Impact of Policies on Tackling Health Inequalities

Evidence and Plausibility
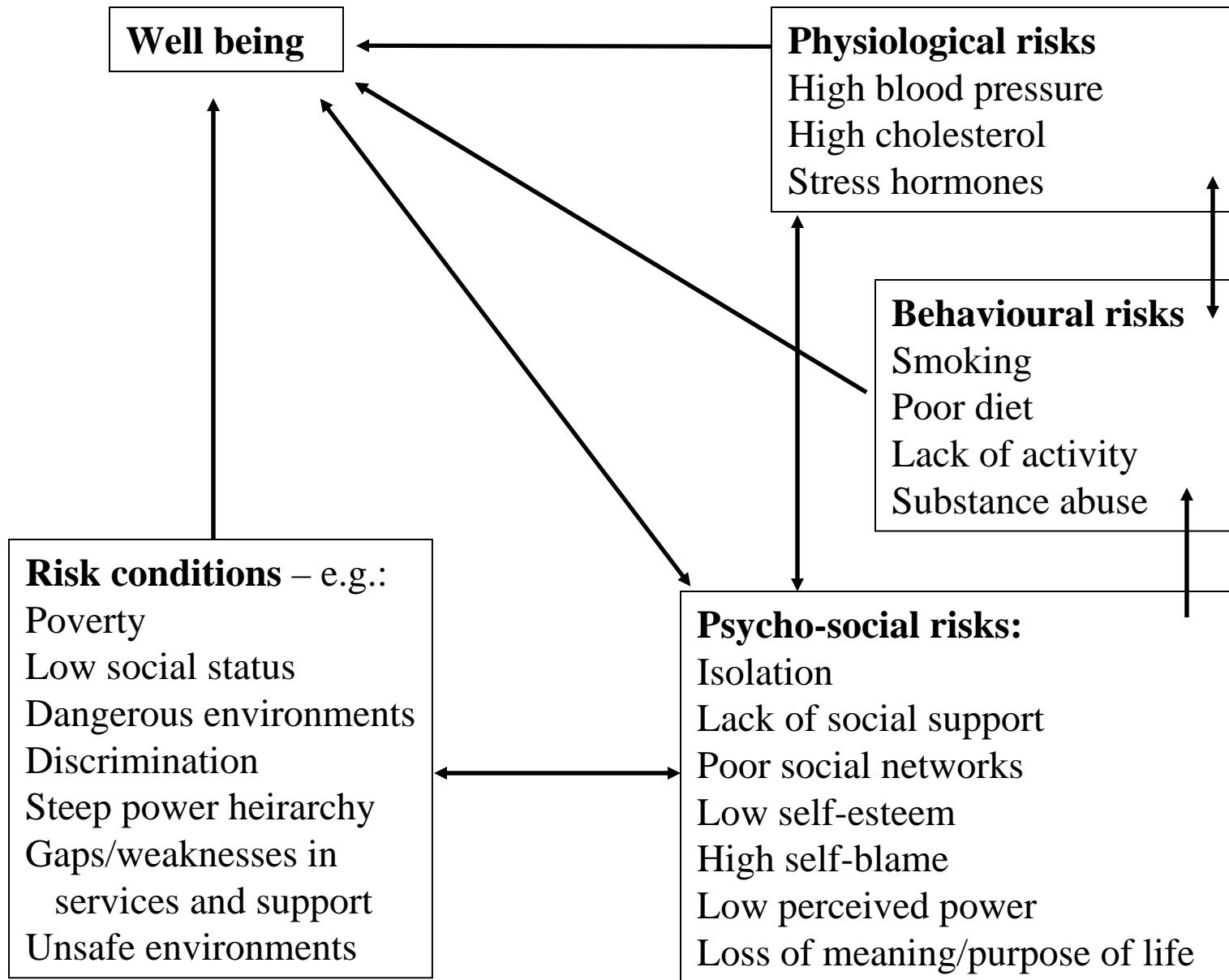
Professor Chris Bentley
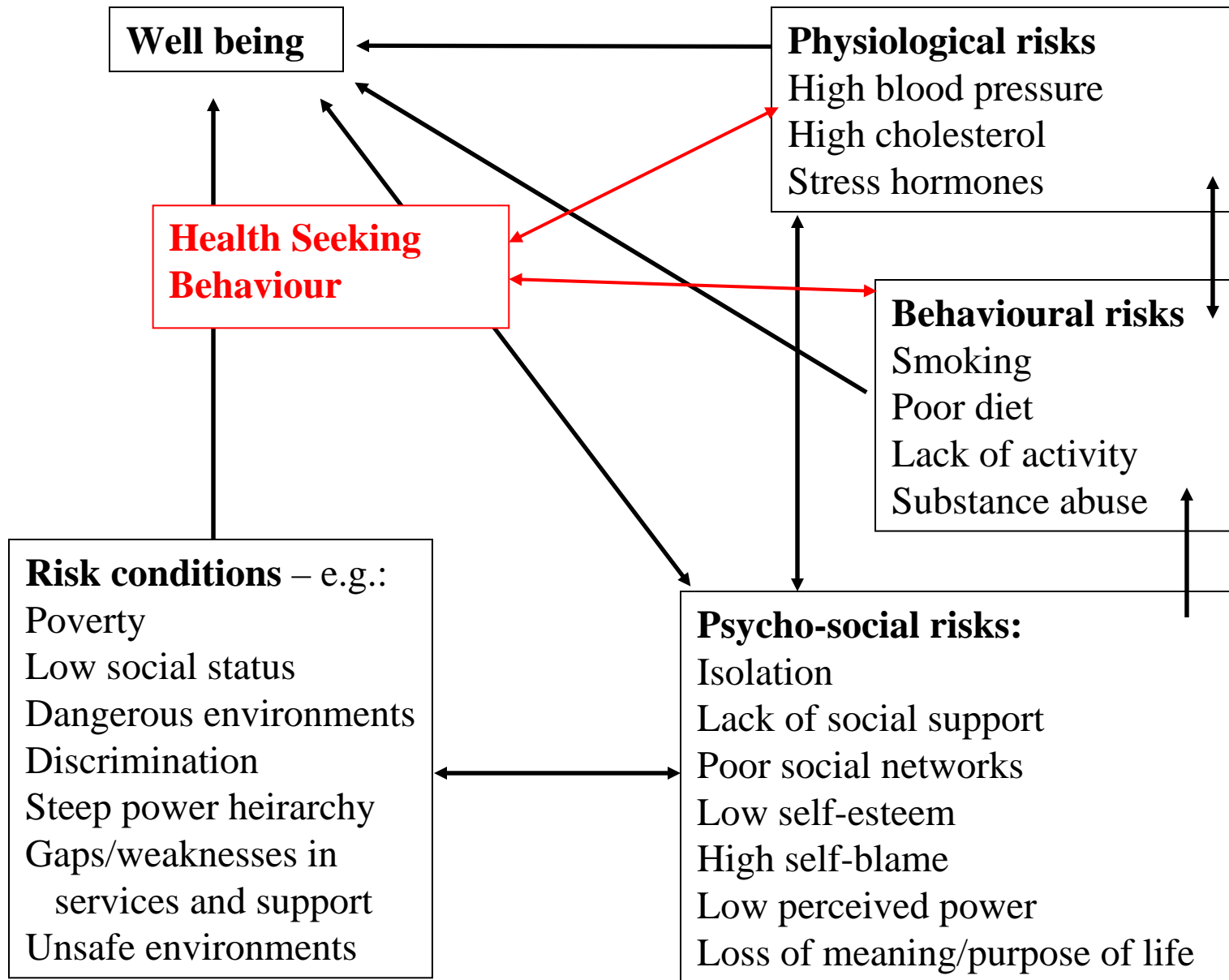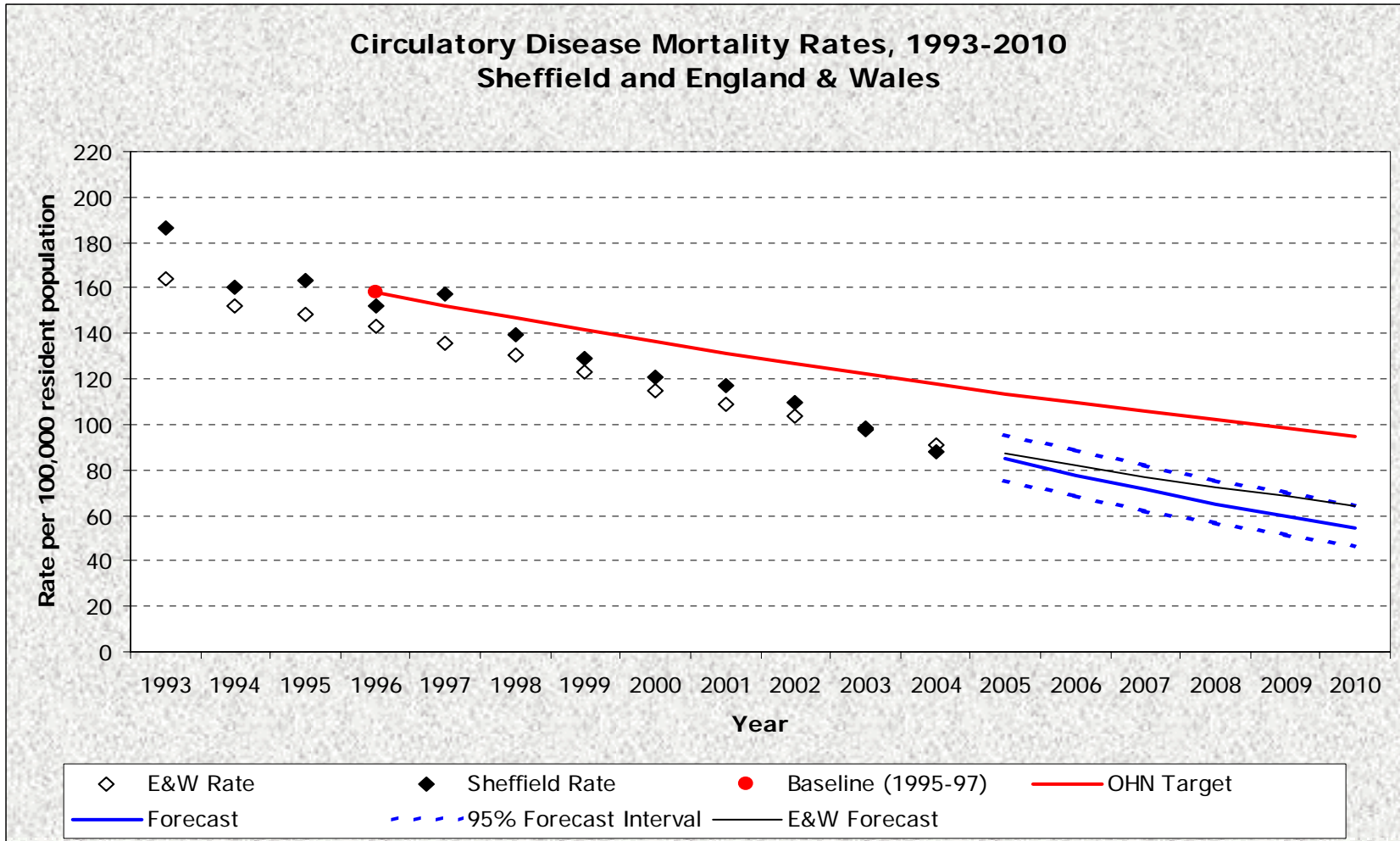
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Public Health

