Paper 1. Health Inequalities – Overview

Box 1: Health Inequality in Islington

Key Facts

- Men in Islington can expect to live 75.1 years, 2.8 years less than the England average and the lowest in London.
- Women in Islington can expect to live 81.0 years, one year less than the England average and the fourth lowest in London
- For men in Islington, those from the best-off backgrounds can expect to live 6.7 years longer than those from the worst-off backgrounds. For women the gap is 4.4 years.
- Male life expectancy in Islington is greatest in Clerkenwell ward at 77.8 years and lowest in Tollington at 72.6 years, a difference of 5.2 years.
- Female life expectancy in Islington is greatest in St. Georges at 82.5 years and lowest in Finsbury Park at 78.1 years, a difference of 4.4 years.
- Between 2004 and 2006 43% of all Islington residents who died of cardiovascular disease before the age of 75 were found to have poor mental health.
- The London Health Observatory reported that from 2005 – 2007 Islington had the highest rate of male suicide of any local authority in England and Wales.
- A report by Islington LINk from 2010 into people's experience of leaving hospital found that people with learning difficulties experienced far more problems in terms of the information and support they received.

Strategy for Islington

- NHS Islington published its Health Inequality Strategy, *Closing the Gap*, in June 2010. The paper sets out its strategy for tackling health inequality in Islington over the next 20 years by preventing early deaths, promoting healthy lifestyles and addressing the socio-economic determinants of health.

Examples of Community Action in Islington

A very small selection of community activities are summarised below. There are many more groups in Islington working to address health inequality.

- Manor Gardens Welfare Trust has pioneered community healthcare projects for nearly 100 years. Today it is a unique community health centre incorporating a wide range of services based at the Manor Gardens Centre. The projects we provide are innovative and carefully targeted at the most disadvantaged groups in our community. We also run a popular healthy eating café which incorporates a training kitchen. Over 2,000 people use the Centre every week. Current projects provide support to people from all age ranges, from a Pre-school nursery to services for housebound older people. 50 organisations deliver activities at the Centre plus it is permanent home to other major charities working in Islington.
- Fit Women: Organises twice weekly gym classes for local women and occasional healthy eating workshops. The classes were set up for women who need a single sex environment to exercise in.
- Islington MIND: The Islington branch of the national mental health charity MIND. Amongst other things they run free Mental Health First Aid Training courses that teach people how to recognise the signs of mental ill health and how to deal with a crisis or the early symptoms of someone developing mental health problems.
- The Stuart Low Trust: Organises events and trips for people to promote health and wellbeing. The Trust works primarily with people who have experienced mental distress but its events are designed as mainstream activities to avoid creating a sense of marginalisation.
- Room2Heal: Provides therapeutic rehabilitation for refugees, asylum seekers and other groups who've suffered gross human rights violations. The group works through psychotherapy support groups which do story-telling, film making, gardening and rural retreats.

Introduction

1.   People in different social circumstances experience avoidable differences in health, well-being and length of life. As set out in the box above, health inequality is as much an issue for Islington as it is for other parts of the UK. The accompanying paper sets out further detail on the NHS Islington 20 year strategy for tackling health inequality.

2.   This paper provides an overview of some of the different ways in which health inequalities can be approached, including some case studies of practical examples of how health inequalities are being tackled in other parts of the UK through public services, the voluntary sector and community groups. The papers should help the Commission in its inquiry into how different sectors, groups and individuals in Islington can help to address health inequality in the borough.

Understanding Health Inequality

3.   In England, people living in the poorest neighbourhoods will on average, die seven years earlier than people living in the richest neighbourhoods. The impact of socioeconomic conditions on health outcomes is exacerbated when you consider disabilities caused by long term conditions like such as chronic obstructive pulmonary disease. People in richer neighbourhoods can expect to live for 17 years longer than people in poorer neighbourhoods, before developing these kinds of disabilities. This means that people in poorer areas not only die sooner, but they will also spend more of their shorter lives with a disability.

4.   The factors which determine these health outcomes include:
- Biological determinants: age, gender, ethnicity

- Behavioural determinants: smoking, physical activity, diet, alcohol consumption

- Psychosocial determinants: stress, isolation, social exclusion

- Socioeconomic determinants: education, employment, housing, environment, access to services and the distribution of income and resources in society

5.   The weight of evidence points to the fact that the very significant gap in health outcomes does not arise by chance, and cannot be attributed simply to genetic makeup, unhealthy behaviour, or difficulties in access to medical care, although these factors are obviously very important. Income is a particularly important social determinant of health as it is often a driver of other determinants such as quality of early life, education, employment and working conditions. However it is not always possible to separate out exactly what is driving poor health outcomes. For example the likelihood of an individual exhibiting unhealthy behaviour such as smoking tends to directly correlate with levels of education, but it is an over simplification to say that there is a causal link between the two. Another example is that there is greater acceptance of young men from certain low-income backgrounds binge drinking or smoking than of people in other age groups or from other low-income backgrounds. This means that the ways in which health inequalities are addressed need to operate at a number of different levels and there are a number of different approaches that can be adopted.

