever level* https://bit.ly/2A4WcGQ
[17] The King's Fund (August 2020) *Quarterly monitoring report 29: how is the NHS performing?* (https://bit.ly/3mA66qf)
[18] Ibid.
[19] The Health Foundation (December 2020) Non-Covid-19 NHS care during the pandemic (https://bit.ly/3dPFMqu)
[20] The Health Foundation (November 2020) 'Hidden backlog' looms as NHS referrals for routine hospital care drop by a third (https://bit.ly/2KiZqhN)
[21] The Telegraph (June 2020) NHS could take up to two years to recover fully from effects of Coronavirus, Royal College warns (https://bit.ly/3iTRMXi)
[22] The Telegraph (July 2020) Coronavirus could lead to 35,000 extra cancer deaths- double previous estimates (https://bit.ly/35PUOs2)
[23] The Health Foundation (December 2020) Non-Covid-19 NHS care during the pandemic (https://bit.ly/3dPFMqu)
[24] IFS (November 2020) COVID-19 and disruptions to the health and social care of older people in England (https://bit.ly/2IIB8Ns)
[25] Local Government Chronicle (2020) DPHs 'kicked in teeth' by Sunak's funding freeze, (https://bit.ly/379lvXM)
[26] WBG (2020) Health and gender (https://bit.ly/2I0Nnoy)
[27] Unite the Union (August 2020) Public Health England is being used as a scapegoat for government's Covid-19 failings, says Unite (https://bit.ly/3bnT8Xm)

Healthcare staff

The NHS is the world's fifth largest employer with 1.7m employees, including around 140,000 doctors and 300,000 nurses and midwives.[28] Women make up 77% of non-medical healthcare staff,[29] 85% of NHS General Practice workers,[30] and 77% of NHS Hospital and Community Service workers.[31] The sector is hierarchically structured by gender. Whilst women make up 53% of doctors in training, only 37% of consultants, 27% of surgeons and 6% Health and Community service doctors are women.[32]

In 2018, 12% of the healthcare workforce were non-British nationals.[33] The new points-based immigration system, which entered into force in January 2021, means that many 'low-skilled' workers who perform essential, yet undervalued contributions to the health and social care systems will not be eligible for a UK work visa. 71% of EU migrants who were 'key workers' in 2020 would not be eligible for a UK work visa under the new immigration system.[34]

The NHS currently has a shortage of 100,000 staff (9% of all posts).[35] The NHS needs an additional 5,000 internationally recruited nurses every year to prevent worsening staff shortages.[36] With so many migrant key workers in health (and social care) likely to be ineligible for work visas going forward, the NHS and social care sectors face a deepening crisis in staff shortages.

Women's health

Women's health service needs and usage differ greatly from men, and at different stages of life. However, women also face greater challenges as a result of a medical sector which overwhelmingly views the male body as the default in research, trials, medical training and public health campaigns.[37]

Women are more likely to use GP services than men. The GP consultation rate for women is 32% higher than for men, in part due to reproductive-related consultations.[38] GP numbers per head of population have been falling from a high of 67 in 2009 to 60 in 2018.[39]

Although they have a longer life expectancy, women are more likely than men to experience ill-health and require health services.[40] In 2018/19, women made up 54.6% of admissions to hospitals.[41]

Maternal health

Admission to hospital to give birth is the single largest cause of admission to NHS hospitals in England.[42] Evidence indicates that nearly half of England's maternity units closed to new mothers at some point in 2017. Capacity and staffing issues were the most common reason.[43]

A 2019 Care Quality Commission in England found that during and after pregnancy only 9% of women had the same midwife through their maternal journey, and only 52% reported their midwives were aware of their medical history.[44] In postnatal

