Health Inequalities

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Health inequalities

The World Health Organization (WHO) defines health inequalities as follows:

‘The differences in health status or in the distribution of health determinants between different population groups.’

In the UK, the population groups showing differences in health and health chances are based on:

Social class

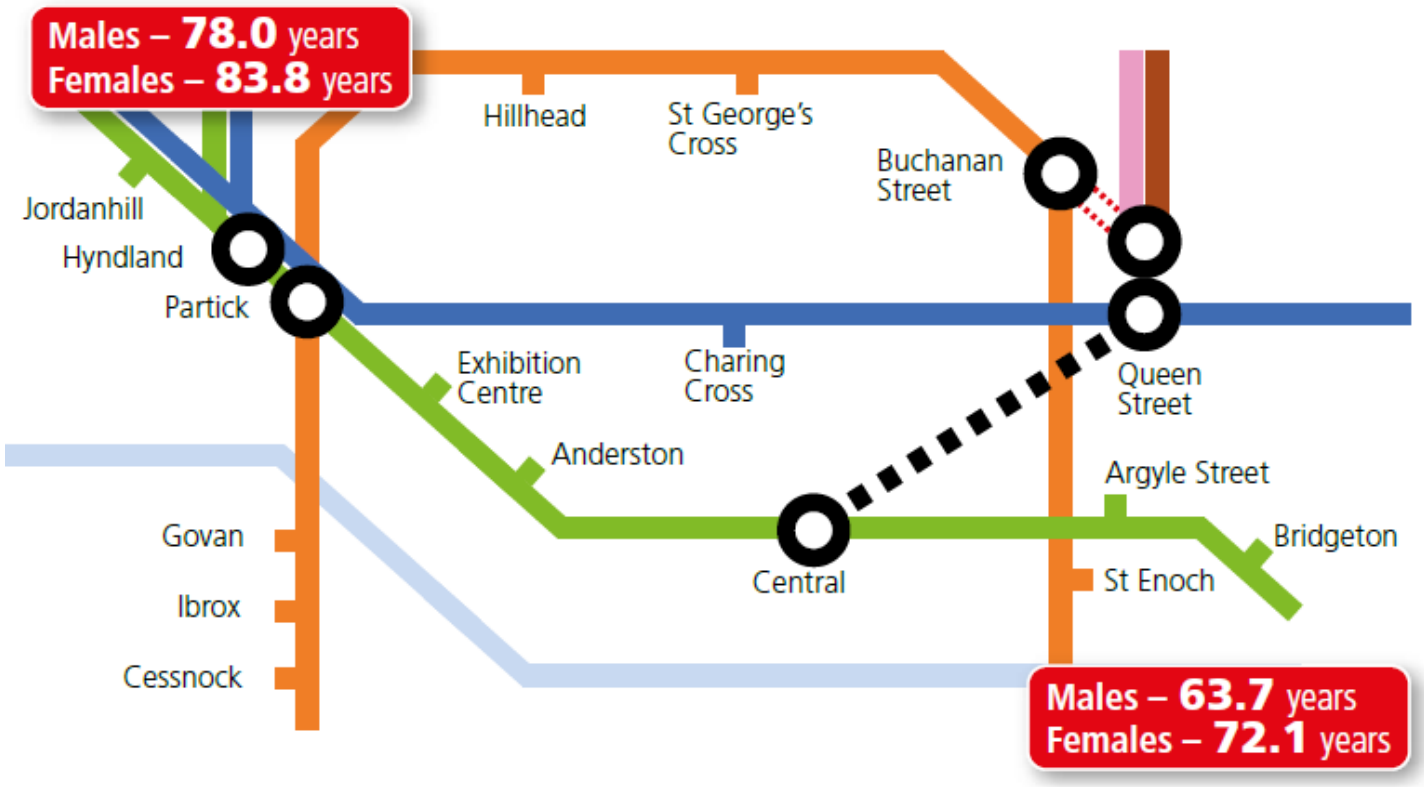
Gender

Ethnicity

Region

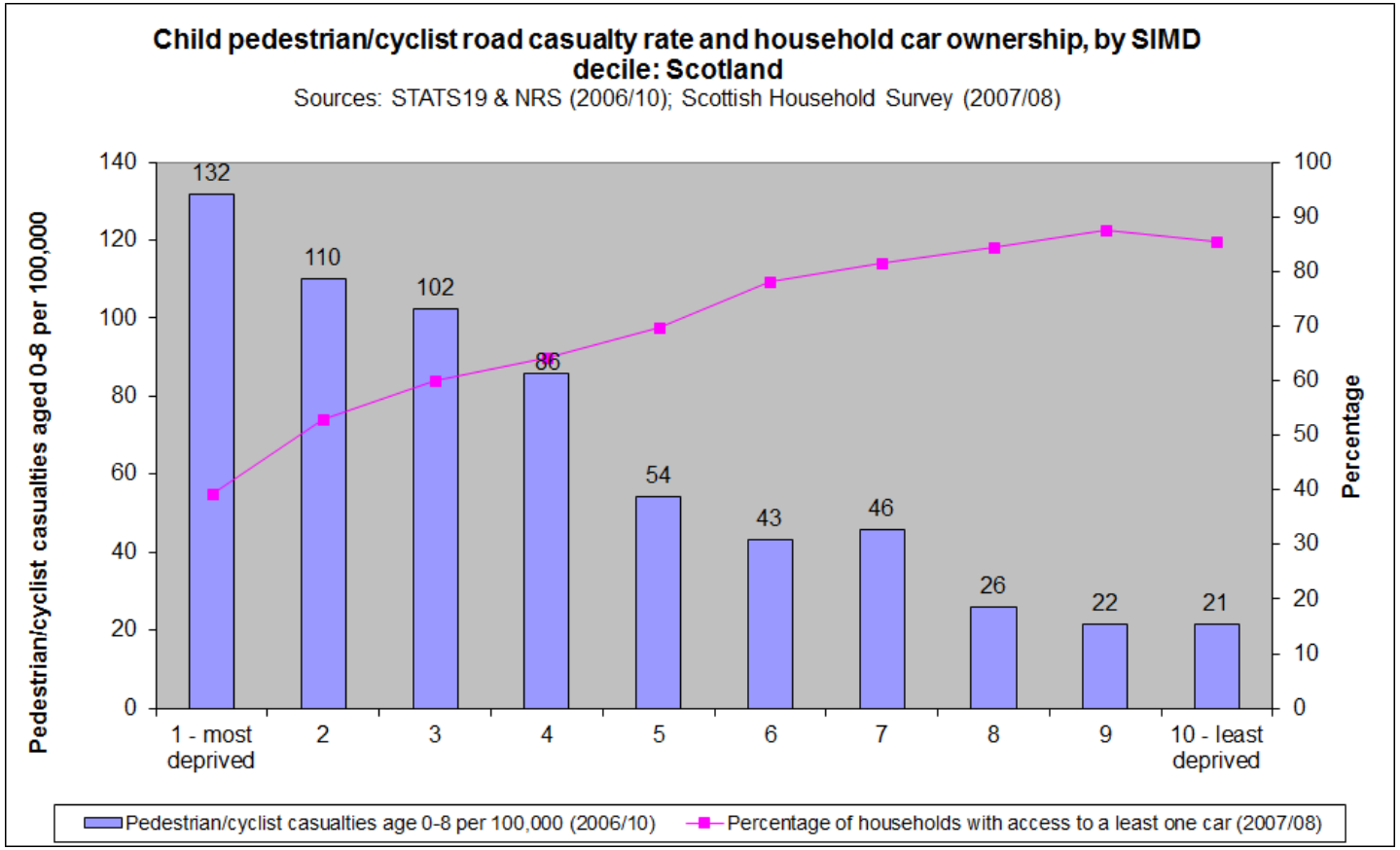
These are not, of course, mutually exclusive — e.g. working-class people tend to live in more deprived areas.