"The science and art of preventing disease, prolonging life and promoting health **(of whole populations)** through the organised efforts of society"

Acheson

1998

Well being ← **Physiological risks**
High blood pressure
High cholesterol
Stress hormones

Behavioural risks
Smoking
Poor diet
Lack of activity
Substance abuse

Risk conditions – e.g.:
Poverty
Low social status
Dangerous environments
Discrimination
Steep power heirarchy
Gaps/weaknesses in
   services and support
Unsafe environments

Psycho-social risks:
Isolation
Lack of social support
Poor social networks
Low self-esteem
High self-blame
Low perceived power
Loss of meaning/purpose of life

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Well being

Physiological risks
High blood pressure
High cholesterol
Stress hormones

Health Seeking Behaviour

Behavioural risks
Smoking
Poor diet
Lack of activity
Substance abuse

Risk conditions – e.g.:
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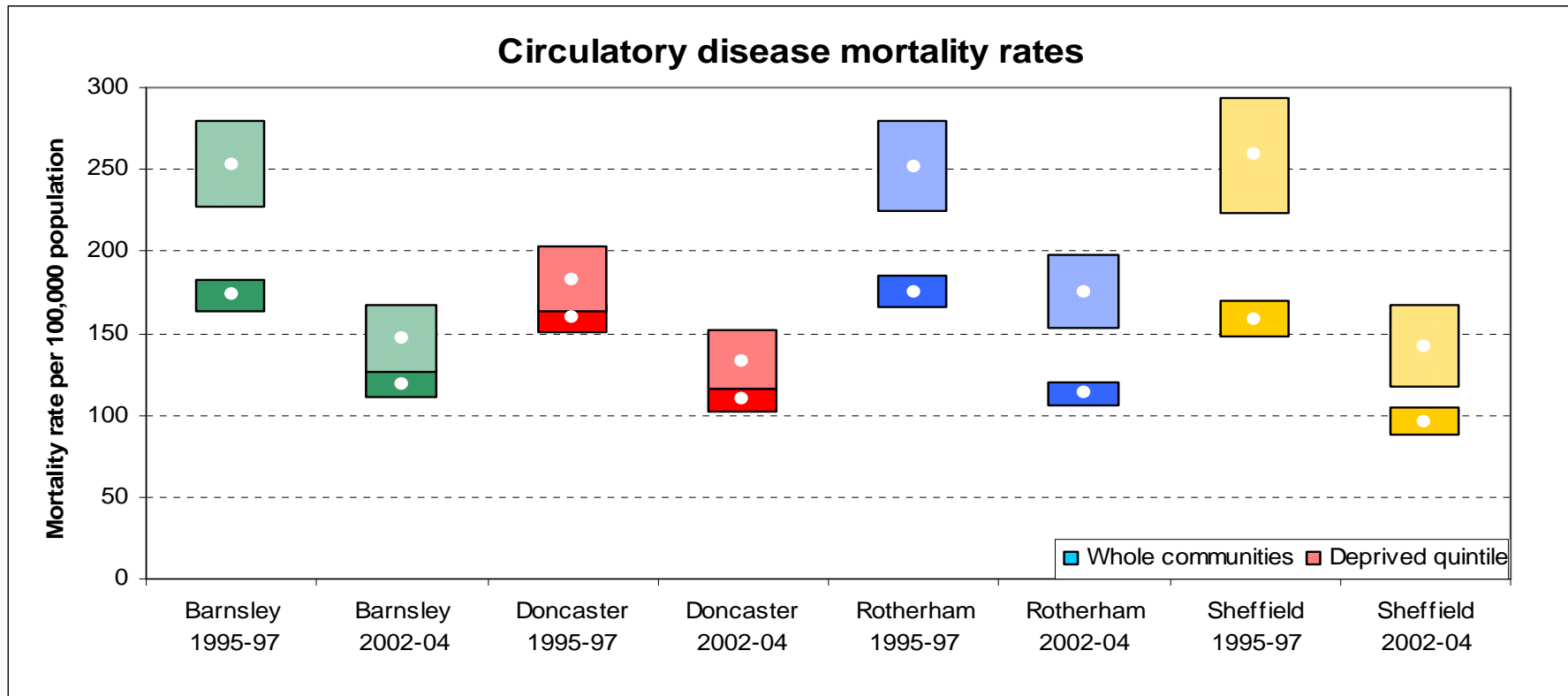Circulatory Disease Mortality Rates, 1993-2010
Sheffield and England & Wales

