An evaluation of the UK policies, means and mechanism in tackling health inequalities now and in the future

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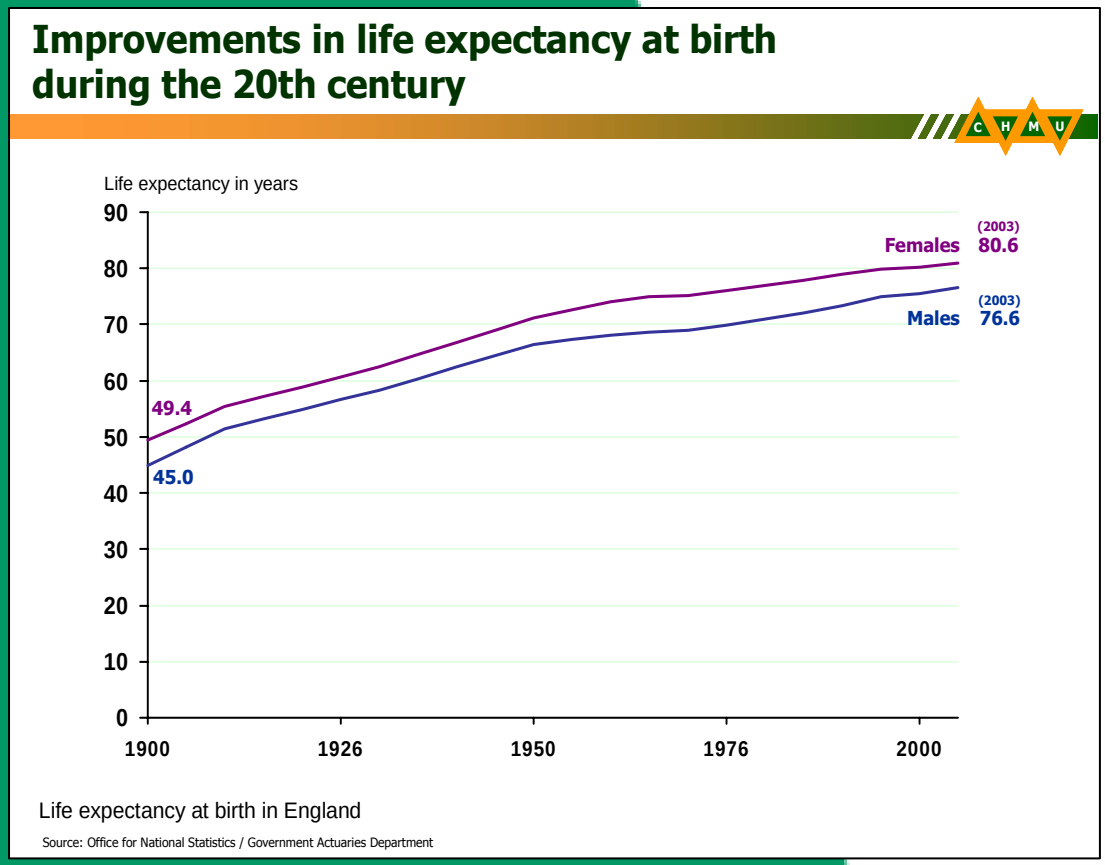
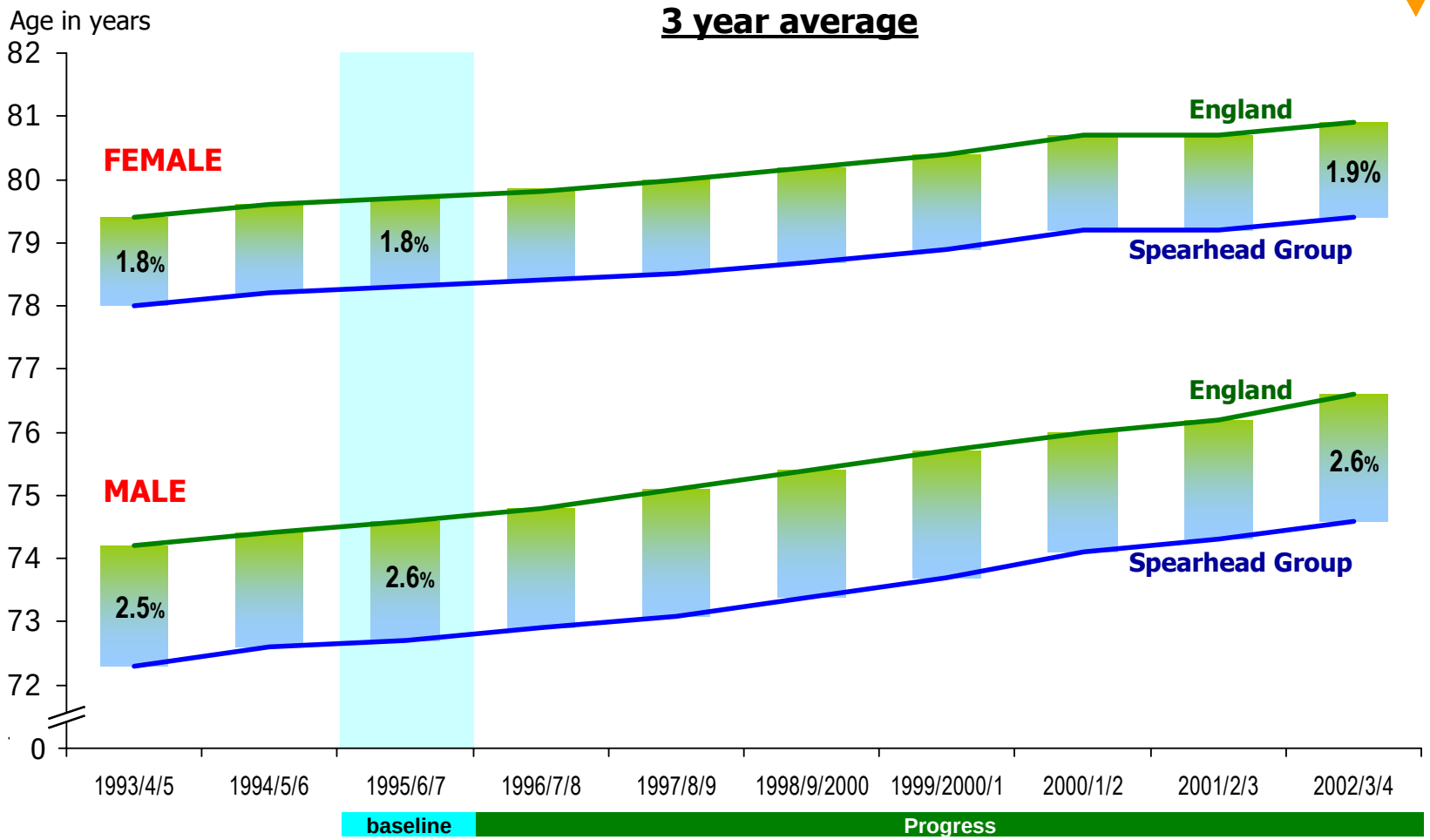
- Health in England has improved dramatically over the last century
- New challenges have emerged which must be tackled
- Unfair inequalities in health persist