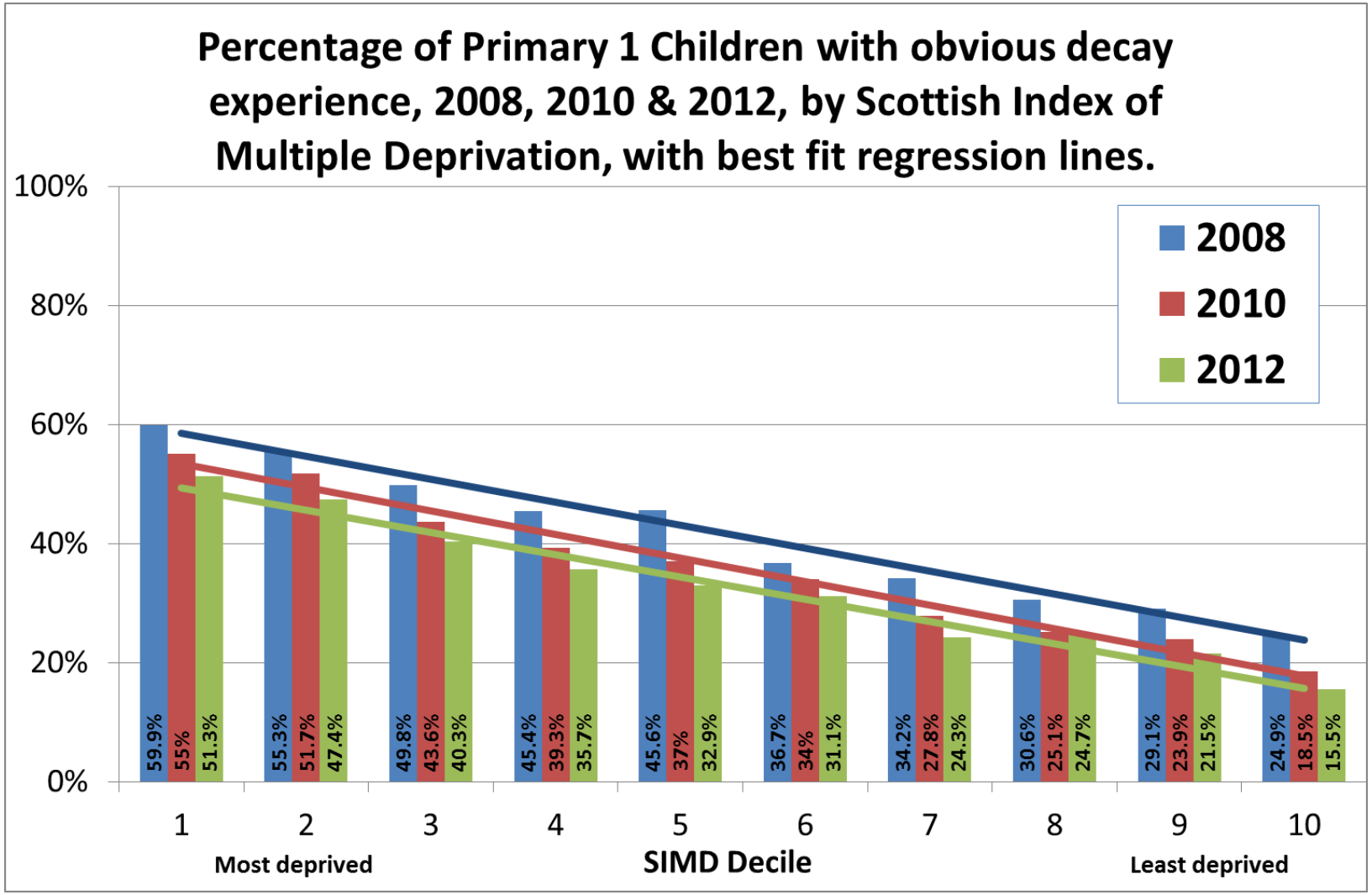
These data have been updated using the ScotPHO profiles published in June 2015 comparing the life expectancies in Broomhill (close to Jordanhill station) and Parkhead & Barrowfield (close to Bridgeton station) intermediate zones.