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Population Health

Public
Health

Personal
Health

Community
Health
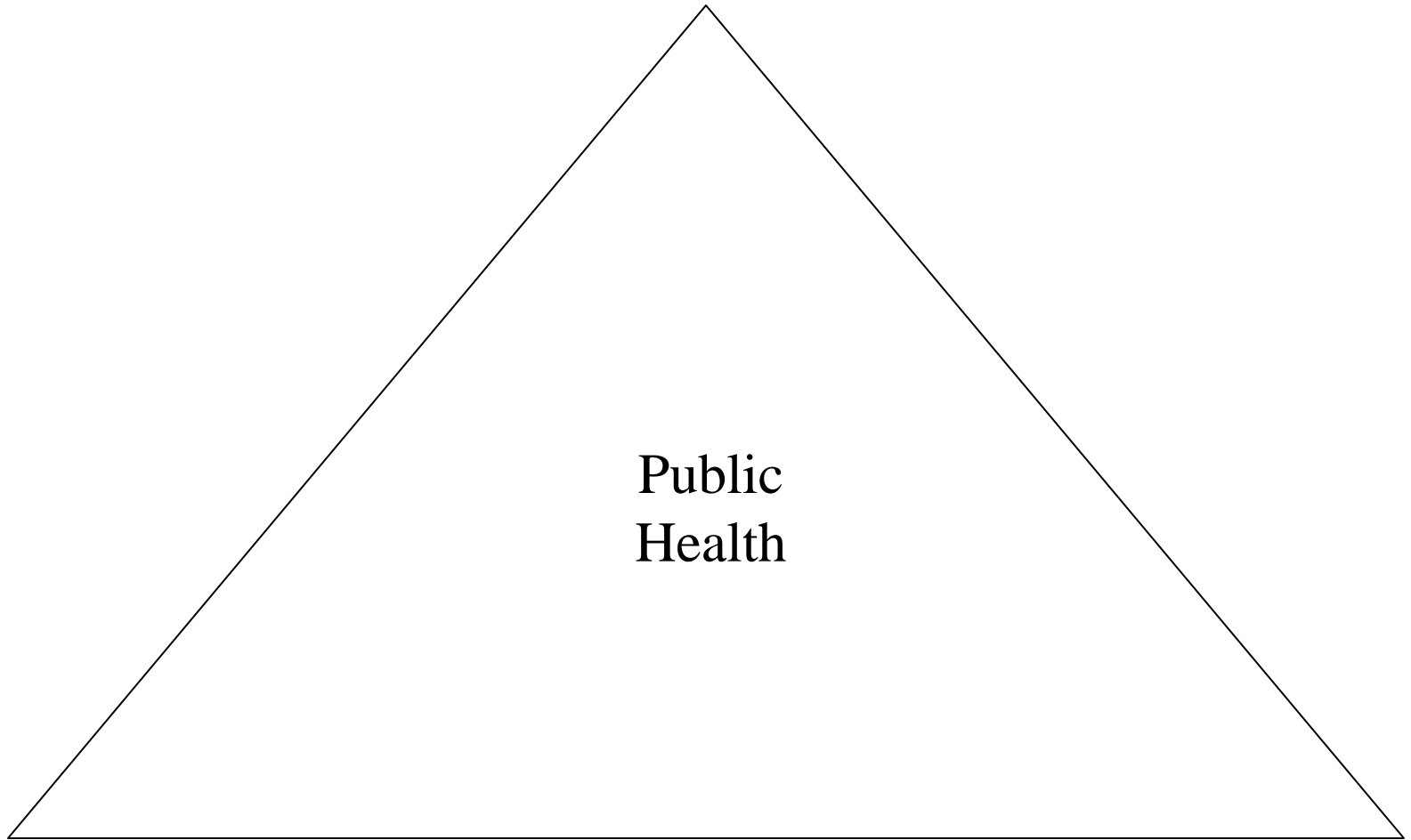
Gestation from Input to Outcome

A

B

C

2005   2010   2015   2020

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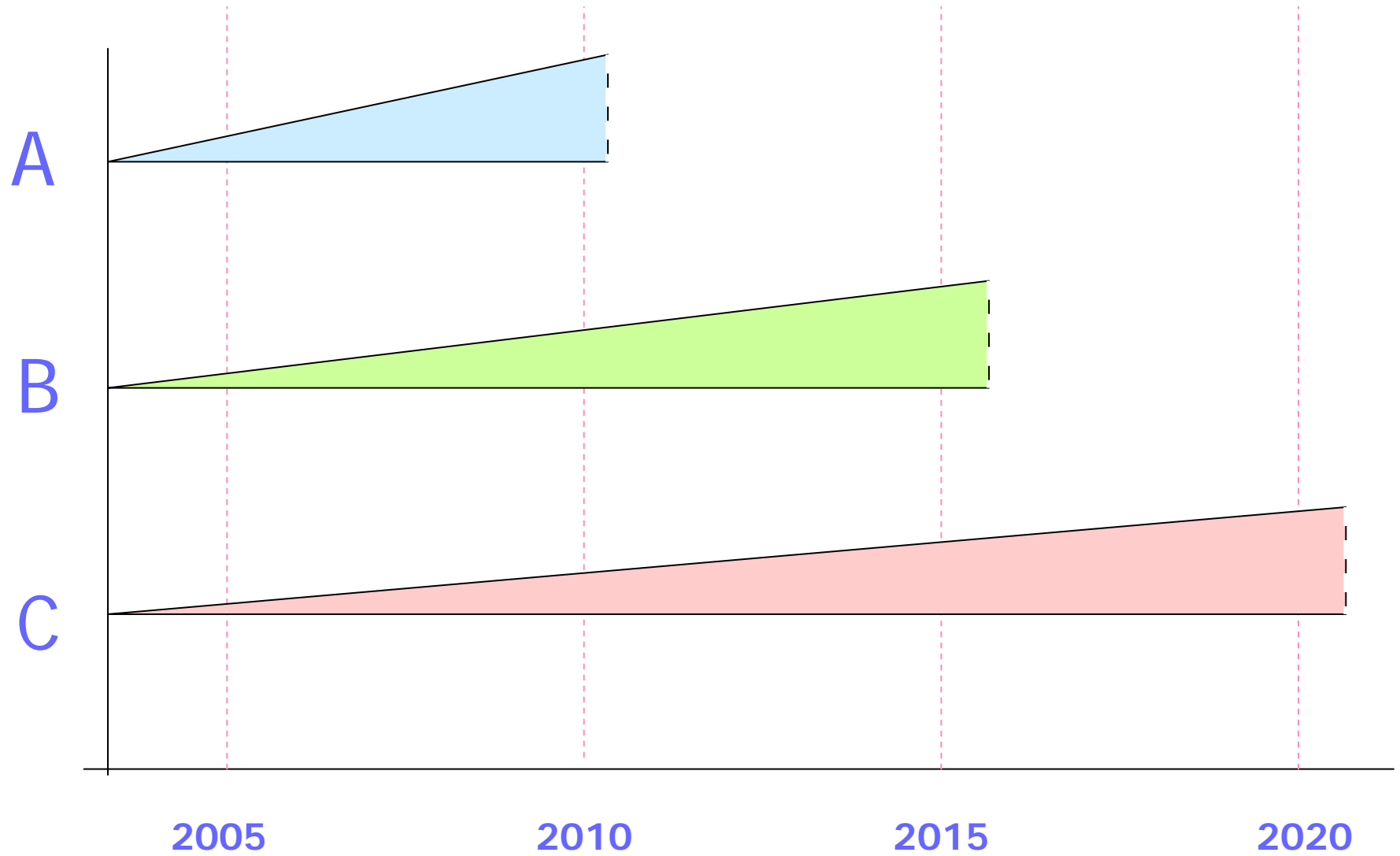
The life expectancy gap for males