Inequality gap - female and male life expectancy at birth

England 1993-2004



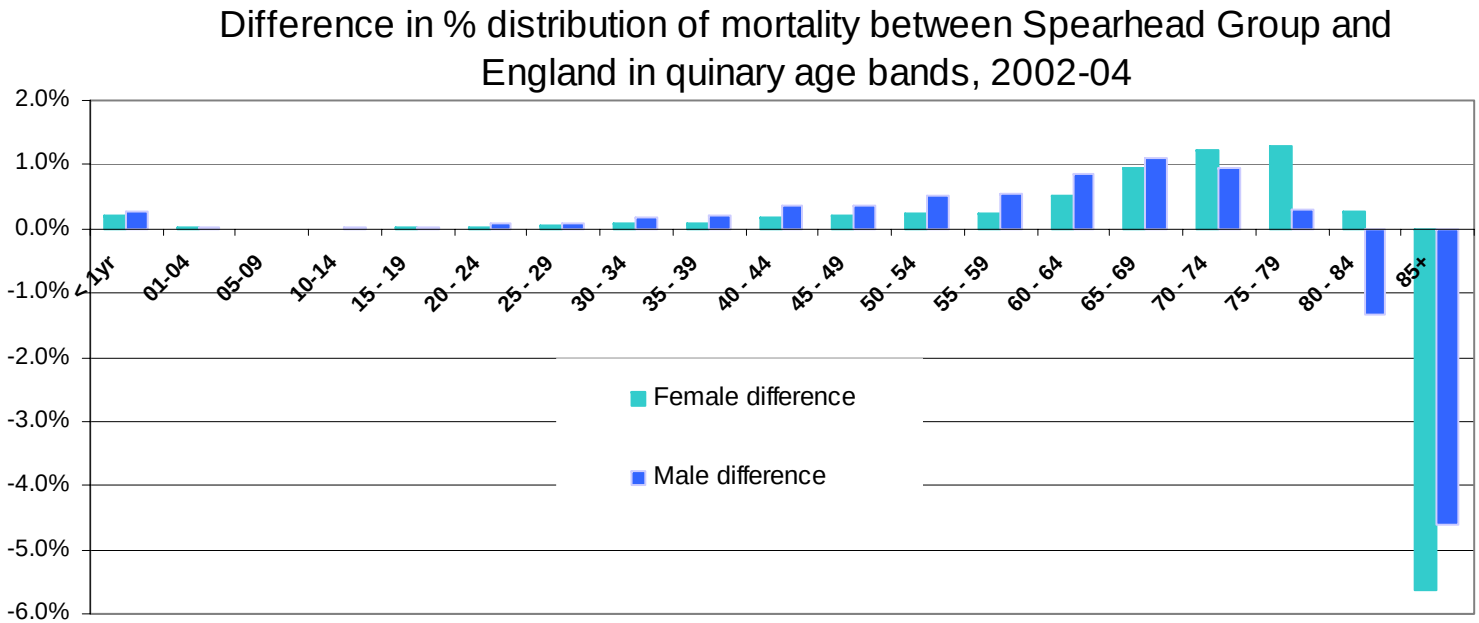
Inequality Gap, in years

X.XX% = Relative gap (The gap between life expectancy at birth in England and in the Spearhead Group. As a proportion of life expectancy for England)