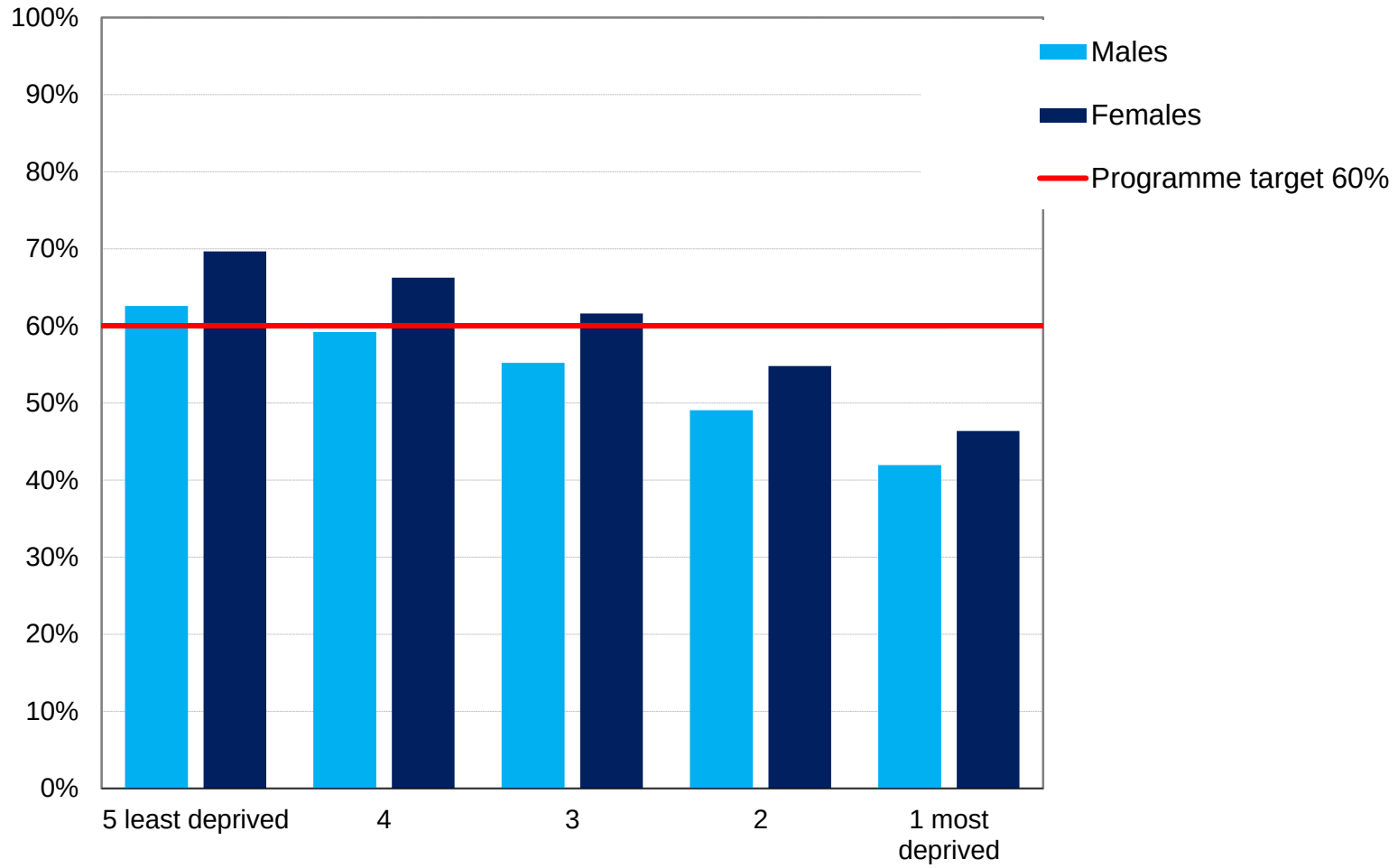
550 people a day in the UK are dying prematurely because of social inequalities that are becoming entrenched.
He said that not only do the poor die on average 7 years earlier than the rich, but they can expect to become disabled 17 years earlier.
If everybody had the same mortality as those with a university education, then we could prevent 202,000 deaths [each year
Unemployed people (those out of work but looking for work) were almost twice as likely as those in employment to have a limiting longstanding illness or disability (17% compared with 9%).

What are the health effects ?




Percentage of Primary 1 Children with obvious decay experience, 2008, 2010 & 2012, by Scottish Index of Multiple Deprivation, with best fit regression lines.
100%
80%
60%
40%
20%
0%
2008
2010
2012
59.9%
55%
51.3%
55.3%
51.7%
47.4%
49.8%
43.6%
40.3%
45.4%
39.3%
35.7%
45.6%
37%
32.9%
36.7%
34%
31.1%
34.2%
27.8%
24.3%
30.6%
25.1%
24.7%
29.1%
23.9%
21.5%
24.9%
18.5%
15.5%
1
2
3
4
5
6
7
8
9
10
Most deprived
SIMD Decile
Least deprived

Bowel Screening
Overall uptake of bowel screening (%) by sex and deprivation category Nov 2013 to Oct 2015.



Cancer Survival study

MacMillan study using ISD Scotland data – published February 2017

Six cancers – of the prostate, breast, head & neck, colorectal, liver, lung

Survival until from 2004-08 until 2013 showed gaps for all, apart from lung cancer which was poor for all people, wherever they stayed.

Solutions:

Early detection and screening?

