Strategies and experiences to tackle health inequalities in England

Dr Marilena Korkodilos
Consultant in Public Health Medicine
Health Inequalities Unit
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Life expectancy is increasing…

Office for National Statistics and Government Actuary’s Department
And Health Inequalities....

Black Report (1980)

- Seminal statement of the impact of health inequalities

- Poorer health experiences of lower occupational groups applied at all stages of life

- If the mortality rates of occupational class I had applied to classes IV and V during 1970-72, **74,000** lives of people aged under seventy-five would not have been lost. This estimate included nearly **10,000** children and **32,000** men aged 15 to 64.

- Much of the problem lay outside the scope of the NHS. However, disadvantaged populations made smaller use of the health care system in a number of different respects, yet needed it more.
And Health Inequalities….


- Reviewed the evidence on inequalities in health in England

- Influenced the White Paper *Saving Lives: Our Healthier Nation* – setting national targets for disease reduction and requiring health improvement plans to be developed by local health authorities
By 2010 to reduce inequalities in health inequalities by 10% as measured by infant mortality and life expectancy at birth.

This target is underpinned by two more detailed objectives.
Infant mortality

- Starting with children under one year, by 2010 to reduce by at least 10 per cent the gap in mortality between the routine and manual group and the population as a whole.
Life expectancy

- Starting with Local Authorities, by 2010 to reduce by at least 10% the gap in life expectancy between the fifth of areas with the “worst health and deprivation indicators” and the population as a whole
Tackling health inequalities


- Cross government
- Planned action across the health service and the wider social determinants
- Monitor developments against the target and other relevant indicators
- Regular updates of progress
- High level reviews of both aspects of the PSA target
Infant Mortality

Source: ONS

*All relates to inside marriage and joint registrations outside marriage, not including "social class not specified" for 1995 and 1999. Sole registration and unlinked births are excluded. Information on the father's occupation is not collected for births outside marriage if the father does not attend the registration of the baby's birth. Figures for live births are a 10% sample coded for father's occupation.
Inequality gap - female and male life expectancy at birth
England 1993-2005

Source: NCHOD Compendium of Clinical and Health Indicators, using ONS data. Analysed by DH analysts

So what was going wrong?

Results of high level reviews of LE and IM

- No recognition of the target or the widening gap
- Lack of leadership and systems to support delivery
- Little knowledge of interventions that would deliver by 2010
- Poor handling and use of data and gaps in the evidence base

Is there another way of looking at the target?
13,700 early deaths in Spearhead areas a more compelling story?
Too many people in Spearhead areas are dying early

- There were approximately 13,700 additional deaths for 30 to 59 year olds in Spearhead groups, across the 3 years 2003-2005, compared to the national average for England.

- The focus needs to be on reducing adult early deaths.

- Action on the overall PSA target to reduce infant mortality will also help deliver the reduction in life expectancy gap target.

**bands, 2003-05**

- Female difference
- Male difference

- Too many people in Spearhead areas are dying early
Reducing pregnancies in <18 years in R&M group by 44% to meet the 2010 target

Targeted interventions to prevent SUDI by 10% in the R&M group

Reducing smoking in pregnancy rate by 2 percentage points by 2010

Reducing the prevalence of obesity in the R&M group to 23%

Other - may include:

**Immediate Actions**
- Optimising preconception care
- Early booking
- Access to culturally sensitive healthcare
- Reducing maternal and infant infections

**Long term Actions**
- Continuing to:
  - Improve infant nutrition
  - Reduce poverty
  - Improve housing / reduce homelessness

**Impact on 2002-04 Gap**
- 1.0%
- 1.4%
- 2.0%
- 2.8%

**Actions / Interventions**
- Targeted prevention work with at risk teenagers and targeted support for pregnant teenagers and teenage mothers
- Maintain current information given to mothers and target the Back to Sleep campaign and key messages for the target group
- Smoking cessation as an integral part of service delivery for the whole family during and after pregnancy
- Targeted weight loss programmes
  - Low calorie diet, physical activity and behaviour therapy
  - Drug therapy
  - Surgical procedures
- Provide comprehensive preconception services
- Provide advice/support for "at risk" groups within the target e.g. black and minority ethnic groups
- Increase direct access to community midwives
- Provide 24/7 maternity direct line for advice and access
- Implement NICE antenatal and postnatal guidelines
- Health equity audit of women booked by 12 weeks and >22 weeks
- Commissioners and maternity service providers agree improvement plans in contract
- Improve uptake of immunisations in deprived populations
- Implement Baby Friendly Standard

This illustrates a **set of interventions**, which could make a **significant** contribution towards narrowing the infant mortality gap by 10%.

There is a need to **commission research** to improve the evidence base on modelling interventions and outcomes and good practice.
Know your gap - England
What is causing the gap for males?