Source: NCHOD Compendium of Clinical and Health Indicators, using ONS data

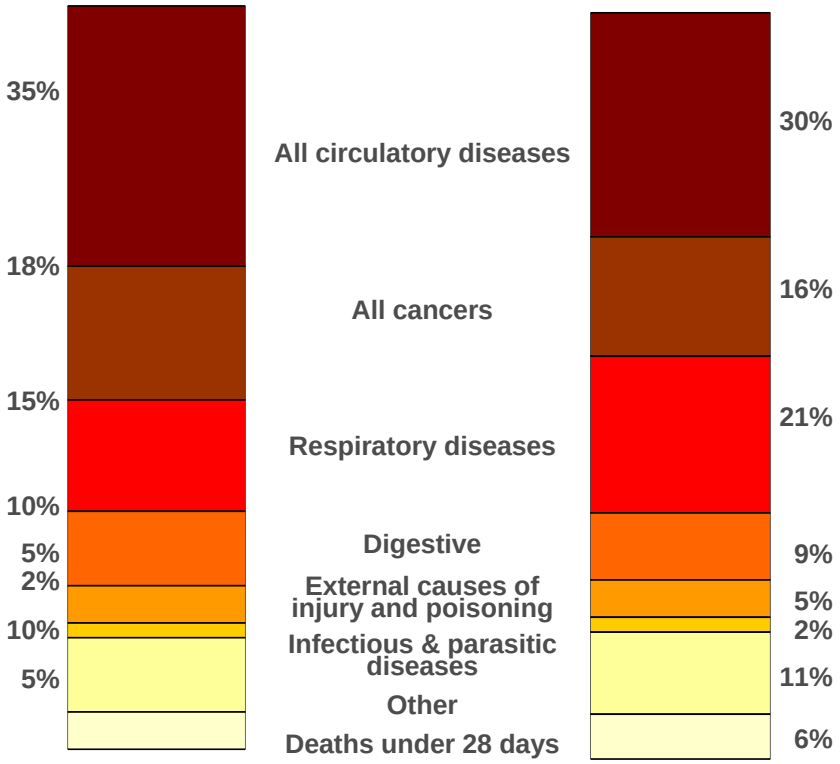
So what is the problem?

- Over the last 30 years the gap between most affluent and the poorest has increased
- There were approximately 13,700 additional deaths for 30 to 59 year olds in Spearhead groups, between 2002-04, compared to the national average for England
- The focus needs to be on reducing adult early deaths



Interpreting the evidence - What are the causes of early death in Spearhead areas?

The pattern of causes of deaths contributing to the life expectancy gap in Spearhead areas is broadly similar for both males and females with cancers, circulatory and respiratory diseases accounting for over 65% in each.



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

Contribution to Life Expectancy Gap in Females
Breakdown by disease, 2003

Main causes of deaths contributing to the Life Expectancy gap in Spearhead areas

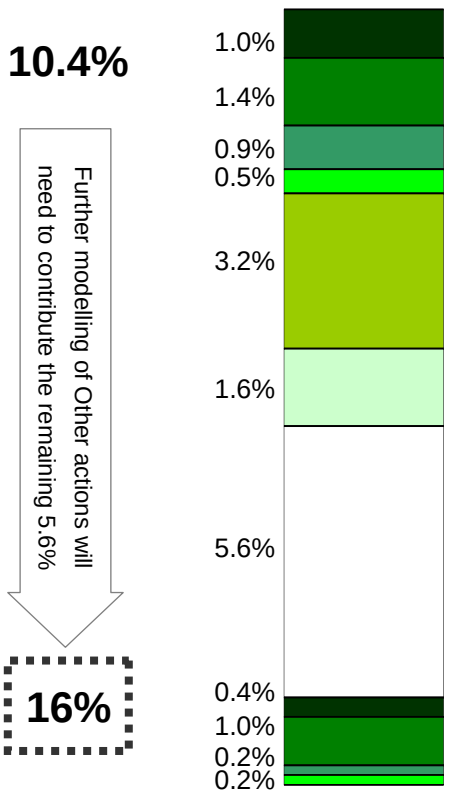
Circulatory diseases account for the largest proportion of excess deaths in Spearhead areas, most of which is attributable to coronary heart disease (CHD) (70% in males and 63% in females).

The target can be delivered if actions are targeted at these causes of early death…

Interventions to reduce the gap

Actions to reduce deaths caused by cardiovascular disease (CVD) can reduce the gap in life expectancy but these will not be sufficient to deliver the targets. There is evidence that actions targeted at other cases of early death will be able to contribute enough to enable the target to be delivered but further work is needed to complete this modelling. It is, however, clear that the NHS can deliver the target if it uses this model (and later refinements to it) to reduce early deaths.

The Impact – for females



The Interventions

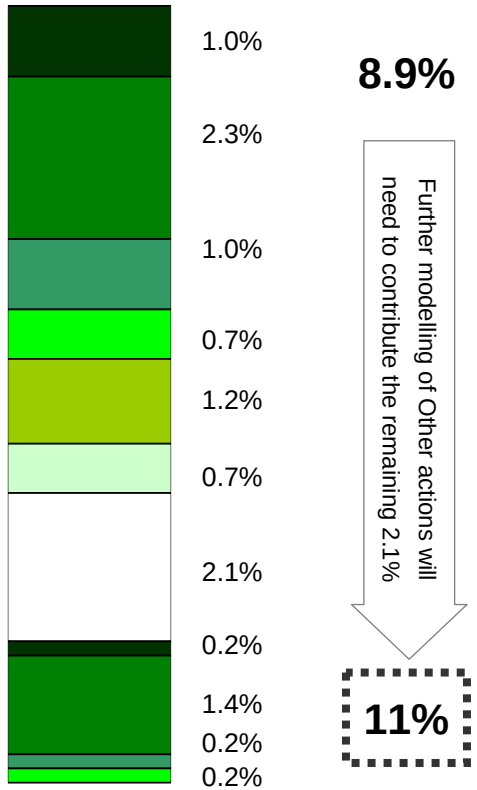
Targeted:

- 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

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



Anderson R, Rae M et al, 2005

60% of Spearhead areas are making some progress towards the target

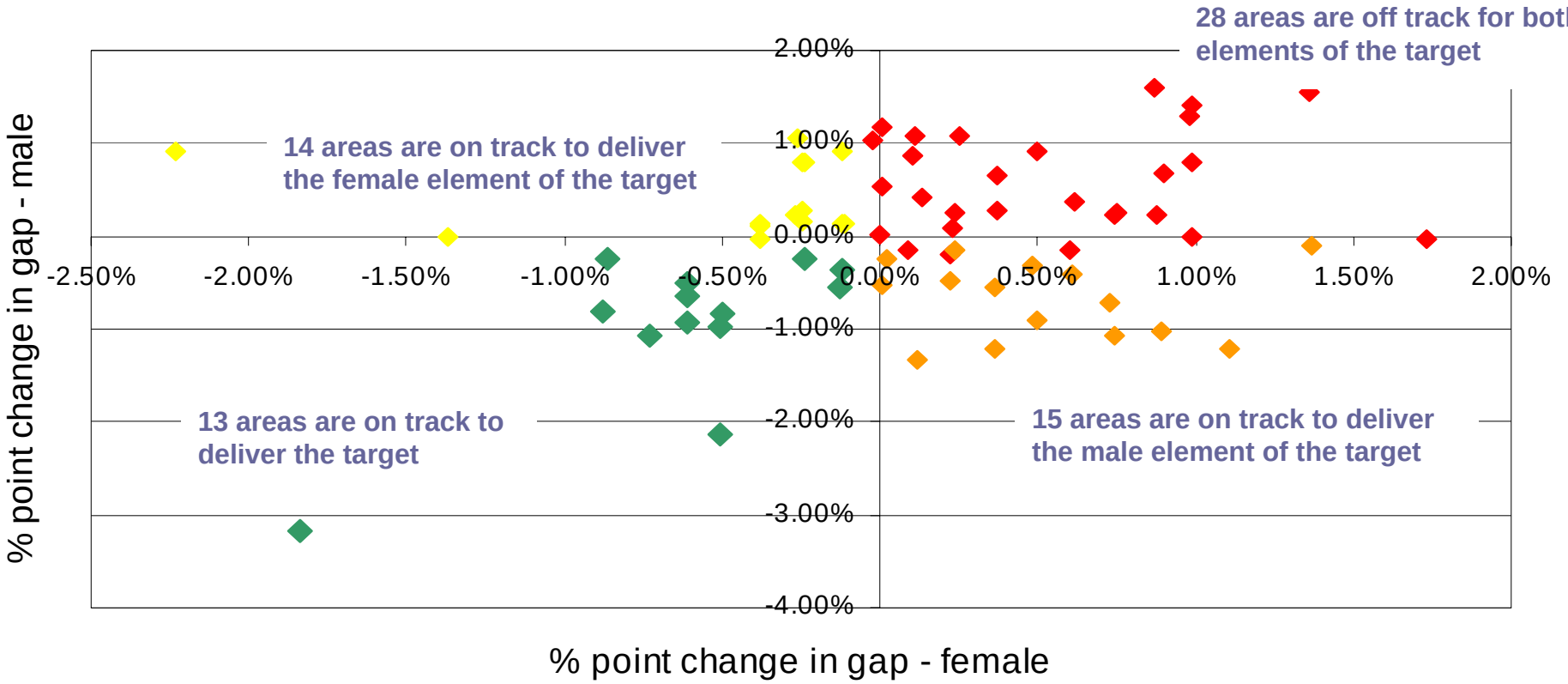
13 Spearhead areas are on track to deliver both male and female elements