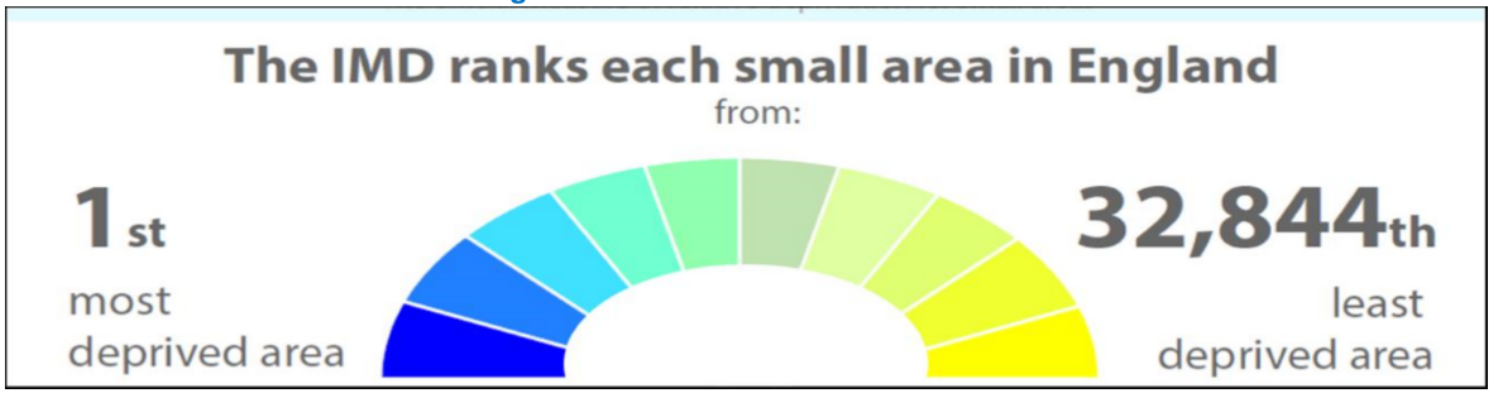
Tackling Poverty?

Inequalities in housing, education, employment, justice….

Measure of Deprivation

Ministry of Housing, Communities and Local Government's Index of Multiple Deprivation (IMD) for 2015

The IMD ranks each small area in England



IMD 2015 covers 7 domains of deprivation: income, employment, education, health, crime, barriers to housing and services and living environment and can be used for the following:

- Comparing small areas across England
- Identifying the most deprived small areas
- Exploring the domains (or types) of deprivation
- Comparing larger areas e.g. local authorities
- Looking at changes in relative deprivation between versions (i.e. changes in ranks)

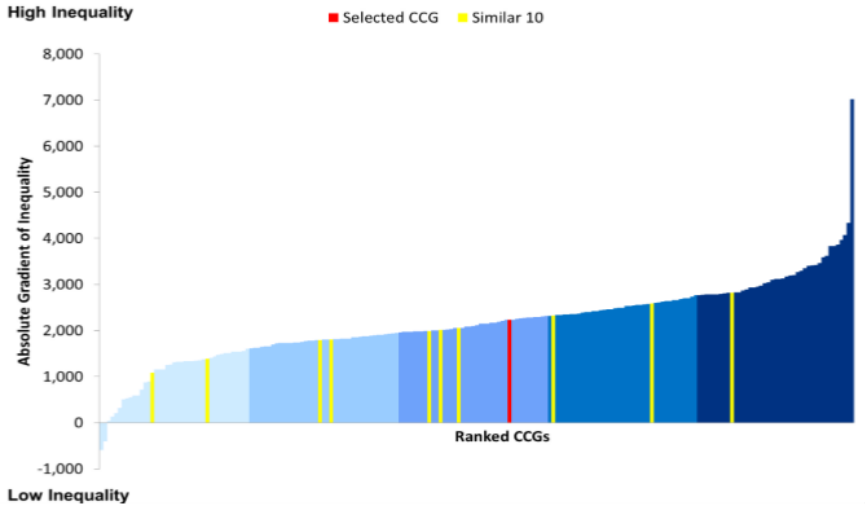
IMD 2015 is used to construct key deprivation based inequality measures within these packs.