Approaches to Health Inequality

6.   Some of the main approaches to tackling health inequalities as practiced by public services, voluntary and community sector groups in the UK are summarised below although this is not a comprehensive list. Many of the approaches are complementary and none of them are mutually exclusive. A number of these approaches are likely to be practiced in Islington.

Marmot Review – "Proportionate Universalism"

7.   Tackling health inequalities has traditionally been addressed by targeting resources at particular segments of society. However in February 2010 the Government published the Marmot Review *Fair Society, Healthy Lives – A Strategic Review of Health Inequalities.* The Marmot Review highlights the social gradient of health inequality. In simple terms the lower an individual's social and economic status, the poorer their health is likely to be. The review argues that while it is tempting to focus limited resources on those in most need, everyone apart from the very wealthiest are in need and if you focus predominantly on the worst-off, then there would still be significant inequality for those who are just above the bottom, or at the median who have significantly worse health than the best off.

8.   It is unlikely that it is possible to eliminate the social gradient in health completely, but it is possible to have a shallower social gradient in health and wellbeing than is currently the case for England. This is evidenced by the fact that there is a steeper socioeconomic gradient in health in some regions of England than in others. To reduce the steepness of the social gradient in health, actions must be universal, but with a scale and intensity that is proportionate to the level of disadvantage. Greater intensity of action is likely to be needed for those with greater social and economic disadvantage. Marmot calls this "proportionate universalism."

9.   The Marmot Review also argues that tackling all the social and environmental determinants of health need to be addressed at the national level.   Working to reduce health inequalities requires the cooperation of central and local government, the NHS, the private, voluntary and third sectors and, perhaps most importantly, local communities and community groups. There can be national or regional leadership of health reduction strategies but successful action requires local and community cooperation and partnership. Marmot also emphasises giving every child the best start in life.

Approaches through local public services

10.   Tackling health inequalities locally is acknowledged to extend to all public services, rather than just the NHS alone. Other local public services have a wider reach than the NHS in influencing the social determinants of health. For example, the provision of housing, green spaces and interventions in the early years of a child's life. The Commission has previously considered evidence on some of these issues.

11.   There are also a range of other levers available to local public services to help them change people's behaviour using different types of incentives, regulations, fees and charges.   The Government has signalled through its Health White paper published in November 2010 that in future "nudging" should increasingly be relied upon to influence people's behaviour. "Nudging" is defined as anything that does not include coercing people or exerting financial pressure on them to behave in certain ways. Examples include displaying healthy food more prominently in canteens and supermarkets rather than sweets or requiring people to opt out of organ donation. Although

there may be a role for nudging some have cast doubt on the effectiveness of these kinds of measures by themselves, for example in January 2011 Cambridge University Behaviour and Health Research Unit reported that the impact of "nudging" behaviour was limited in many cases because there were other powerful influences on peoples lives, for example the fact that healthy food can be relatively more expensive than unhealthy food.

12.   Box 2 includes some case studies that illustrate how the NHS and local authorities have tried to tackle health inequalities through behaviour change.

Box 2: Examples of how other local authorities and NHS partners are tackling health inequalities

LB Greenwich 'Health: Everyone's Business'

Greenwich council initiated a health improvement course called 'Health: Everyone's Business' (HEB). The HEB is a course that gives staff the knowledge, skills and language they need to promote health and health improvement in their roles. It is offered to staff across all council departments, and to staff in the NHS and partner organizations it has been highly successful and the model is now being shared with several boroughs in the North East.

The HEB course also requires participants to undertake a health promotion project within their own role. This requirement has resulted in positive action across council departments and several innovative projects. Beacon status was awarded to Greenwich in recognition of their commitment to reducing health inequalities and the achievements of the HEB course.

NHS Sheffield Ethnicity Project - Champions for Achieving Better Health in Sheffield (CABS)

NHS Sheffield identified that South Asian men were 50% more likely to die prematurely of coronary heart disease (CHD) than the general population. One of the most effective ways to reduce CHD is to encourage regular screenings so that the condition can be caught early and treated.

NHS Sheffield therefore targeted a group of South Asian taxi drivers who were invited to become 'health champions' for the project. The champions then spread the word about CHD screening, distributed leaflets and held meetings to publicise the screening. 80 drivers attended the first screening and 30 follow up appointments were made and attended by 20 drivers. In addition, the initial 'champions' recruited a further 17 drivers to join the project and become champions. A further screening was attended by 98 drivers.