[28] The Nuffield Trust (2018) *The NHS workforce in numbers* https://bit.ly/2yhKVns
[29] The King's Fund (2017) *Overview of the health and social care workforce* http://bit.ly/2zMw9V8
[30] Calculated (not including staff where gender was unspecified) from NHS Digital, General Practice Workforce data interactive dashboard data (https://bit.ly/34VT4Ny)
[31] NHS Digital (2019) *Gender in the NHS* (https://bit.ly/31TPiT4) Note that these data do not include agency staff.
[32] Ibid.
[33] House of Commons Library (2019) *The health and social care workforce gap* (https://bit.ly/3gXhuZs)
[34] IPPR (19 Feb 2020) *Immigration plans analysis: two thirds of current EU migrants in health and social care sector would have been found ineligible* (https://bit.ly/3jyBpiW)
[35] The King's Fund (2019) *Brexit: the implications for health and social care* (https://bit.ly/3hVhESh)
[36] Ibid.
[37] C. Criado Perez (2019) *Invisible women*
[38] Y. Wang, K. Hunt, I. Nazareth, N. Freemantle, I. Petersen (2013) *Do men consult less than women? An analysis of routinely collected UK general practice data*, BMJ https://bmjopen.bmj.com/content/3/8/e003320
[39] Nuffield Trust, 2019, Is the number of GPs falling across the UK? https://bit.ly/2WBOcHk
[40] Touchstone (2017) *Ill health is a class and gender issue* http://bit.ly/2zJU33E
[41] NHS Digital (2019) *Hospital Admitted Patient Care Activity 2018/19* https://bit.ly/36p4FD7
[42] Institute for Fiscal Studies (September 2017) *Under pressure? NHS maternity services in England* https://bit.ly/2gVivI3
[43] The Royal College of Midwives (August 2018) *Maternity unit closures highlighted in new data* https://bit.ly/2RJ4YkE
[44] Care Quality Commission (2019) *2019 survey of women's experiences of maternity care* (https://bit.ly/34YNVEi)

care only 67% were asked specifically about their mental health, and 20% did not know who to ask for support or information about mental health.[45]

Sexual and Reproductive Health and Rights

Sexual and Reproductive Health and Rights (SRHR) are important for everyone, but women bear the brunt of reproductive ill health due to biology but also social, economic and political disadvantage.[46] This is also the case for the LGBT community who face discrimination when accessing SRHR.

There has been a 14% reduction in SRHR spending between 2013-18, despite a 13% increase in demand.[47] Advice, prevention and health promotion lost 35% to prioritise testing and treatment which was reduced by 10%.[48] This widens health inequalities and puts more pressure on the NHS.

Women's health has seen particular fragmentation, with services like cervical screening covered by the NHS rather than SRHR, meaning women are subject to multiple invasive procedures. Similarly, access to Long Acting Reversable Contraception (LARC) has diminished as local authority funding means GPs are less incentivised to provide them. This has led to a 13% drop in their use despite being an effective type of contraception, particularly for young and vulnerable women.[49]

Mental health

In England, women are more likely than men to have a 'common' mental health problem (mixed anxiety and depression); with 19% displaying such symptoms compared with 12% of men. Women are almost twice as likely to be diagnosed with an anxiety disorder than men.[50] Mothers are more likely than fathers to have mental health problems; 10% compared with 6%.[51]

For both women and men, lower socioeconomic groups have a higher incidence of poor mental health. Research in England, Scotland and Wales has shown a correlation between mental health disorders and level of personal debt. At every level of income distribution, women have a higher percentage of mental health disorders than men.[52]

The Mental Health Foundation recognises that data collected on mental health in BAME communities is often subject to small sample sizes and is therefore limited. More data disaggregated by ethnicity and sex is needed.