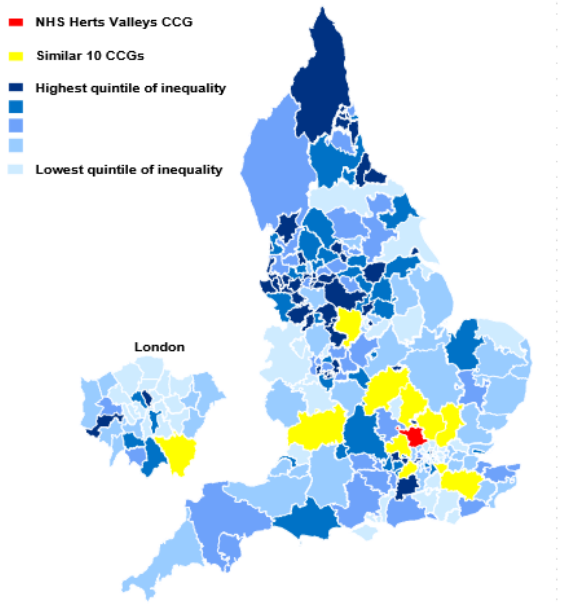
See the link below for more on IMD 2015

https://www.gov.uk/government/statistics/english-indices-of-deprivation-2015

Inequality in your CCG compared with your Similar 10 and other CCGs in England

Each ranked bar on the chart represents the level of inequality in a CCG*. The red bar is your CCG and the yellow bars are the Similar 10 CCGs. These CCGs are also shown in the table below alongside their Absolute Gradient of Inequality (AGI) value, ranked from lowest (1) to highest (11) inequality. The CCGs in the highest quintile have the highest levels of inequality. The heatmap shows the geographical variation in levels of inequality across the country. The darkness of shades shows the CCGs' inequality with the darkest quintile having the highest inequality.





Rank	CCG Name	AGI
1	NHS Bromley CCG	1,084
2	NHS West Essex CCG	1,386
3	NHS North West Surrey CCG	1,790
4	NHS Chiltern CCG	1,807
5	NHS West Kent CCG	1,991
6	NHS Southern Derbyshire CCG	2,009
7	NHS Gloucestershire CCG	2,059
8	NHS Herts Valleys CCG	2,233
9	NHS East and North Hertfordshire CCG	2,325
10	NHS Bedfordshire CCG	2,583
11	NHS Nene CCG	2,816

Sources: Unplanned hospitalisations: SUS 2016/17, NHS Digital, population data - CCG registered population, October 2016, NHS Digital
Notes: * Difference in age sex standardised rates of unplanned hospitalisation per 100,000 population between the most and least deprived neighbourhoods in England if England had the same inequality as the CCG. See NHS England CCG Improvement and Assessment Framework Technical Annex for more details.

Health inequalities-causes

Living in poor housing that is damp and poorly insulated.

Living in temporary accommodation, e.g. bed and breakfast, without access to proper cooking facilities, and in extreme cases being homeless.

Malnutrition caused by lack of food.

Obesity — often a result of comfort eating and/or lower resistance to advertisements for ‘junk’ food and sugary drinks.

High levels of stress and anxiety, which can lead to mental health problems and have other health effects such as high blood pressure.

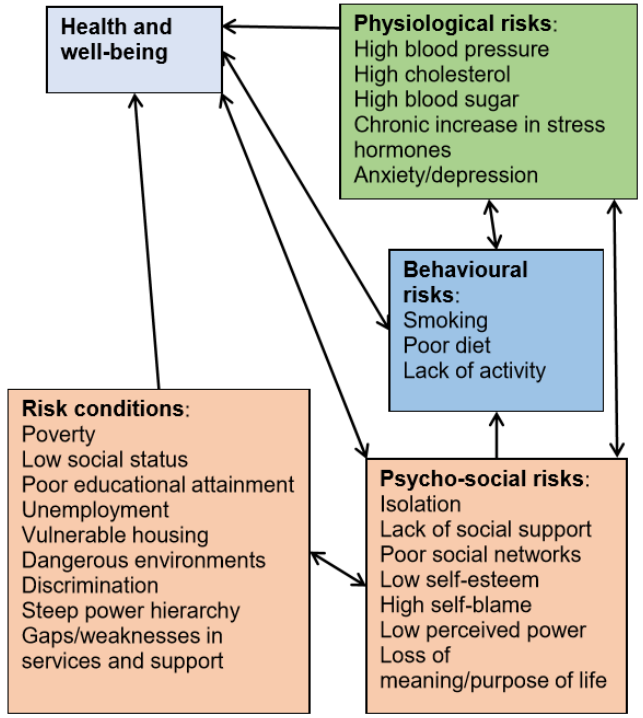
Living in an area with poorer than average health facilities — it is harder to attract well-paid doctors and surgeons to live and work in poorer areas.