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 75yrs:
    40% coverage antihypertensives

    statin therapy

- Primary prevention of CVD in hypertensives 75yrs +:
    40% coverage antihypertensives

    statin therapy

- Other*, including:
    Early detection of cancer
    Respiratory diseases
    Alcohol related diseases
    Infant mortality

*locally determined

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

The Impact – for males

1.0%

2.3%

1.0%

0.7%

1.2%

0.7%

2.1%

0.2%

1.4%

0.2%

0.2%

8.9%

11%

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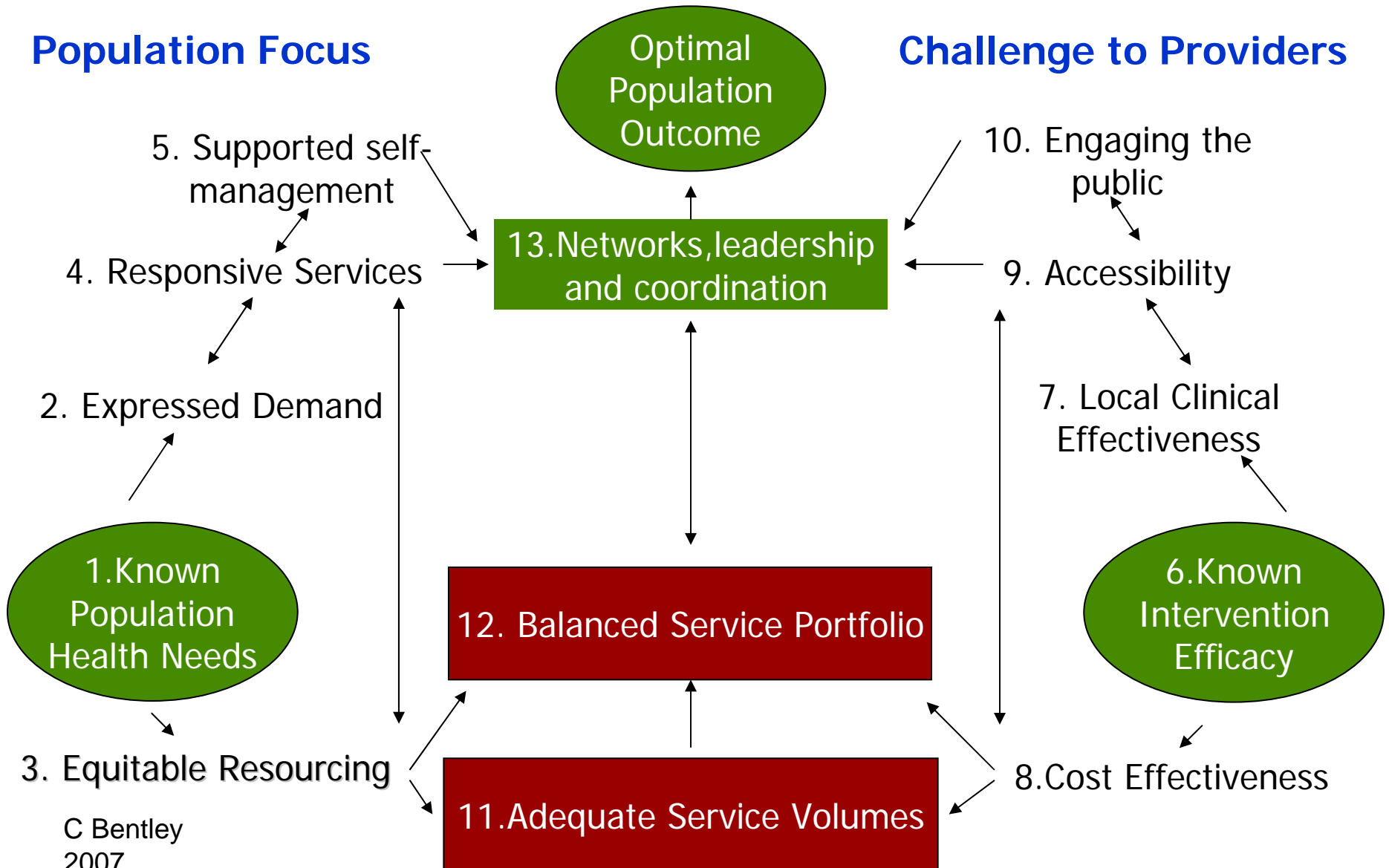
Achieving Percentage Change in in Population Health