The Gap – for males

- 35% All circulatory diseases, 70% of which are Coronary Heart Disease (CHD)
- 18% All cancers, 61% of which are lung cancer
- 15% Respiratory diseases, 53% of which are chronic obstructive airways disease
- 10% Digestive, 50% of which are chronic liver disease and cirrhosis
- 5% External causes of injury and poisoning, 60% of which are suicide and undetermined death
- 2% Infectious & parasitic diseases
- 10% Other
- 5% Deaths under 28 days

Contribution to Life Expectancy Gap in Males
Breakdown by disease, 2003
### The Interventions

#### Targeted:
- Smoking cessation clinics: double capacity in Spearhead areas for 2 years
- Secondary prevention of CVD: additional 15% coverage of effective therapies in Spearhead areas 35-74 yrs
- Primary prevention of CVD in hypertensives under 75 yrs:
  - 40% coverage antihypertensives
- Primary prevention of CVD in hypertensives 75yrs +:
  - 40% coverage antihypertensives
- Other*, including:
  - Early detection of cancer
  - Respiratory diseases
  - Alcohol related diseases
  - Infant mortality

#### Universalist:
- Smoking reduction in clinics – as at present
- Secondary prevention of CVD: 75% coverage of 35-74yrs
- Primary prevention of CVD in hypertensives under 75 yrs:
  - 20% coverage antihypertensive statin therapy

### The Impact – for males

<table>
<thead>
<tr>
<th>Category</th>
<th>Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Smoking reduction in clinics</td>
<td>1.0%</td>
</tr>
<tr>
<td>Secondary prevention of CVD</td>
<td>2.3%</td>
</tr>
<tr>
<td>Primary prevention of CVD in hypertensives</td>
<td>1.0%</td>
</tr>
<tr>
<td>Primary prevention of CVD in hypertensives 75yrs +</td>
<td>0.7%</td>
</tr>
<tr>
<td>Other* including:</td>
<td></td>
</tr>
<tr>
<td>Early detection of cancer</td>
<td>0.7%</td>
</tr>
<tr>
<td>Respiratory diseases</td>
<td>1.2%</td>
</tr>
<tr>
<td>Alcohol related diseases</td>
<td>0.7%</td>
</tr>
<tr>
<td>Infant mortality</td>
<td>2.1%</td>
</tr>
</tbody>
</table>

*locally determined

Further modelling of Other actions will need to contribute the remaining 2.1%

8.9% 11%

And what can you do about it?
And for females?

The Gap – for females

30% All circulatory diseases, 63% of which are Coronary Heart Disease (CHD)
16% All cancers, 75% of which are lung cancer
21% Respiratory diseases, 57% of which are chronic obstructive airways disease
9% Digestive, 44% of which are chronic liver disease and cirrhosis
5% External causes of injury and poisoning, 40% of which are suicide and undetermined death
2% Infectious & parasitic diseases
11% Other
6% Deaths under 28 days

Contribution to Life Expectancy Gap in Females
Breakdown by disease, 2003
So what can we do about this?

"I think you should be more explicit here in step two."
So what can we do about this?

- Understand cause of local gap
- Model interventions
- Plan & IMPLEMENT interventions

ENGAGE LOCAL PARTNERS
Making it happen locally: support and tools
National Planning and Alignment of Incentives → Joint Local Planning

DH has aligned incentives for the NHS and Local Government:

- New line on All Age All Cause Mortality as proxy for life expectancy is now mandatory for Spearheads as part of the LAA and LDP processes

- Same Local trajectories agreed in LAA and LDP, based on nationally provided indicative figures

- LDP Refresh: strengthened inequalities elements of existing Blood Pressure, Cholesterol, Practice Based Registers and, in some Spearhead Areas, smoking cessation
## Local Planning: Health Inequalities Intervention Tool