29 are on track to deliver one element, less than 20% are on track

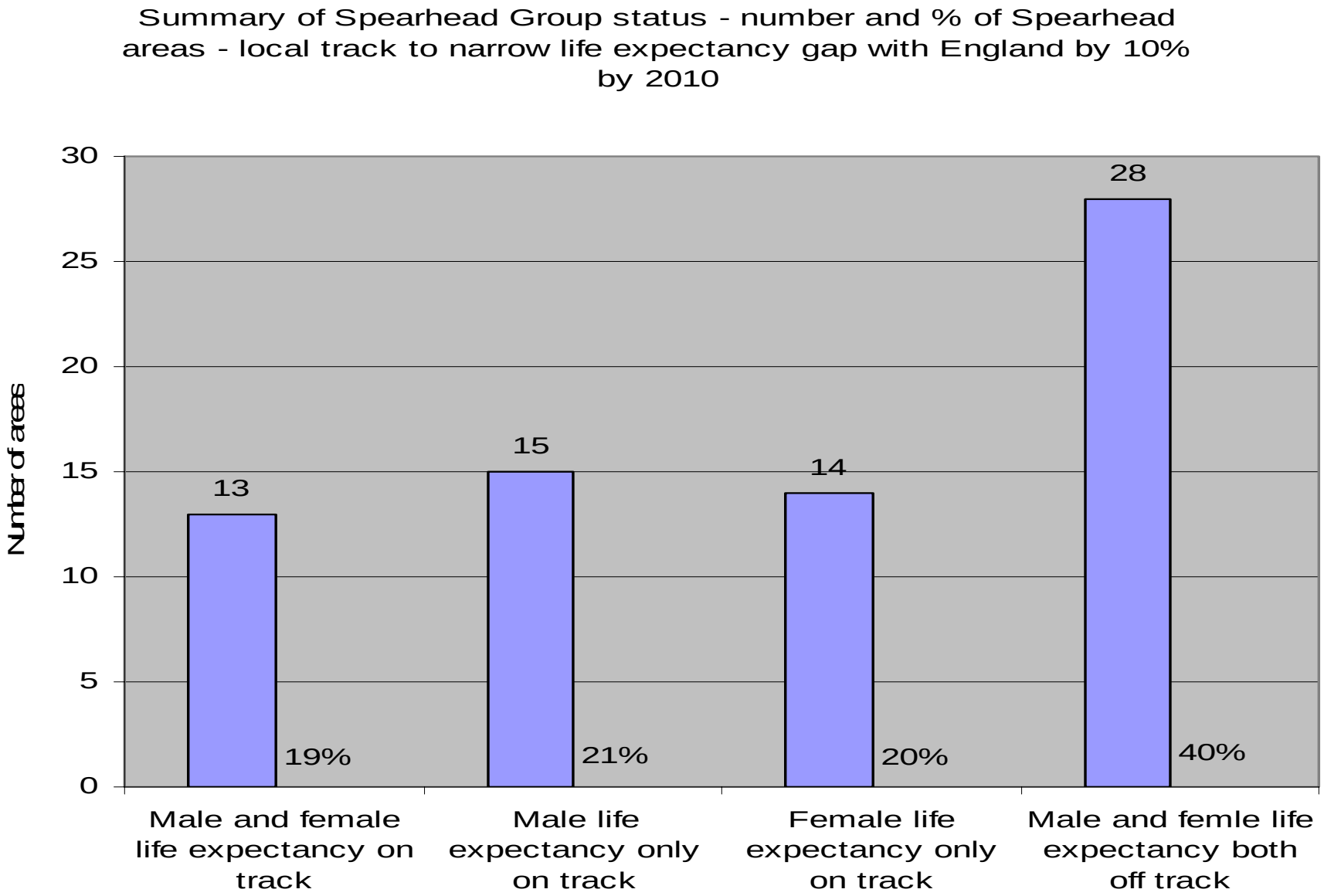
28 are off track for both elements

Department of Health

Female vs male % point change in life expectancy gap, by local authority, 1995-97 to 2002-04

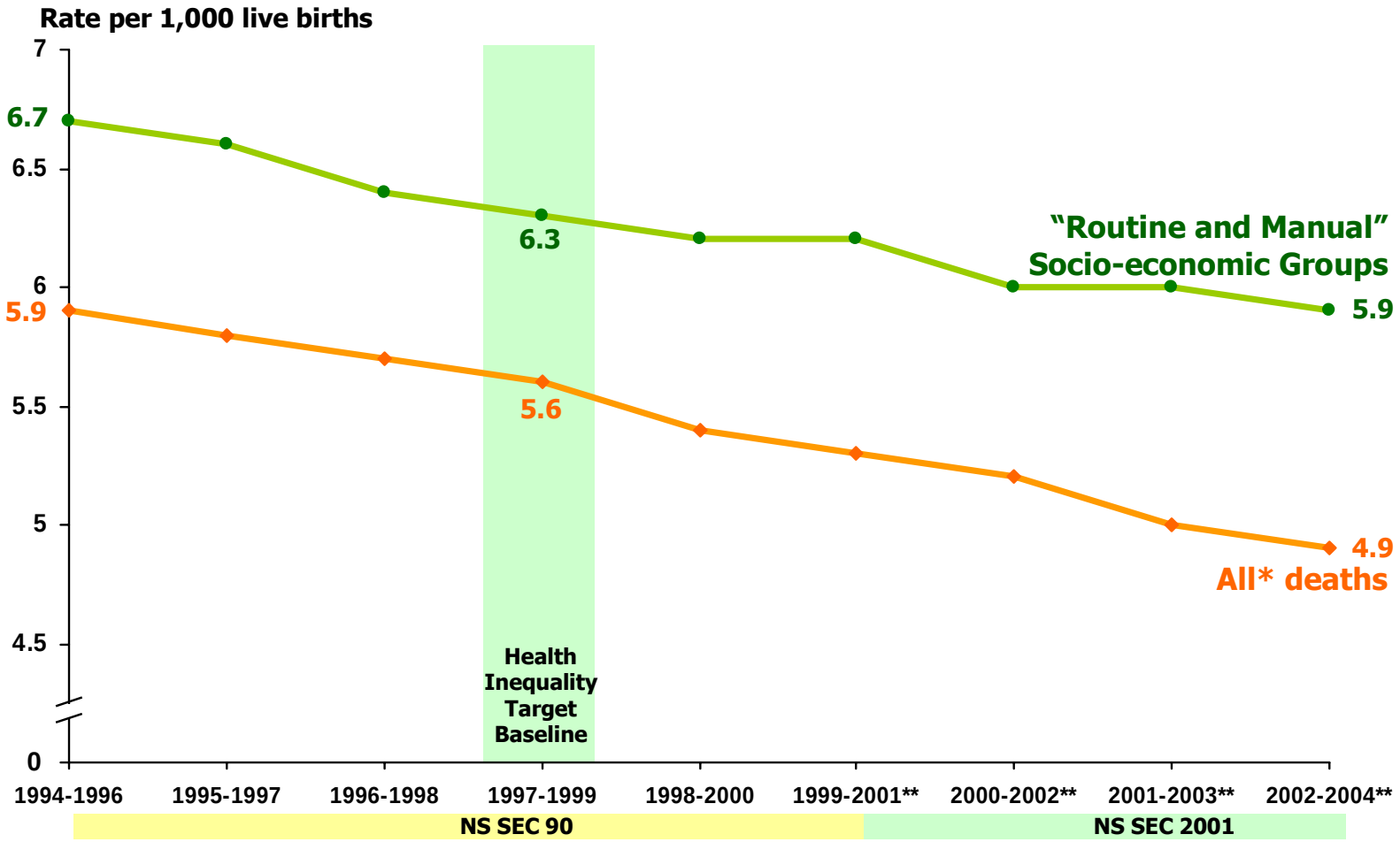


Summary of life expectancy delivery status as of 2002-04



Infant mortality by Socio-economic Group

Three year rolling average trend, 1994 - 2004, England and Wales



* "All" relate 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.

**using NS SEC for 2001 and later years' data

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 per cent sample coded for father's occupation.