Asylum seekers and refugees are more likely to experience poor mental health and more than 61% will experience serious mental distress.[53] This group are also less likely to receive support than the general population.[54]

Over half of LGBT, 67% of transgender people and 70% of non-binary people have reported experiencing depression in the last year (reported 2018). BAME LGBT people (62%) and LGBT people in lower income households (64%, compared with 48% for higher income households) were more likely to experience depression.[55]

The Covid-19 pandemic has exacerbated mental health inequalities, with women and young people experiencing the most severe worsening.[56] Women were in general more likely to be anxious than their male counterparts, but that this was highest for disabled women, at 53.1%.[57]

[45] Ibid.
[46] BMA (2018) *Reproductive health and wellbeing- addressing unmet needs* (https://bit.ly/2QPGQh2)
[47] House of Commons Health and Social Care Committee (2019) Sexual Health (https://bit.ly/3lNS7Ni)
[48] Ibid.
[49] Ibid.
[50] Mental Health Foundation (2016) *Mental health statistics: men and women* (https://bit.ly/31UkilD)
[51] Ibid.
[52] BMA (2018) *Health inequalities and women- addressing unmet needs* (https://bit.ly/3lKePG6)
[53] Mental Health Foundation (2016) *Mental health statistics: refugees and asylum seekers* (https://bit.ly/2F21gke)
[54] Ibid.
[55] Stonewall (2018) *LGBT in Britain Health Report* (https://bit.ly/31RvjUP)
[56] IFS (Jun 2020*) The mental health effects of the first two months of lockdown and social distancing during the Covid-19 pandemic in the UK* (https://bit.ly/3cWryzJ)
[57] WBG (June 2020) *Disabled women and Covid-19* (https://bit.ly/2YVACku)

Intersecting inequalities in healthcare

Inequalities in healthcare relate to unequal access, health outcomes, treatment of those working in health and social care and disparities in interpretation of pain/illness.

Class

There is a significant gap in healthy life expectancy (years lived in good health) between the richest and poorest parts of England. Healthy life expectancy for both women and men in the richest areas is 70.4 years. In the poorest areas healthy life expectancy for women is 52 years and for men 51.7 years.[58] ONS life expectancy figures from March 2019 show that life expectancy for women in the poorest parts of the country is falling.[59] This means that women in the poorest 10% of areas in England can expect 26.7 years of poor health at the end of their lives compared to men in the richest 10% who can expect 12.9 years of poor health at the end of their lives.

Black, Asian and minority ethnic women

BAME communities generally experience poorer health than the overall population, and health inequalities exist between different minority ethnic groups.

Women from Black ethnic backgrounds are five times and women from Asian ethnic backgrounds are two times more likely than white women to die during or within 42 days after pregnancy.[60] The NHS Long-Term Plan commits to reducing health inequalities and includes goals for greater midwife care for BAME women and women from deprived groups.[61]

BAME staff working in health and social care are consistently more likely to be subject to bullying, abuse and discrimination than white staff members.[62]

Disabled women

Disabled people are more likely to experience health inequalities, major health conditions and to die younger than non-disabled people.[63] In 2014, 28.8% of disabled adults in England reported having bad or very bad health (0.9% for non-disabled populations).[64] Life expectancy for a woman with a learning disability is 18 years less than for a non-disabled woman.[65]

There are significant barriers to healthcare for this population including inadequate or unaffordable transport links, lack of staff training, under-diagnosis and misdiagnosis.[66]

Migrant women

Although migrants make up only 13.3% of the UK population,[67] a quarter of women who died during maternity in 2012-14 were born outside of the UK; 46% of these were not UK citizens.[68] Under the current immigration system, undocumented migrant women have to pay for essential ante-natal maternity care, saddling women with thousands of pounds of debt.[69]

Whilst there are no significant differences between health for migrant men over the age of 60 compared with men born in the UK, older migrant women are 71% more likely than UK-born women to report health problems that limit everyday activity.[70]