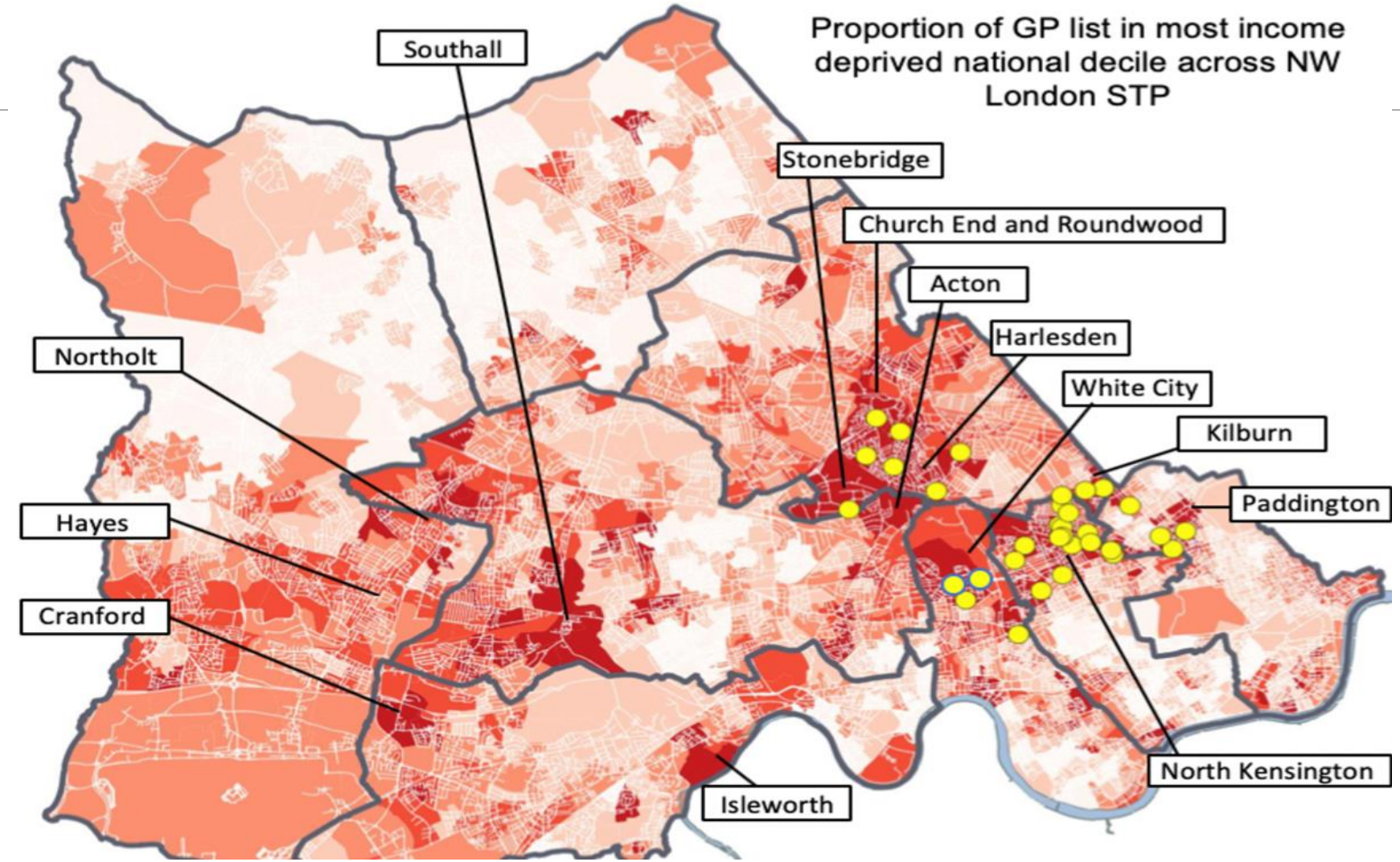
Engaging in ‘poor lifestyle behaviours’ such as smoking, excessive drinking and physical inactivity.

Being the victim of a violent attack — members of the lower social classes are at greater risk of this.

Determinants of health

Figure 1: Pattern of risks affecting health and wellbeing




Proportion of GP list in most income deprived national decile across NW London STP
Southall
Stonebridge
Church End and Roundwood
Acton
Harlesden
White City
Kilburn
Paddington
North Kensington
Northolt
Hayes
Cranford
Isleworth

GP training

GP training practices are less likely to be situated in areas of deprivation; little is known about GP views of postgraduate training in such areas. Interview research

Results: The importance of producing ‘well-rounded’ GPs who are able to work in a variety of environments was highlighted. Trainees need exposure to the specific challenges of deprived contexts (such as early multimorbidity, child protection, and addiction) and the benefit of this for trainees was thought to be invaluable.

Overwhelming workload was the main reason for not becoming a training practice, though some would consider it if supported to develop a training culture. All the GPs, including non-trainers, were involved in optional activities which were felt to be important for resilience.