### Health Inequalities Intervention Tool

#### Life expectancy gap by disease (2002-04)

<table>
<thead>
<tr>
<th>Disease</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infectious and parasitic diseases</td>
<td>0.9%</td>
<td></td>
</tr>
<tr>
<td>Oesophageal cancer</td>
<td>0.2%</td>
<td>2.1%</td>
</tr>
<tr>
<td>Stomach cancer</td>
<td>0.6%</td>
<td>0.3%</td>
</tr>
<tr>
<td>Colorectal cancer</td>
<td>0.8%</td>
<td>0.1%</td>
</tr>
<tr>
<td>Lung cancer</td>
<td>2.4%</td>
<td>9.1%</td>
</tr>
<tr>
<td>Breast cancer</td>
<td>0.0%</td>
<td>4.9%</td>
</tr>
<tr>
<td>Other cancers</td>
<td>3.5%</td>
<td>9.0%</td>
</tr>
<tr>
<td>Endocrine, nutritional, metabolic diseases</td>
<td>2.1%</td>
<td>2.6%</td>
</tr>
<tr>
<td>Mental and behavioural disorders</td>
<td>9.1%</td>
<td>2.7%</td>
</tr>
<tr>
<td>Diseases of nervous system</td>
<td>3.2%</td>
<td></td>
</tr>
<tr>
<td>Coronary heart disease</td>
<td>8.8%</td>
<td>7.7%</td>
</tr>
<tr>
<td>Heart failure</td>
<td>0.7%</td>
<td>3.3%</td>
</tr>
<tr>
<td>Stroke</td>
<td>6.5%</td>
<td>6.7%</td>
</tr>
<tr>
<td>Other cardiovascular disease</td>
<td>8.3%</td>
<td>7.8%</td>
</tr>
<tr>
<td>Pneumonia</td>
<td>3.5%</td>
<td>7.0%</td>
</tr>
<tr>
<td>Chronic obstructive airways disease</td>
<td>5.6%</td>
<td>7.5%</td>
</tr>
<tr>
<td>Other respiratory disease</td>
<td>1.0%</td>
<td>4.1%</td>
</tr>
<tr>
<td>Stomach ulcer</td>
<td>1.5%</td>
<td>2.1%</td>
</tr>
<tr>
<td>Chronic cirrhosis of the Liver</td>
<td>12.3%</td>
<td>13.0%</td>
</tr>
<tr>
<td>Other digestive diseases</td>
<td>4.2%</td>
<td>3.3%</td>
</tr>
<tr>
<td>Musculoskeletal diseases</td>
<td></td>
<td></td>
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<tr>
<td>Genitourinary diseases</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Perinatal conditions</td>
<td>0.1%</td>
<td></td>
</tr>
<tr>
<td>Congenital anomalies</td>
<td></td>
<td>0.2%</td>
</tr>
<tr>
<td>Ill defined conditions</td>
<td>1.9%</td>
<td></td>
</tr>
<tr>
<td>Road traffic accidents</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other accidents</td>
<td>9.2%</td>
<td>3.1%</td>
</tr>
<tr>
<td>Suicide and undetermined injury</td>
<td>12.0%</td>
<td>3.3%</td>
</tr>
<tr>
<td>Other external causes</td>
<td>0.3%</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>1.3%</td>
<td></td>
</tr>
<tr>
<td>Deaths under 28 days</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>100.0%</td>
<td>100.0%</td>
</tr>
</tbody>
</table>
Tools: Programme Budgeting – CVD Correlation

Circulatory system programme budget per capita: Expenditure (million pounds) per 100,000 unified weighted population, 2004/5
Mortality from all circulatory diseases: DSRs, All ages, 2002-04, Persons
North Tyneside PCT: Expenditure (million pounds) per 100,000 unified weighted population, 2004/5: 11.3 >> DSRs, All ages, 2002-04, Persons: 24.4

Spearman Rank Correlation Coeff. (r) = -0.26
p (2-sided) > 0.05

CVD Mortality
CVD Spend
Local Planning: Health Equity Audit

1. Agree partners and issues
   - Choose issue(s) with highest impact e.g. cancer, CHD, primary care, over 50s, infant health
   - Relate issues to service planning & commissioning, take opportunities where changes are planned
   - Identify factors driving low life expectancy
   - Take on views of front line staff and users
   - Scope for joining up services with local government

2. Equity profile: identify the gap
   - Use data to compare service provision with need, access, use & outcome
   - measures including proxies for disadvantage, social class, ward in the bottom quintile, BME, gender or other population group
   - Focus on the third of population with poorest health outcomes

3. Agree high impact local action to narrow the gap
   - Quality & quantity of primary care in disadvantaged areas
   - Address inequalities through NSF implementation
   - Commission new services, change or amend existing contracts
   - Develop LIFT projects where health need is highest
   - holistic services through partnerships

4. Agree priorities for action
   - Identify highest impact interventions for effective local action, for example:
     - Diet & physical activity
     - Promoting healthy life styles in over 50’s
     - Ensure choice, responsiveness & equity for all
     - Smoking prevalence
     - Screening
     - Flu vaccinations
     - Accidents
     - Statins & antihypertensives

5. Secure changes in investment & service delivery
   - Move resources to match need
   - Develop service delivery to match need
   - Ensure changes in contracts & commissioning are reaching areas & groups with highest need

6. Review progress & assess impact
   - Ensure effective monitoring systems are in place using indicators etc
   - Review progress
   - Assess the impact of action, has change been made and is it fast enough?
   - Identify local areas or groups where more action is required

Use data on Health Inequalities to support decisions at all levels: make appropriate comparisons by area, ethnicity, socio-economic group, gender, age etc

Focus on the third of population with poorest health outcomes

Agree high impact local action to narrow the gap

Quality & quantity of primary care in disadvantaged areas

Address inequalities through NSF implementation

Commission new services, change or amend existing contracts

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holistic services through partnerships