Workforce Development Programme

A number of local authorities have recognised the potential for their own staff to act as "missionaries" to improve health in the authority. Sponsored by the Department of Health and Local Government Improvement and Development, the Workforce Development Programme aims to build capacity among staff to improve their health and wellbeing. This in turn is expected to result in a cascade effect, positively impacting on the health of the friends and family of staff, and the wider community.

The programme is based on the need to change behaviour to improve health and the recognition that behaviour change needs to be guided by skilled practitioners. The programme was piloted in three local authorities and it was found that it is essential that staff are given sufficient time to undertake necessary training. The programme also identified the need to be sensitive and creative in responding to individual needs such as the reluctance amongst some men to visit GPs. The success of the project has led to the development of a healthy workforce toolkit for authorities.

Tackling Health Inequalities through Local Community Action

13.	The Marmot Review emphasised the importance of community engagement and partnership to address health inequalities. In part this is about the public services showing leadership and providing resource to allow community groups to find their own solutions to improve their health. In many instances family, neighbours and other peers have greater influence about the choices people take to improve their health than public bodies.

14.	In April 2010 the Local Government Association, Improvement and Delivery Agency (IDeA) published a report called *A Glass Half-Full* which focused on taking an "asset-based" approach to tackling health inequalities which builds on the existing resources of communities. The report argues that by focusing on the problems, needs and deficiencies in a community, residents often feel disempowered and dependent and become passive recipients of services rather than active agents in their own and their families' lives. Instead, the report says that public services need to help communities to help themselves by using the health assets which they have. Assets are defined as anything operating at the level of the individual, family or community which enhance their abilities to maintain or sustain health and wellbeing. Assets include things such as practical skills and knowledge and networks of local residents, the passions and interests of local residents that give them energy to change, the effectiveness of local community and voluntary associations, and physical and economic resources.

15.	Box 3 below sets out some examples of community activity to tackle health inequalities.

Box 3: Examples of how community groups are tackling health inequalities

Healthwise Hull - Community Health Champions

Healthwise Hull is a community project that received funding from the Big Lottery Fund to train people as 'community health champions' who will encourage communities in Humber and Yorkshire to eat better, be more physically active and improve their mental health. The aim of Healthwise Hull is to empower local residents to make a difference to the overall health of Hull by improving the health choices that they, their families and friends make. Becoming a community health champion allows individuals to learn new skills, gain confidence and make a difference to the health of their community.

Witton Country Park Green Gym

The Witton Country Park Green Gym is a community group that offers older people an opportunity to improve their fitness through practical conservation sessions. The group provides all the equipment and training and undertakes activities such as planting hedges, creating community gardens and improving footpaths.

Race based approaches to tackling health inequalities

16.	Some people argue that understanding and addressing the drivers of health inequalities through the prism of race is useful and necessary to tackle health inequality. For example, people from Bangladeshi origin have the highest incidence of mortality from coronary heart disease and stroke. The latest available national statistics on health and ethnicity in England indicate that Bangladeshi men are the most likely group to smoke and that although very few Bangladeshi women smoked cigarettes, a relatively large proportion 26% chewed tobacco. Bangladeshi men are also disproportionately represented within the lowest socio-economic groups, however the Equality and Human Rights Commission report, *How Fair is Britain?* found that self reported

outcomes for Bangladeshi people tended to be significantly worse than outcomes for other groups even adjusting for socio-economic group which suggests there are other factors in play.

17.   The Afiya Trust suggests that there are several reasons for continuing health inequalities experienced by black and ethnic minority people in the UK. These include individual/community factors including cultural behaviours and structural explanations such as deprivation and exclusion. Equally the Afiya trust believes there is compelling evidence that racism, racist victimisation and discrimination which have an impact on a person's and a community's health. The Afiya framework to achieve health equality specifies the following recommendations:

- Address the diversity of identities and experiences within communities while delivering services
- Develop systems to enable racialised communities to influence policy making at the top level
- Support community - led social marketing campaigns to challenge inequalities and raise awareness
- Set mandatory duty for accountability on health equality outcomes
- Monitor the commissioning process for effectiveness in meeting community needs
- Ensure service users carer leadership in evaluation of services
- Recognise and respect cultural heritage, identify belief systems of communities

18.   Box 6 below, sets out some examples of steps to tackle from a race perspective.

Box 4: Examples of race based approaches to health inequalities

Arlaadi Somali Community Luton

Arlaadi is a community group for members of the Arlaadi Somali community. The group provides support and advice and runs activities such as drop-ins, football clubs and cultural activities for fourhundred families across Luton. As part of their work they promote healthy living and provide advice and support on health services.