Source: Office for National Statistics

Health Inequalities: Infant Mortality

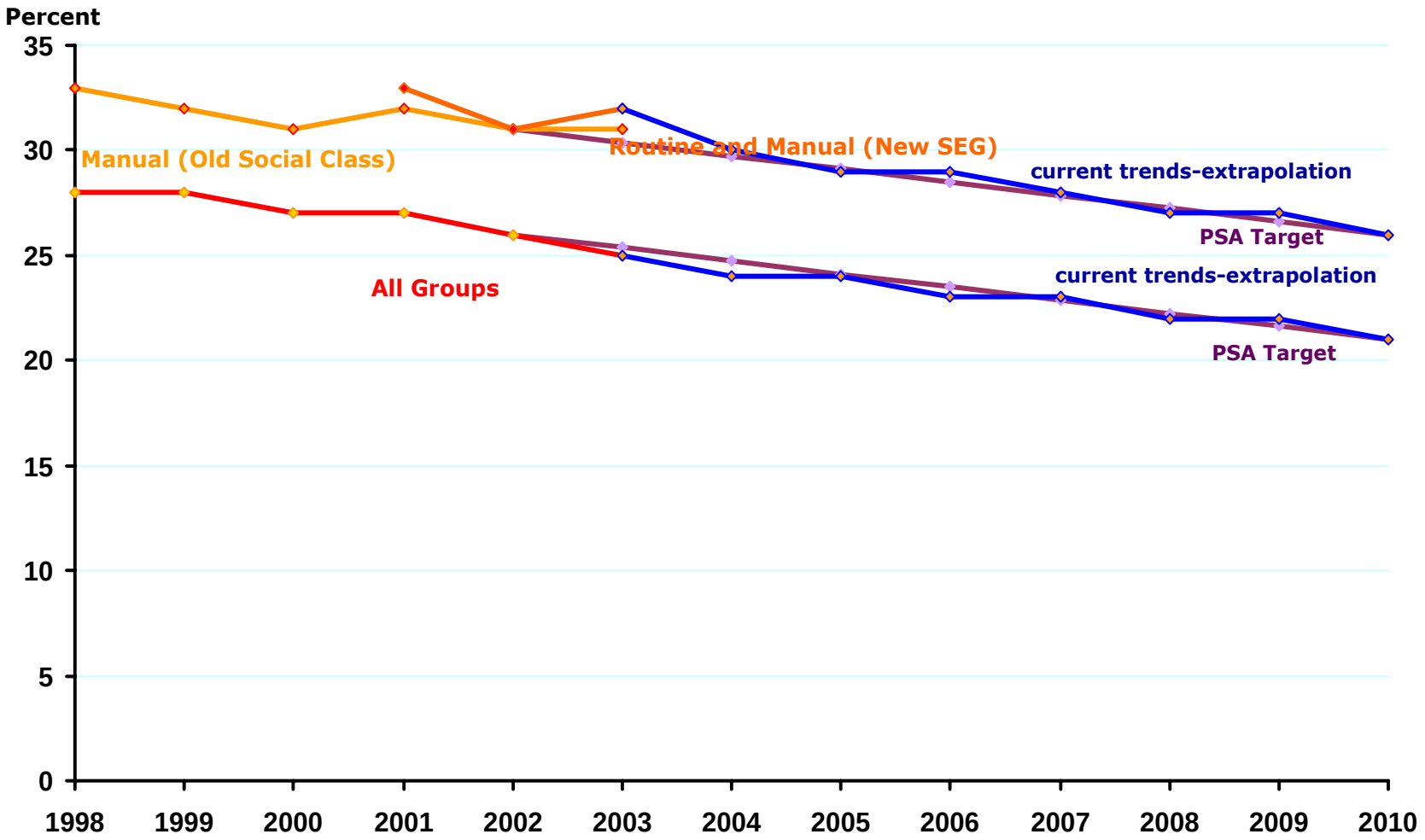
What will make a difference

- Better maternity care will address major factors contributing to IM gap between manual groups and total population
- Early booking in antenatal care
- Tackling smoking in pregnancy, the incidence of low birth weight is twice as high in smokers as non-smokers
- Targeted interventions to reduce sudden infant death syndrom
- Close links with action on teenage pregnancy

What actions are needed in the next six months?

- Quantifying interventions and actions to reduce IM and improve delivery plans
- Use data sets to give more rapid indicators of action
- Implement plans to increase action using local leadership in areas with the highest IM rates
- Replicate evidence of good practice across the country

Smoking


Percent
35
30
25
20
15
10
5
0
1998
1999
2000
2001
2002
2003
2004
2005
2006
2007
2008
2009
2010
Manual (Old Social Class)
Routine and Manual (New SEG)
current trends-extrapolation
PSA Target
All Groups
current trends-extrapolation
PSA Target