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Screening
Flu vaccinations
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Joint Strategic Needs Assessment

- Key building block of the commissioning process
- Will be a duty of the local authority and the PCT (DPH, DASS, DCS)
  - LAA and local targets based on the SNA
- Must be focussed on outcomes
- Must be focussed on the future
  - 3-5 years: improvements in outcomes/reductions in health inequalities
  - 5-15 years: for major infrastructure planning (transport, housing, healthcare facilities)
  - 1 year: contractual changes at frontline / PBC level
JSNA and the Commissioning Cycle

**Inputs** (Data/information needed)
- Demography
- Social & environmental context
- Current known health status of populations
- Current met needs of the population
- Patient voice
- Public demands
- Analysis of inequalities
  - Outcomes
  - Service Access
- Evidence of effectiveness
- Programme budgets and outcomes

**Joint Strategic Needs Assessment**
the desired health and well being outcomes in 3 – 5 years time for your population

**Outputs** (The link to other stages of commissioning)
- Programme of systematic service reviews
  (NHS / Social Care)
- Prioritisation framework for annual contracting procurement
- Medium-term market development: capacity to deliver desired service configuration
  (Local Government and NHS)
- Primary Care Investment Commissioning decisions
  (NHS)
- Capital Investment Plans
  (local / regional government and NHS)

**What decisions will be made by whom?**
- PCT
- PCT Prospectus & outcome metrics chosen
- SCS, LAA and Outcome indicators (35/200)
- LSP

Analysis of inequalities - Outcomes - Service Access
Evidence of effectiveness
Programme budgets and outcomes

- Outcomes - Service Access

Programme budgets and outcomes

- Outcomes - Service Access
Life Check

Early Years Life Check
Teen Life Check
Mid-Life Life Check
NHS Health Trainers
National agenda – local delivery

- Lifestyle not social determinants of health
- Focus on health inequalities
- Not another ‘professional’ advice giver
- Visible and accessible
- Engage with people where they are to be found
- Motivate, support, set goals, overcome barriers
- Competent to practice
What we think health trainers do:

**What is a Health Trainer?**

- A key tool in addressing Health Inequalities.
- Drawn from the local community or knowledgeable about the community they will serve.
- Either paid or unpaid within the NHS or be part of a 3rd party partner organisation.
- They will be:
  - trained in a variety of settings, determined according to local requirements, including classroom-based learning and on the job training.
  - accredited locally in the first instance and, once the appropriate mechanisms are in place, nationally.
  - either identify, or have referred to them, appropriate ‘clients’ drawn from hard to reach, disadvantaged groups. Clients can self refer too.
  - work with those clients 1:1 to assess their lifestyle and wellbeing and identify any areas they wish to work on.
  - work with the client to set goals, agree an action plan and provide individual support where necessary focussing on behaviour change.
  - monitor and review their clients progress and revise the plan where necessary to meet the clients goals.
- There are many examples where health trainers are delivering their service within different settings.
National Support Team for Health Inequalities

- We have developed a National Support Team (NST) for Health Inequalities
- The NST aims to disseminate best practice across all Spearhead areas, and to provide intensive support to those areas that need it
- The NST uses a diagnostic tool which is used to systematically identify gaps in current provision and use of services
- The recommendations made by the NST form the core of local action on health improvement and reducing health inequalities
Achieving Balance

Health Inequalities

2010 Target

Wider Social Determinants
Achieving balance – infant mortality

NHS actions

- Provision of high quality, safe maternity and paediatric care
- Promotion of early access to antenatal care
- Provision of smoking cessation services
- Support to breastfeeding
- Advice regarding prevention of sudden unexpected deaths in infancy
- Screening and immunisations

Action on wider determinants

- Department of Work and Pensions
  Meeting the 2010 and 2020 child poverty target
- Communities and Local Government
  Reducing overcrowding
- Department for Children, Schools and Families
  Reducing under 18 conception rate
  Promotion of healthy diet and exercise
Lessons Learned

1. Targets can help focus action but are not enough

2. Local engagement is key

3. Tell a good story...
Next Steps

- Comprehensive strategy for reducing health inequalities
- Our NHS Our Future
- New PSA on promoting better health and wellbeing
Web addresses

- Health Inequalities Intervention Tool
  - www.lho.org.uk/HEALTH_INEQUALITIES/Health_Inequalities_Tool.aspx

- Commissioning framework for health & Well being

- Programme Budgeting
  - nww.nchod.nhs.uk

- Health Equity Audit
  - www.dh.gov.uk/healthinequalities

- Health Poverty Index
  - www.hpi.org.uk
Contact:

- Dr Marilena Korkodilos
- Health Inequalities Unit
- Marilena.Korkodilos@dh.gsi.gov.uk