Sheffield African-Carribean Mental Health Association(SACMHA) - Maat Probe

SACMHA is a small charity that provides mental health outreach and advocacy for the African Caribbean community in south Yorkshire. Maat Probe was originally a small peer support group within SACMHA, but when they became concerned about the stigma and discrimination being experienced by African-Caribbean patients with mental health issues, they applied and were granted funding from the lottery-funded anti-stigma campaign 'Time to Change'.

They conduct research into the experiences of in-patients at mental health facilities and are using their results to lobby service providers to change practices that it is felt are contributing to the bad experiences of patients. The project is ongoing but has received significant media attention for its achievements in challenging issues of stigma and discrimination around mental health

Chinese Health Information Centre (CHIC)

The Chinese Health Information Centre (CHIC) was set up in 1987 to tackle health inequalities among the Chinese communities of Manchester, and to improve access to health services after it was discovered that fewer Chinese people were accessing GPs services compared with the population as a whole. The centre is staffed by volunteer Chinese GPs, as language barrier was thought to be one of the barriers to access. The centre runs a range of services including a diabetes clinic because rates of Diabetes are higher in Chinese

Gender Perspectives on local healthcare

19.   Gender is also sometimes highlighted as a prism through which to consider health inequalities. While there are obvious differences in the health needs of men and women and women tend to live marginally longer than men, the evidence does not suggest a clear trend of either gender experiencing worse health outcomes than the other. Both genders may find that their health needs are not met: men are less likely to use their GP; women have specific concerns about maternity services. Both genders have a mixed record when it comes to looking after health. Men are more likely to take exercise but less likely to eat the recommended amounts of fruit and vegetables, and women vice-versa.

Mental Health

20.   Poor mental health is both a manifestation of health inequality and a driver of it. In addition to mental health issues driving things like suicide rates there is evidence to suggest that people with mental health issues experience worse health outcomes overall. An analysis of primary care records and mental health issues by the Disability Rights Commission in 2006 found that people with major mental health problems are more likely to develop a significant illness like diabetes, coronary heart disease, stroke or respiratory disease, they are more likely to develop it earlier in life (before 55), and once they have it they are more likely to die of it within five years. Some of the reasons suggested for this are healthcare professionals not trying to address some behavioural factors such as smoking, diet or alcohol abuse where they appear to give the person with mental health some kind of comfort. It has also been suggested that the prevalence of mental health issues are often underestimated because of wider public stigma and so a reluctance to seek help.

Access to health care

21.   While in principle access to health care is available free at the point of use for everyone through the NHS, there is a range of evidence to suggest that the needs of some people are not met and they experience barriers in accessing the healthcare that they need, in terms of knowing where to go for help, receiving appropriate care or feeling comfortable with the treatment they receive. The Equality and Human Rights Commission report *How Fair is Britain* found that almost all groups held the same belief about their ability to access healthcare. For example, the available evidence suggests that people who report a disability are as likely as the average to say that the health service treats them with dignity and respect.

22.   However, people with learning disabilities experience far more problems in terms of the information and support they received. A research report by the Islington Local Involvement Network (LINk) on the experiences of patients leaving hospital specifically examined the experiences of patients being discharged from hospital and found that for those with learning difficulties there was often little coordination with individual's support workers about continuing their care. Additionally, those with learning difficulties described feeling ill informed about their medications, instructions, and the services available to them.

23.   Currently some people such as those who have overstayed their visas or those who have been denied asylum are denied free access to most forms of secondary healthcare and aren't exempt from fees or charges. Secondary healthcare is defined as services that are provided by medical specialists who generally do not have first contact with the patient. This exemption from the provision of free health care ranges from HIV medication to non-emergency operations. A

report by Newham PCT found that at present in the UK there is a lack of alternative low-cost health-care provision outside of the NHS to meet the needs of individuals who are unable to afford to pay private medical fees.

24.   There is also evidence to suggest that the health service sometimes deals with some older people in ways that they find humiliating or distressing. Box 5 includes examples of some of the activities to promote access to healthcare for groups who find this difficult.

Box 5: Examples of access based approaches to health inequalities

The Elfrida Society
The Elfrida Society is an Islington based charity that works with people with learning difficulties. The Society runs an "Access to Health" project that supports adults with learning difficulties to learn about their health and to access health services. The Society also organises short theatre pieces for healthcare providers that demonstrate how to properly interact with people with learning difficulties.

Project London
Project London is an advocacy project run by the international aid organisation, Medicins du Monde. Established in 2006 the Project provides information, advice and practical assistance to help vulnerable people access the NHS and other services. The majority of staff working for Medicins du Monde are doctors and nurses volunteering in their spare time.

GP Regsitration
GP's have discretion to register patients, regardless of their immigration status and whilst Islington GPs have a good reputation for registering all new patients (where their list is open) we have also been fortunate to benefit from a new walk-in GP service, the Angel Medical Centre.