Programme characteristics will include being :-

* **Evidence based –** concentrate on interventions where research findings and professional consensus are strongest
* **Outcomes orientated –** with measurements locally relevant and locally owned
* **Systematically applied –** not depending on exceptional circumstances and exceptional champions
* **Scaled up appropriately –** "industrial scale" processes require different thinking to small " bench experiments"
* **Appropriately resourced –** refocus on core budgets and services rather than short bursts of project funding
* **Persistent –** continue for the long haul, capitalising on, but not dependant on fads, fashion and policy priorities
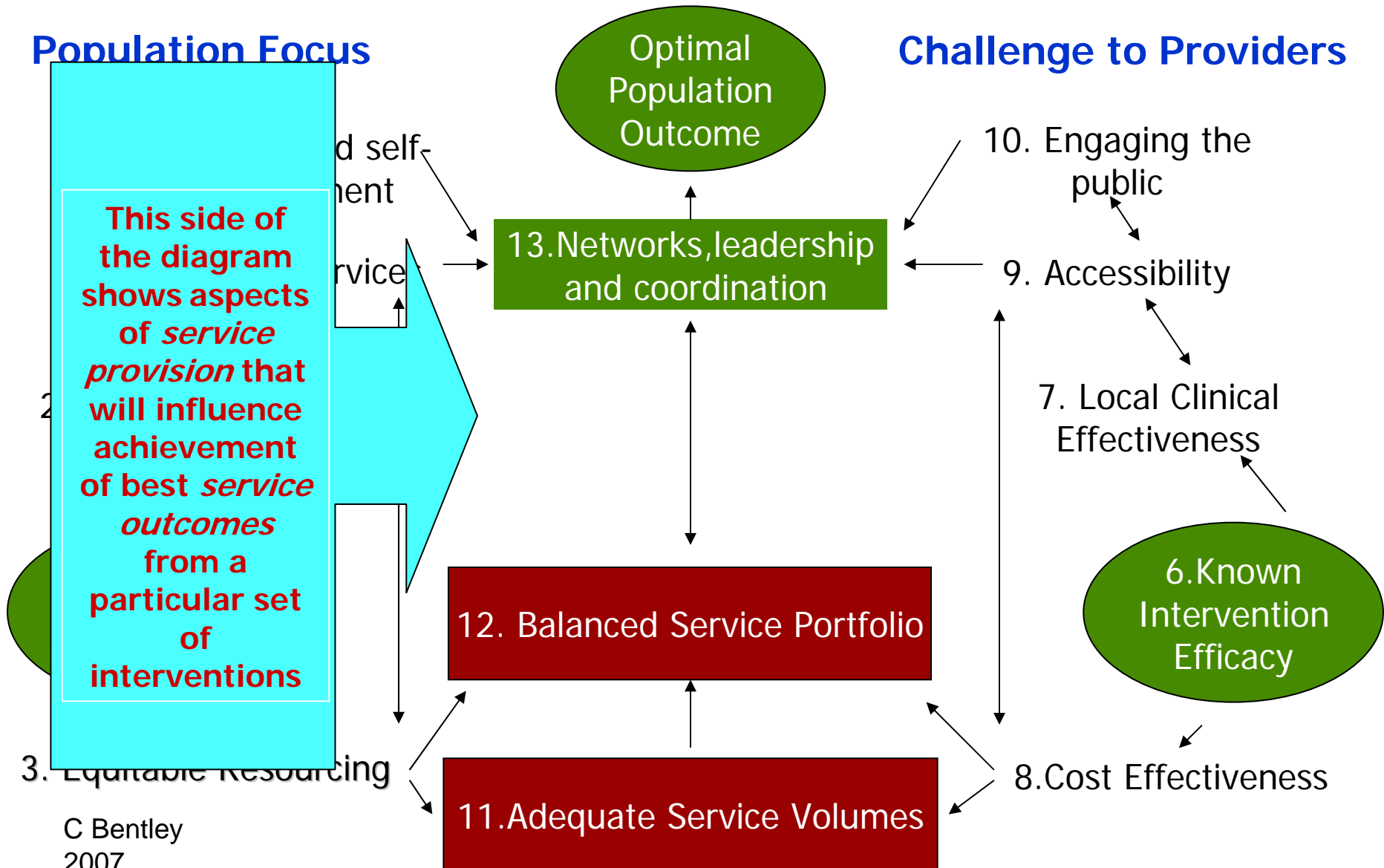
Commissioning Healthcare for Best Outcomes
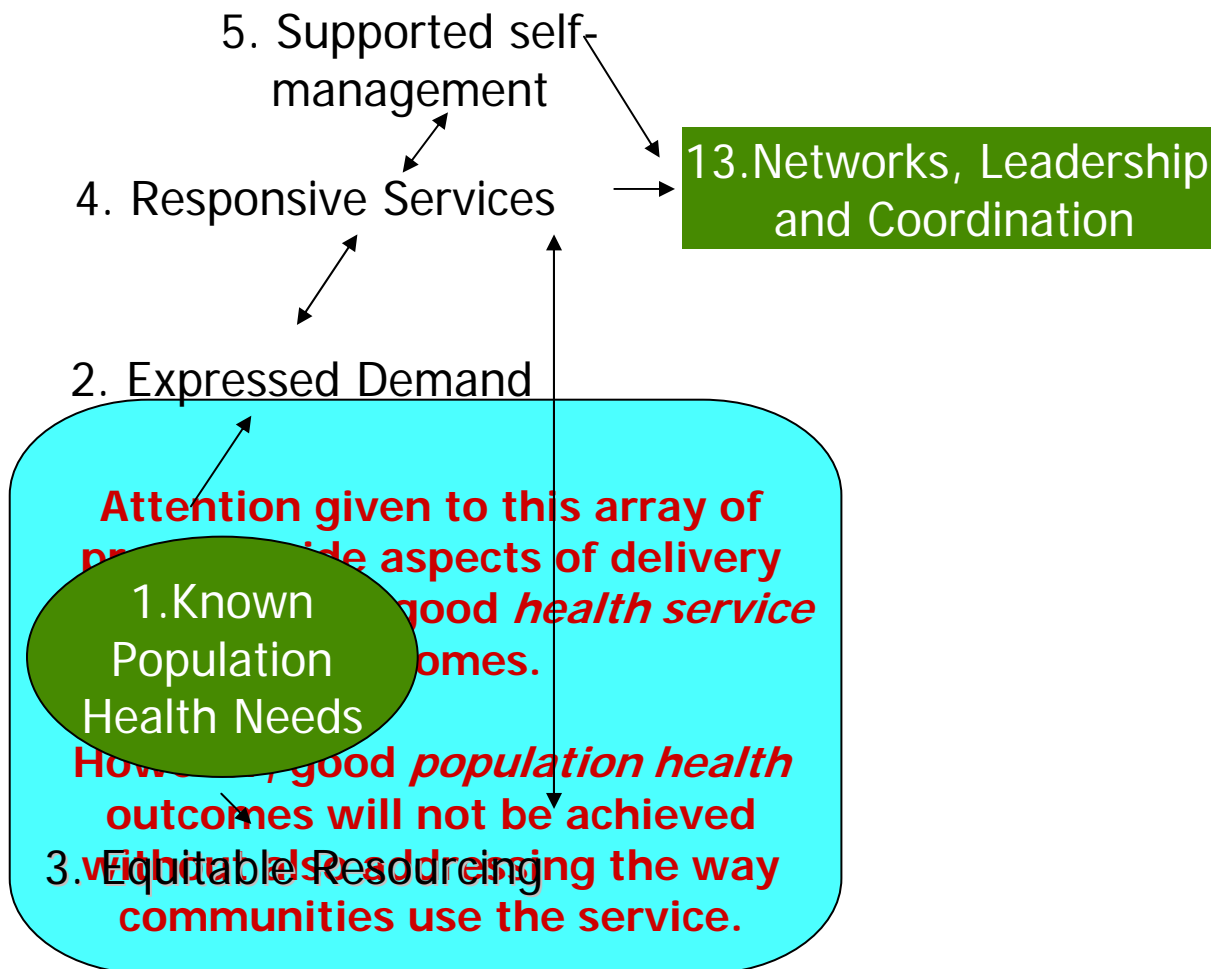
Population Focus

Challenge to Providers

Optimal Population Outcome

5. Supported self-management

4. Responsive Services

2. Expressed Demand

1.Known Population Health Needs

3. Equitable Resourcing

13.Networks,leadership and coordination

12. Balanced Service Portfolio

11.Adequate Service Volumes

10. Engaging the public

9. Accessibility

7. Local Clinical Effectiveness

6.Known Intervention Efficacy

8.Cost Effectiveness

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Population Focus

Challenge to Providers

Optimal Population Outcome

This side of the diagram shows aspects of *service provision* that will influence achievement of best *service outcomes* from a particular set of interventions

d self-
ment

rvice

13.Networks,leadership and coordination

10. Engaging the public

9. Accessibility

7. Local Clinical Effectiveness

2

12. Balanced Service Portfolio

6.Known Intervention Efficacy

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Commissioning Healthcare for Best Outcomes

Population Focus

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Attention given to this array of provider side aspects of delivery good *health service* outcomes.

1. Known Population Health Needs

However good *population health* outcomes will not be achieved

3. Equitable Resourcing

without addressing the way communities use the service.
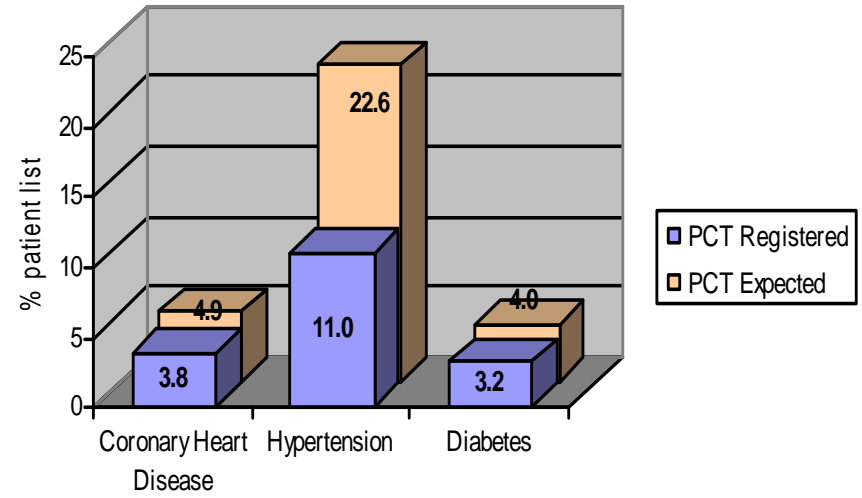
6. Known Intervention Efficacy

8. Cost Effectiveness

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Commissioning Healthcare for Best Outcomes

Population Focus

5. Supported Self-Management

4. Responsive Services

13. Networks, Leadership And Co-ordination

2. Expressed Demand

1. Known Population Health Needs

3. Equitable Resourcing

It is now possible to get good estimates of health need, either from census, local survey, extrapolation from national surveys or, increasingly, from local clinical systems. Geographical systems can map down to tailored neighbourhoods, census output areas and population quintiles.
There are still problems of obtaining good intelligence by ethnicity and other social groupings.