[58] ONS, 2019, Health state life expectancies by national deprivation deciles, England and Wales: 2015 to 2017, https://bit.ly/2N8bUrr
[59] Ibid.
[60] MBRRACE-UK (2019) *Saving Lives, Improving Mothers Care* (https://bit.ly/32NQiHz)
[61] The King's Fund (2019) *The NHS long-term plan explained* (https://bit.ly/3jEecMf)
[62] The King's Fund (July 2020) *Workforce race inequalities and inclusion in NHS providers* (https://bit.ly/3bl9RuF)
[63] Equality and Human Rights Commission (2017) *Being disabled in Britain* (https://bit.ly/32Z7UQW)
[64] Ibid.
[65] Mencap (2019) Health inequalities (https://bit.ly/3jF0BEz)
[66] Ibid.
[67] BMA (2018) *Health inequalities and women- addressing unmet needs* (https://bit.ly/3lKePG6)
[68] Ibid.
[69] Maternity Action (2019) *What Price Safe Motherhood? Charging for NHS Maternity Care in England and its Impact on Migrant Women* (http://bit.ly/2QyIQd4)
[70] BMA (2018) *Health inequalities and women- addressing unmet needs* (https://bit.ly/3lKePG6)

The LGBTQ+ community

The LGBTQ+ community faces significant discrimination within healthcare settings; one in eight have experienced unequal treatment by healthcare staff because of their gender identity and/or sexual orientation. This rises to 32% for transgender people, 20% for both non-binary and disabled LGBT people, and 19% of BAME LGBT people.[71] 14% have avoided treatment for fear of discrimination and 5% have been pressured to change their sexual orientation when accessing health services.[72]

Health inequalities and Covid-19

The Covid-19 crisis has replicated, and in some cases exacerbated existing health inequalities. Diagnosis rate and mortality are higher for BAME communities and those living in disadvantaged areas.[73] In February 2021 ethnicity and deprivation were officially recognised as risk factors for Covid-19, leading to an estimated 2 million additional people being asked to shield, and 800,000 being 'fast-tracked' for the Covid-19 vaccination.[74]

The Black Caribbean population have the highest number of per capita hospital deaths from Covid-19. In England, mortality levels were 3.8 times higher for Black African men, and 2.9 times higher for Black African women than the White ethnic population (excluding care home residents).[75] All ethnic groups other than Chinese women were at higher risk of Covid-19 mortality than the White ethnic population.[76] Among NHS staff, Black and minority ethnic staff account for 21%, 20% of nursing staff and 44% medical staff. However, they made up 63%, 64% and 95% of the mortality rates in these groups respectively.[77] Socio-economic disadvantage and demographic factors (e.g. place of residence, occupational exposures) are recognised as the driving factor for the higher mortality rates, which cannot be explained by pre-existing health conditions.[78] Black and minority ethnic people are more likely than the White ethnic population to work in jobs outside of the home, be key workers, live in overcrowded housing, have less financial capital to buffer against Covid-19 and be less likely to have been given adequate PPE during the crisis.[79]

People from a BAME background are also more concerned about accessing medication during the crisis.[80] This could be a response to the higher mortality risk, but also important are the racial inequalities and discrimination BAME groups face within the NHS, including misdiagnosis and dismissing concerns of pain.[81]

Disabled people make up almost 6 in 10 (59.5%) of all Covid-19 related deaths (most recent ONS data January-November 2020).[82] Adjusting for region, population density, socio-demographic and household characteristics, mortality rate due to Covid-19 is 3.5 times higher for 'more-disabled'[83] women and 2.0 times higher for 'less-disabled' women than non-disabled women (3.1 for 'more-disabled' men and 1.9 times for 'less-disabled' men compared with non-disabled men).[84] Disabled people have also seen 'Do not attempt resuscitation' (DNAR) notices placed in their medical files without their knowledge.[85]