Conclusion: GPs in areas of deprivation highlighted specific skills that could be gained by undertaking at least a part placement in deprived areas, with different skills likely to be gained from affluent areas.

Why Should Addressing Health Inequalities be a Priority for CCGs?

RightCare

The NHS is dedicated to delivering better care for individuals, lowering per-capita cost and improving population health. Health inequalities are an important component of population health and one that should be a central priority for CCGs.

- **It is a moral imperative concerning social justice.** The issue should be of great importance to a caring and compassionate service.

- **It is a legal requirement.** The Health and Social Care Act (2012) placed responsibilities on CCGs (amongst others) to "demonstrably take account of inequalities in access to and outcomes of healthcare".

- **It makes good business sense.** The burden of ill health and disability, as well as premature mortality, is disproportionately focussed on the most deprived populations. These sections of society are least equipped and resourced to make best and most appropriate use of services. If the 'unmet need' for preventive services and those for early detection and management is not addressed in those at greatest risk, a large part of the growing burden and cost will persist.

‘Deep end’ project

However, deprivation in outer London is worsening. There are already significant volumes of people with severe if not yet extreme IMD scores, and in parts of outer London, communities are now starting to fall into the most deprived national decile.

This makes it difficult to tackle inequities of health and healthcare provision using traditional commissioning mechanisms, especially as NW London does not have a strong culture of proportionate universalism.

In 2009 a group of GPs in Glasgow convened a conference and set out to explore how they could work together to address the issues they faced with caring and continuing to care for deprived communities. As a result of this they established the ‘GPs at the Deep End’ program.

This has increased the resilience of the GP workforce, improved connections with community services, facilitated recruitment of new GPs, and addressed GP learning needs in relation to deprivation-specific problems encountered in general practice.

New Care Model Case Study

Healthy Lives (Sandwell and West Birmingham CCG)

This is an intervention in the Connected Care Partnership New Care Models Vanguard in Sandwell and West Birmingham CCG. The aim of this intervention is to offer an extended appointment with a GP for motivational coaching to identify person centred goals for lifestyle changes such as weight loss and increased physical activity. The GP also completes a review to identify any medicines that no longer need to be taken.

Key impacts

The early analysis (6-9 months post programme) for participating patients showed a noticeable downward trend in A&E activity post intervention. Similarly, for participating patients, re-active GP and Advanced Nurse Practitioner appointments fell noticeably. All of the 32 patients who filled out pre and post evaluation questionnaires indicated an improvement in mobility, depression and pain management. The patients who filled out the programme satisfaction questionnaire would all recommend the service to others.

Example patient case studies

- Denise is 65, she lives alone and has had a very difficult past that included domestic abuse, bereavement, alcoholism and depression. Two years ago she developed poor mobility after suffering lower back pain. She has spinal stenosis, obesity, type 2 diabetes, asthma, hypertension, ischaemic heart disease, osteoarthritis and gout. She has a high level of primary care consultations. During her healthy lives appointment she was provided with advice and education about her health problems and how they affect her. Her plan of action was agreed and Denise felt extremely motivated to change her daily routine, starting with gentle movement and social interaction. She felt empowered and felt that her viewpoint was respected. A follow up telephone consultation suggested this change is likely to be sustainable.
- Jaswinder is 62, lives with his extended family and runs his own business. He had poorly controlled type 2 diabetes, obesity, and hypertension. He had frequent GP visits to manage his condition. He had a poor understanding of the benefit of improving weight, diabetes and hypertension to prevent future illness. As part of the healthy lives initiative, he was provided with a detailed explanation of his condition and a plan for making changes to his daily lifestyle to improve his health. A few weeks later, during his regular blood sugar check-up, his results showed an improvement in his diabetes control. He continues to attend the support group to sustain a healthy lifestyle.

For more information on healthy lives services please contact:

Dr. Mohanpal Singh Chandan

Summary GP role - Approaches and Principles

1. ***Focusing on the most disadvantaged groups****:* This targets the worst off or poorest groups and aims to improve their health through specific measures. This approach can improve the health of those who are worst off, even if the health gap between rich and poor is unchanged.

2. ***Narrowing health gaps*** *:*This aims to improve the health of those who are poorest or most disadvantaged by raising their health outcomes closer to those who are most advantaged. This usually involves target setting to reduce the disparity in health outcomes between the most advantaged and most disadvantaged groups.

3. ***Reducing the social gradient*** *:*Tackling the social gradient in health involves reducing differences and equalising health all along the income ladder