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Population Focus

Neighbourhood Cluster Types

For example:

- **Older large estates**
- **New estates**
- **Rural and small towns**
- **Ex-Coalfields communities**
- **Mixed young families**
- **Established non-caucasian ethnic**
- **Mobile young**

1.Known Population Health Needs

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Population Focus

2. Expressed Demand

1.Known Population Health Needs

One of the major problems of obtaining optimal population health outcomes from service delivery is that people in deprived circumstances often do not present with major health problems until too late.

Barriers to presentation include structural issues such as poor access and transport; language and literacy problems; poor knowledge; low expectation of health and health services; fear and denial , and low self esteem.

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Rotherham PCT

Actual v Expected Numbers on GP Registers

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Diabetes prevalence – expected v actual (by practice)

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Population Focus

2. Expressed Demand

1.Known Population Health Needs
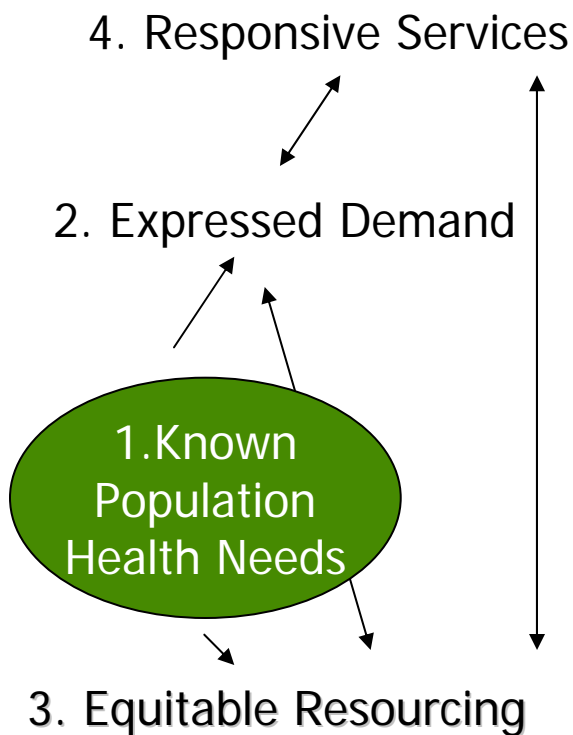
3. Equitable Resourcing
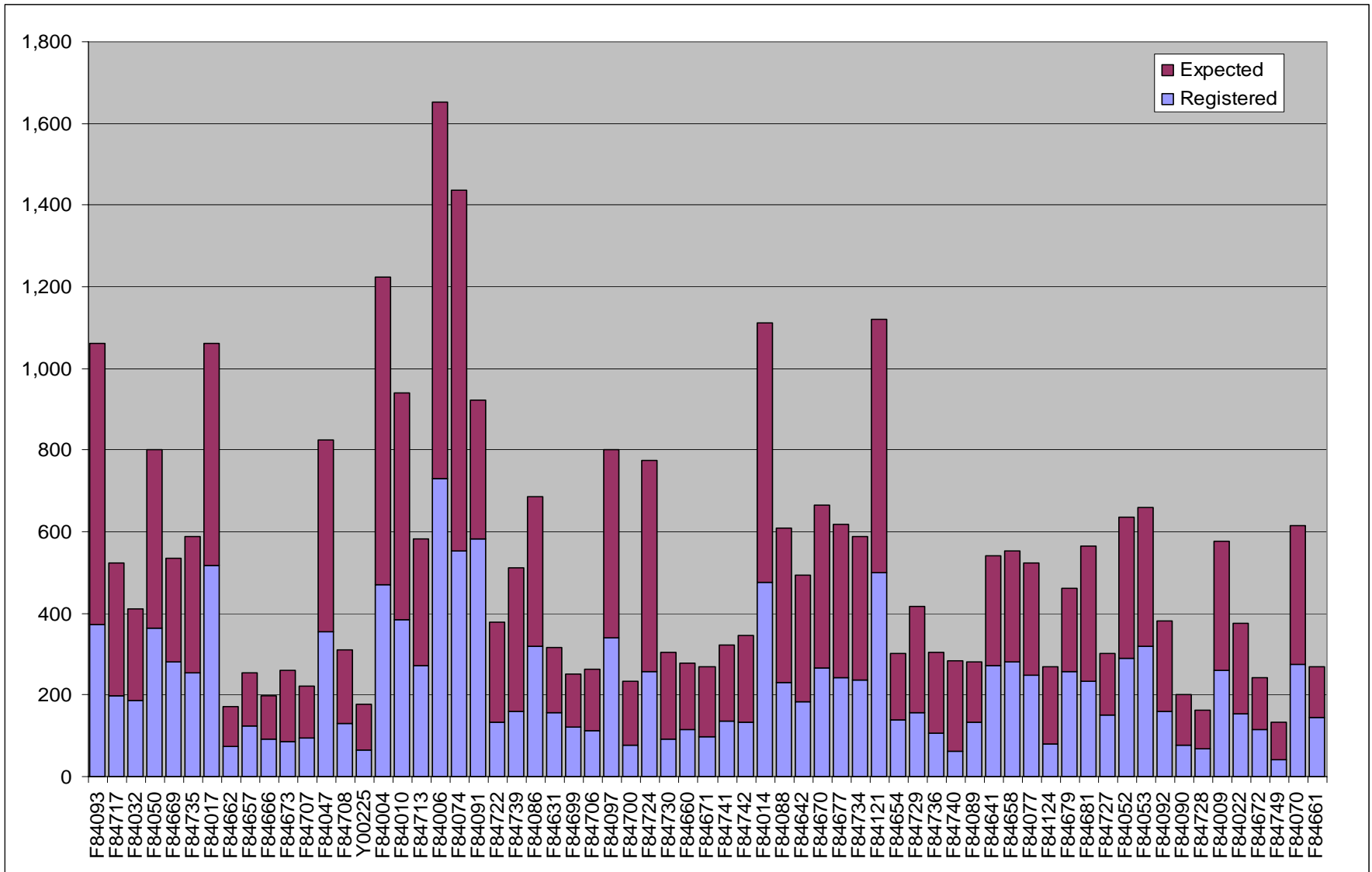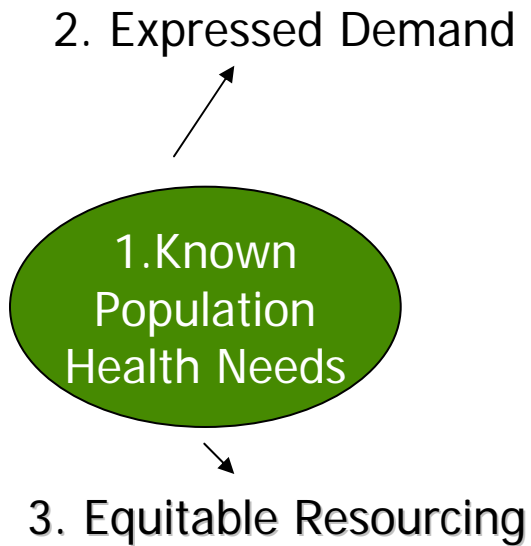
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In order to achieve equitable outcomes for deprived populations, resources applied need , firstly, to be *proportionate* to need . But they also need *disproportionate* supplements to reflect the extra effort and support required.
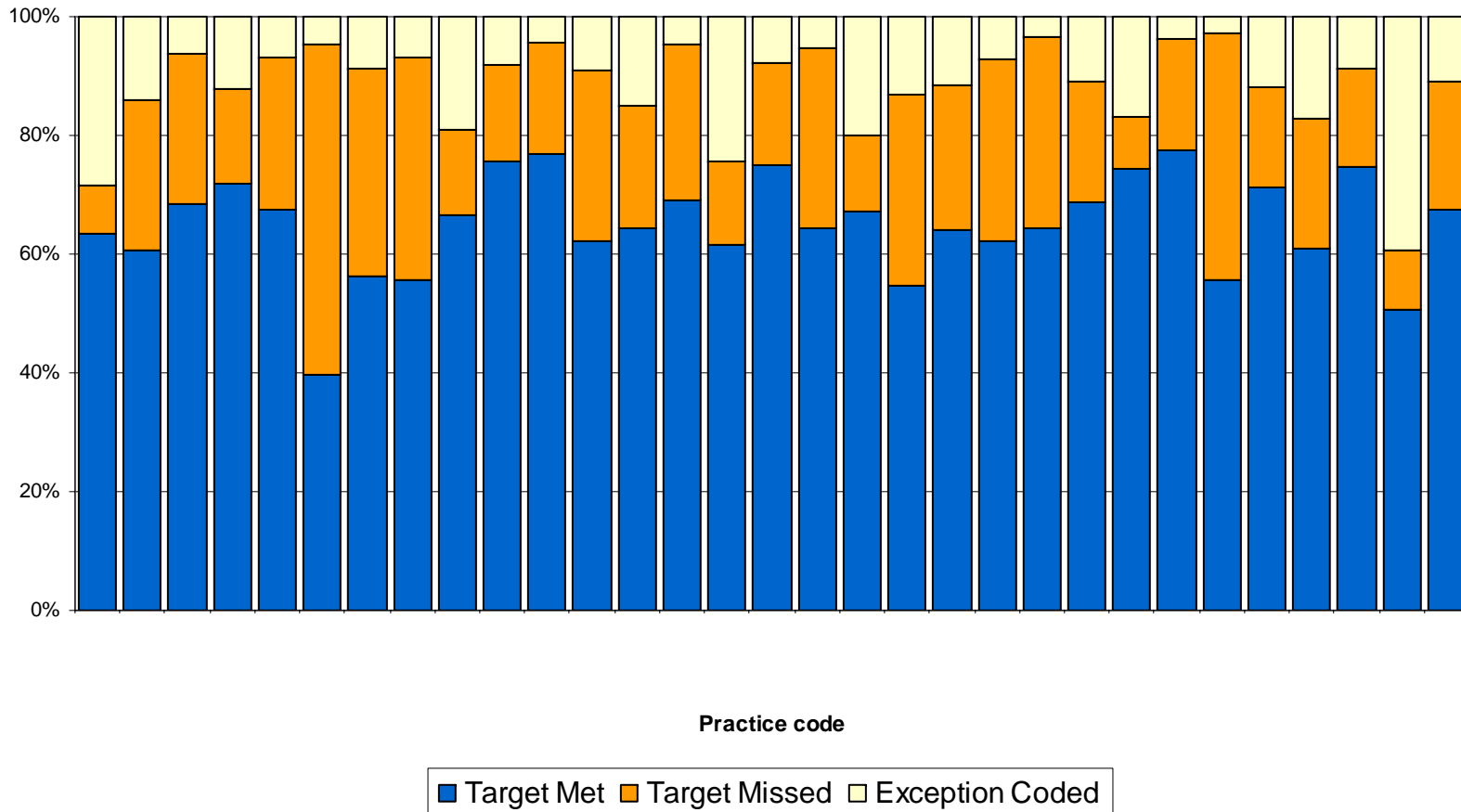
Commissioning Healthcare for Best Outcomes