[71] Stonewall (2018) *LGBT in Britain Health Report* (https://bit.ly/31RvjUP)
[72] Ibid.
[73] Public Health England (August 2020) *Disparities in the risks and outcomes of Covid-19* (https://bit.ly/3jEgnzr)
[74] Guardian (February 2021) Ethnicity and poverty are Covid risk factors, new Oxford modelling tool shows (https://bit.ly/3knV0Ec)
[75] ONS (October 2020) Updating ethnic contrasts in deaths involving the coronavirus (Covid-19), England and Wales: deaths occurring 2 March to 28 July 2020 (https://bit.ly/3pVwueR)
[76] Ibid.
[77] Runnymede Trust (February 2021) Facts Don't Lie: One Working Class: Race, Class and Inequalities (https://bit.ly/3swFIjw)
[78] ONS (October 2020) Updating ethnic contrasts in deaths involving the coronavirus (Covid-19), England and Wales: deaths occurring 2 March to 28 July 2020 (https://bit.ly/3pVwueR)
[79] Runnymede Trust (February 2021) Facts Don't Lie: One Working Class: Race, Class and Inequalities (https://bit.ly/3swFIjw)
[80] WBG (Jun 2020) *BAME women and Covid-19* (https://bit.ly/3gZtDy6)
[81] The BMJ Opinion (June 2020) *If we do not address structural racism, then more black and minority ethnic lives will be lost* (https://bit.ly/2YdaPD1)
[82] ONS (February 2021) Updated estimates of coronavirus (COVID-19) related deaths by disability status, England and Wales: 24 January to 20 November 2020 (https://bit.ly/2HaQR7x)
[83] ONS defines 'more' and 'less' disabled status through self-reported data collected in the 2011 Census, where 'more' disabled was defined as limiting daily activities a lot, and 'less' disabled as limiting daily activity a little.
[84] Ibid.
[85] Turning Point (June 2020) DNACPR: Campaign Targets Unlawful 'Do Not Resuscitate' orders issued during Covid-19 crisis (https://bit.ly/3kjYdDt)

36% of disabled LGBT people have been unable to access medication or are worried that they might not be able to access medication during the crisis.[86]

Brexit and healthcare in the UK

On Christmas Eve 2020, a new EU-UK trade and cooperation deal was agreed and brought into law on 1 January 2021.

The UK imports £18 billion worth of medicines and medical devices from the EEA, compared with £9 billion in UK exports. Changes in the regulation of as a result of Brexit may lead to a duplication of effort for manufacturers and traders operating in both the UK and Europe, leading to cost increases. It has also raised concerns that patients in the UK could face delays in accessing new medicines.[87]

Whilst UK legislation has transferred the European Working Time Regulations into law, concerns have been raised that the UK government could attempt to limit or water down workers' rights over time.[88]

Brexit is likely to negatively impact scientific research, training and development in the UK, which received €8.8 billion through collaborative EU schemes such as Horizon 2020. Decreased funding opportunities combined with the new immigration system could see a decrease in recruitment and retention of scientific academics; 2017, after the Brexit referendum, saw an 11% increase in EU academics leaving Russell Group universities.[89]

Conclusion

The healthcare sector faces increasing challenges ahead. This includes the ongoing pressure of Covid-19, possible shortages and price increases in medicines and medical supplies due to Brexit, and a likely rise in staff shortages now that the new immigration system has been implemented.

Gender equality in the healthcare workforce requires a re-valuation of feminised roles such as nursing and care work, and greater opportunities for training and career progression. Workforce shortages should be tackled, to alleviate the chronic excessive workload and burnout of the existing staff. There must also be recognition of the increased discrimination faced by BAME and disabled staff.

For a gender-equal health service, the needs of a diverse range of groups must also be prioritised, including those of older, BAME, migrant, disabled, and LGBT people.

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[86] LGBT Foundation (May 2020) *Hidden Figures: The impact of the Covid-19 pandemic on LGBT communities in the UK* (https://bit.ly/3bIP6il)
[87] The King's Fund (January 2021) Brexit and the end of the transition period: what does it mean for the health and care system? (https://bit.ly/3kp20k4)
[88] IPPR (December 2020) The agreement on the future relationship: a first analysis (https://bit.ly/3uzINRy)
[89] The King's Fund (2019) *Brexit: the implications for health and social care* (https://bit.ly/3hVhESh)