Smoking

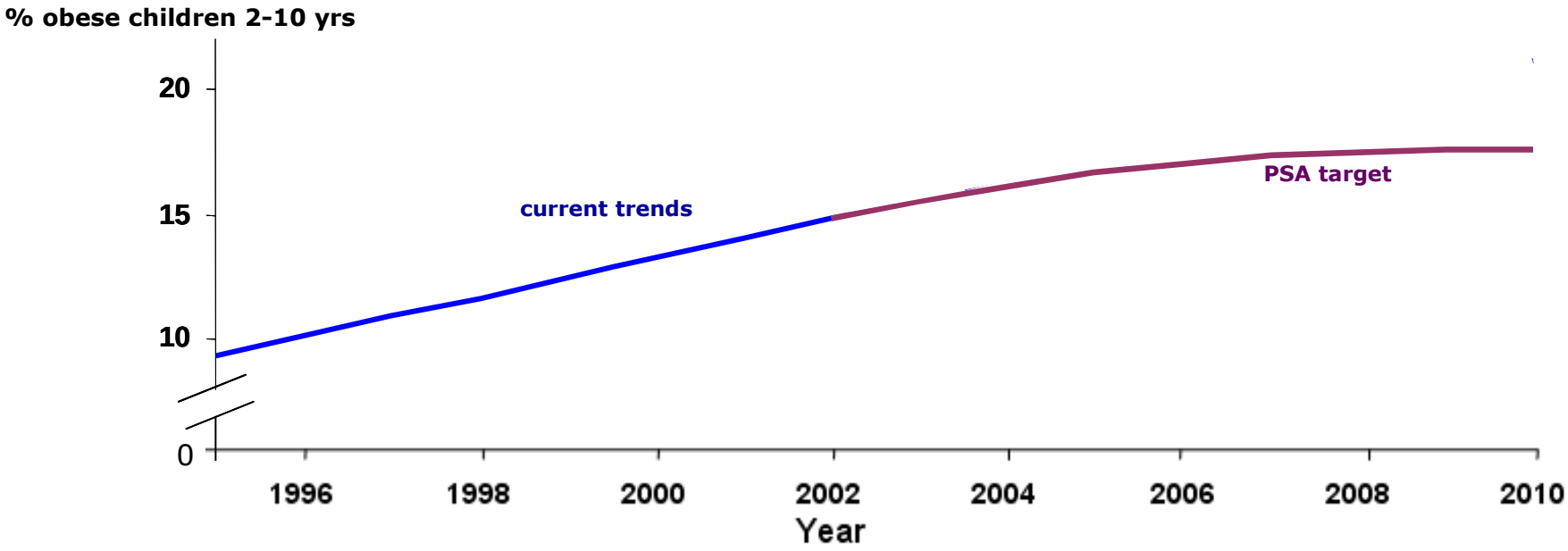
What will make a difference?

- Going smoke free (up to 1.7% point fall)
- Helping smokers quit - better NHS Stop Smoking services (0.5%)
- Boosted media campaign (2%)
- Restrictions on tobacco promotion (2.5%)
- Increase price/tackle smuggling (10% £rise =4% fall)
- Regulate products (0.5%)

What actions are needed in the next six months?

- Take smoke free Bill and regulations through Parliament
- Publish regulations on picture warnings
- Major quitting education campaign New Year promoting NHS help
- Evidence on smoking cessations in more settings (NICE Guidance March 2006)
- Learning from the best services eg NE to help others in deprived areas (NICE March 2006)
- Establish national support team for smoking cessation

Childhood obesity



Childhood Obesity

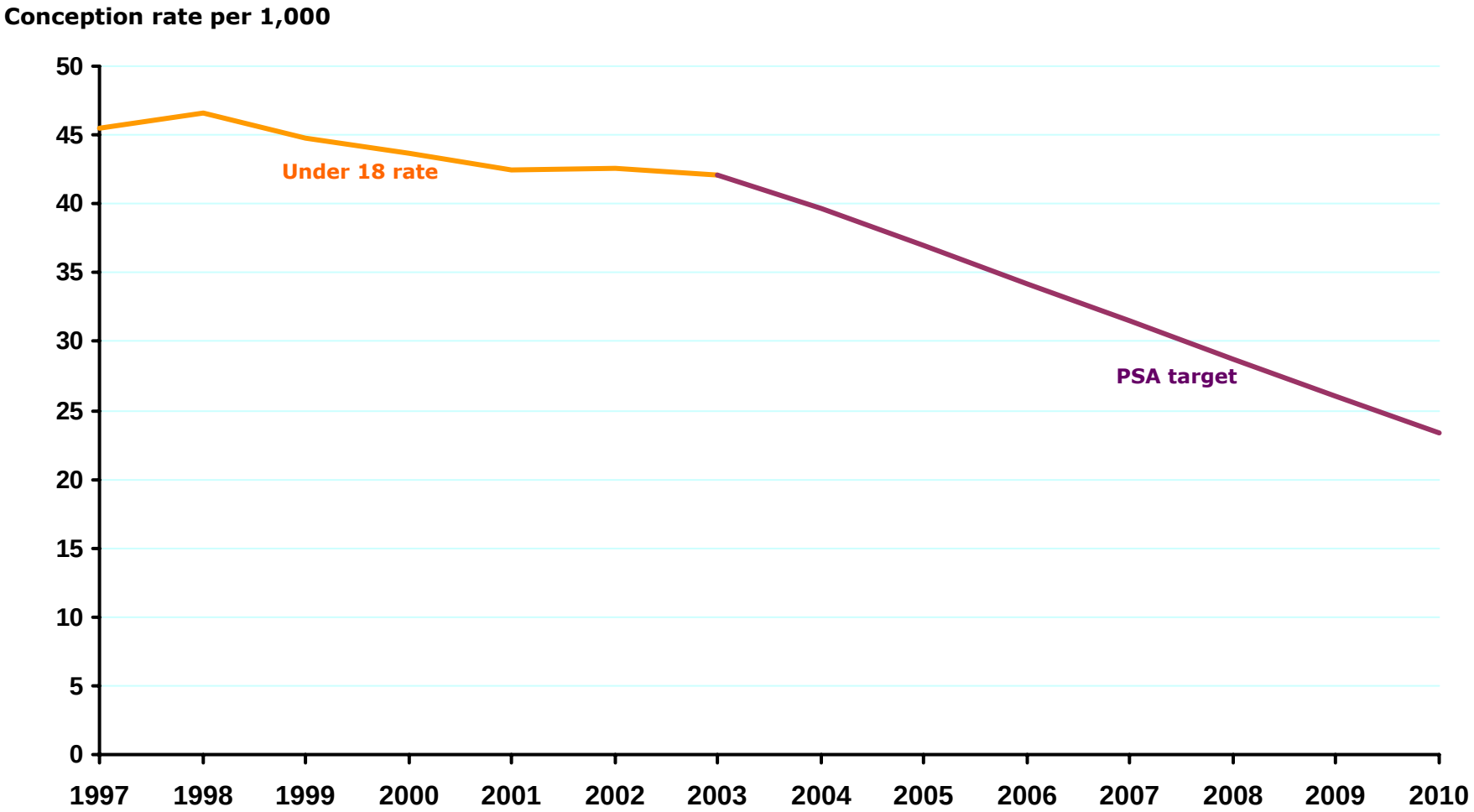
What will make a difference?