Population Focus

4. Responsive Services

2. Expressed Demand

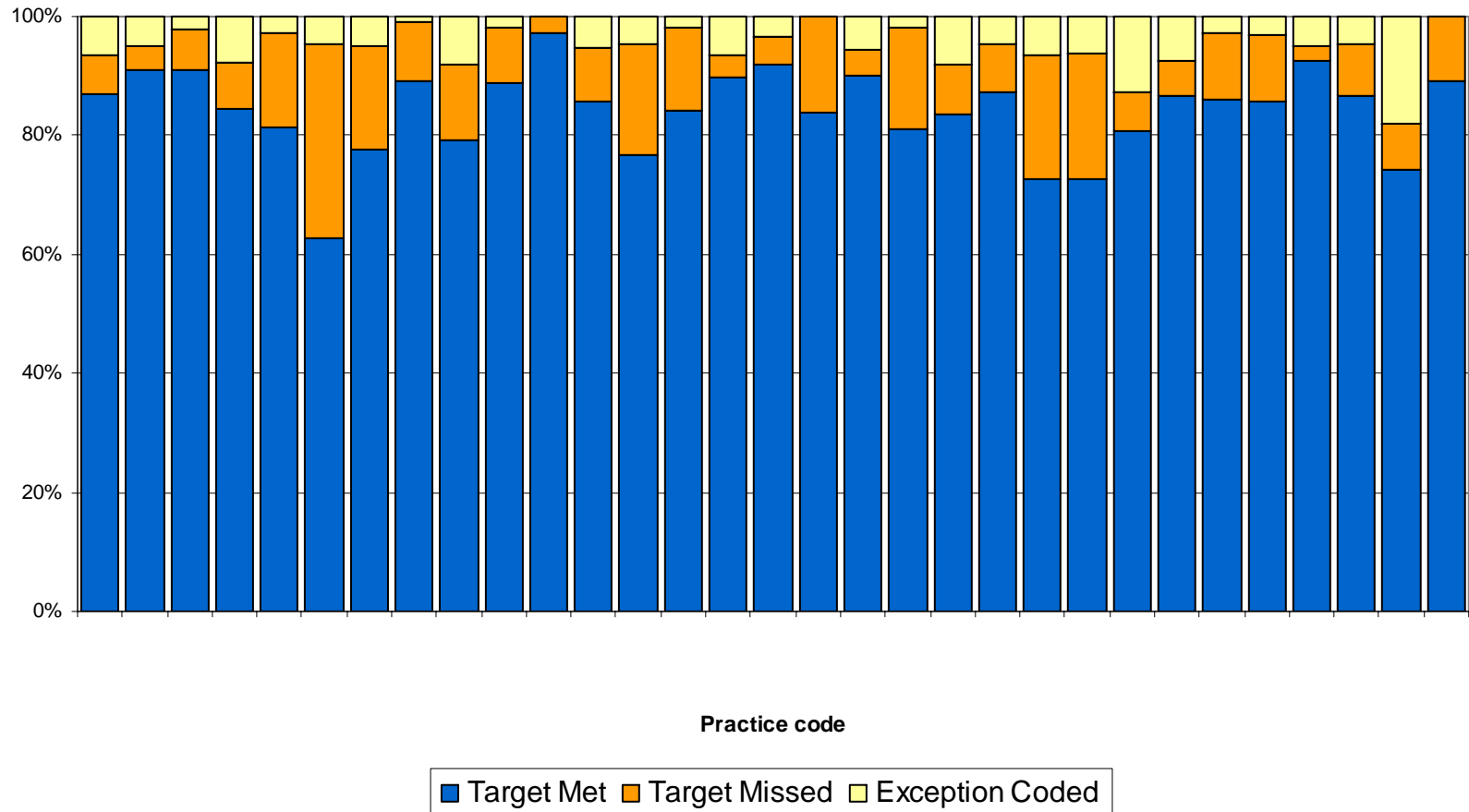1.Known Population Health Needs

3. Equitable Resourcing

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When patients do express demand and present for service appropriately, and with resources targeted and available, services should respond actively to channel them effectively to interventions they will benefit from.
This should happen regardless of entry point chosen.
Patients should receive culturally sensitive help to navigate to relevant service, and should be followed up to ensure arrival and engagement.
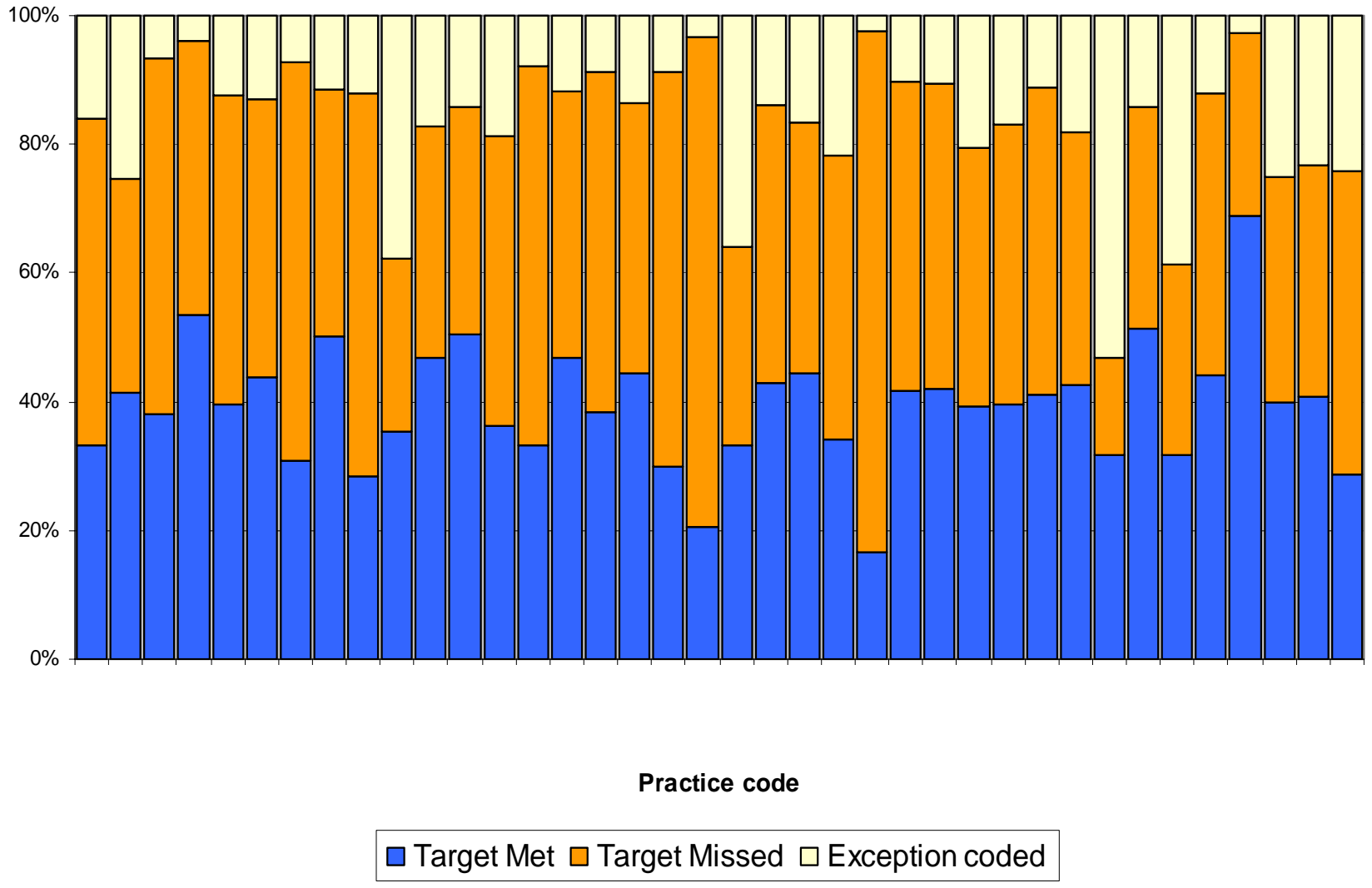
CHD 8 - %patients whose last measured cholesterol <= 5mmol/l (measured in last 15 months)

Practice code

■ Target Met ■ Target Missed □ Exception Coded

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CHD 6 - %patients whose last BP reading <= 150/90 (measured in last 15 months)

Practice code

■ Target Met ■ Target Missed □ Exception Coded

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DM 6 - % patients whose HbA1C <= 7.4 (measured in last 15 months)

Practice code

■ Target Met ■ Target Missed □ Exception coded

Commissioning Healthcare for Best Outcomes

Population Focus

5. Supported Self-management

4. Responsive Services

2. Expressed De[...]
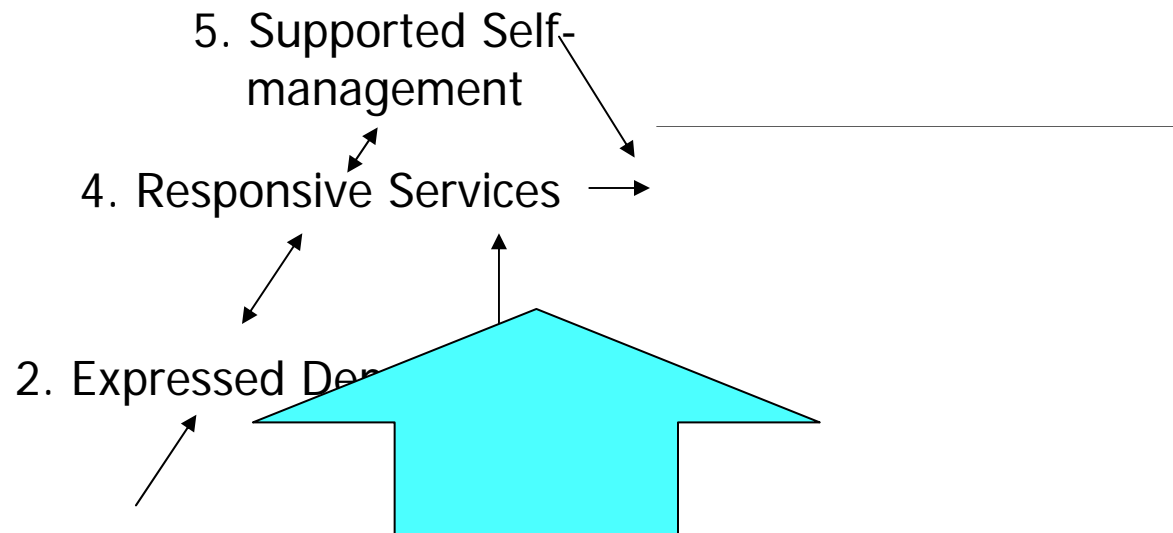
Commissioners and providers should ensure that patients are empowered to make informed choices about their treatment, and are educated and supported to utilise treatments and therapies to best effect. This should take into account factors such as literacy, language, culture and IQ.

2007

Commissioning Healthcare for Best Outcomes

Population Focus

5. Supported Self-management

4. Responsive Services

> **What support is systematically available to improve self-management?:-**
>
> •Education and training for clients
>
> •Support materials
>
> •Supportive staff time
>
> •Support groups
>
> **Is adherence to treatment followed up?**
>
> **Are social marketing principles applied?**

Commissioning Healthcare for Best Outcomes

Population Focus

Challenge to Providers

Optimal Population Outcome

5. Supported Self-management

4. Responsive Services

13. Networks, Leadership and Co-ordination

10. Engaging the Public

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2. Expressed Demand

7. Local Clinical Effectiveness

+

1.Known Population Health Needs

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11.Adequate Service Volumes

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