- Strongest predictor is parental overweight/obesity
- School food agenda, PE in schools, pedometers, school fruit scheme all have potential to achieve change
- Strong evidence of positive impact of breastfeeding & importance of early years

What actions are needed in the next six months?

- Disseminate evidence on what works & national obesity programme to the field (DH, DCMS, DfES)
- Ofcom to consult on preferred options for Food Promotion
- Obesity Social Marketing strategy on track for June 06 rollout with effective industry partnerships
- Review mapping of interventions against target groups (early years & children of overweight parents)

Sexual Health - Teenage pregnancy



Sexual Health – Teenage pregnancy

What will make a difference?

- Factors identified in high-performing areas
- Local champion
- Good quality sex and relationships education in schools
- Visible and trusted young people's contraceptive/sexual health services
- Sex and relationships education training for non-health professionals
- Targeted work with at risk groups

What actions are needed in the next six months?

- Intensify delivery in high rate wards/ at risk groups with PCTs contributing to Local Authority Children and Young People's Plans
- Disseminating 'what works' in autumn 2005
- Improved access to contraception will help (eg possible VAT reduction)
- New DH Campaign to normalise condom usage – early 2006

Community engagement

- We need clinical interventions to save people's lives, but we also need to engage with people and give them a reason for living

The professionals said…

Life expectancy? It's the Cinderella target.

Local people don't talk about life expectancy, the news is so grim.

The words are there from DH and then there's real life.

The public said…

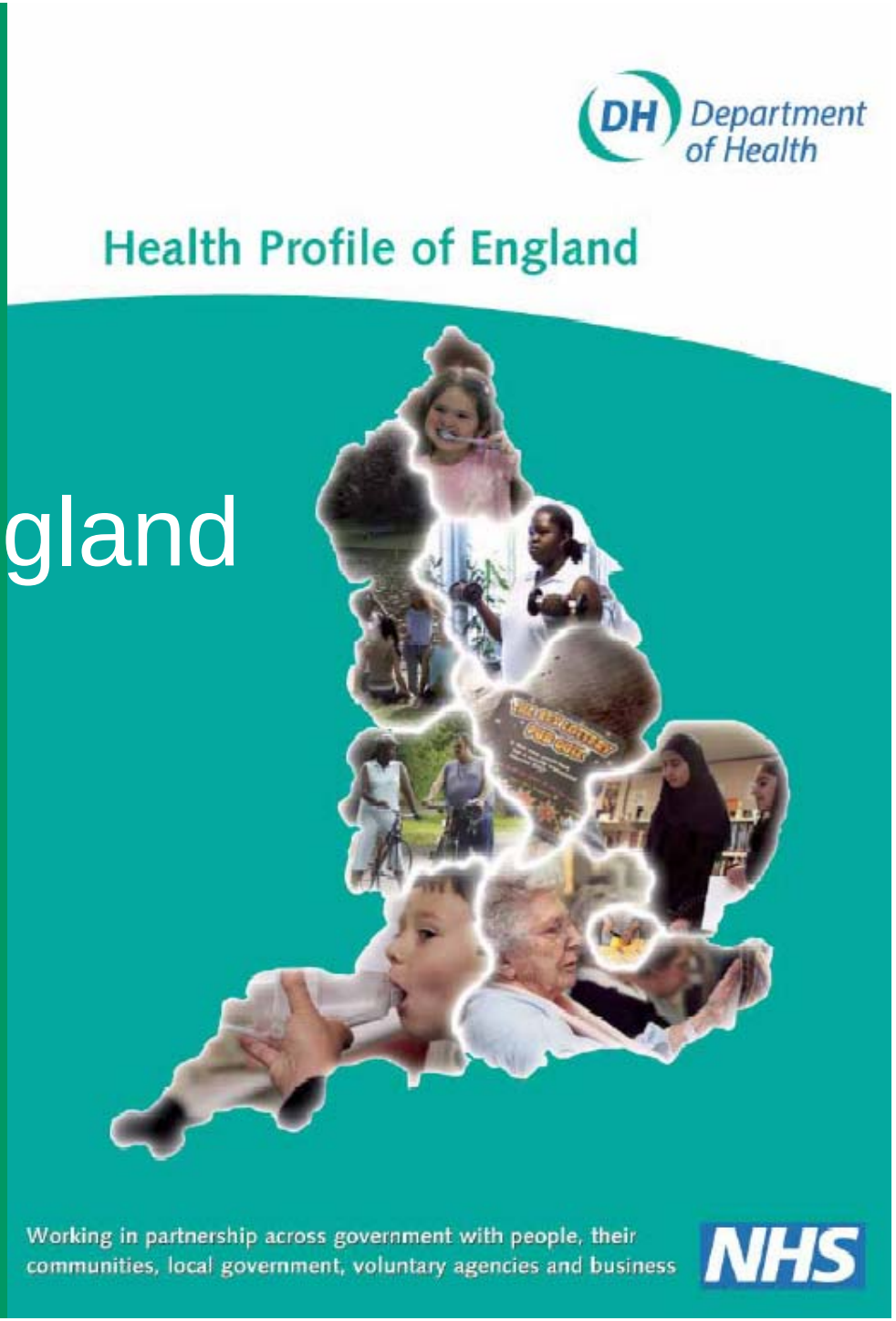
I'm not ill, I'm just getting old (49 year old patient).

Doctor told me 'I have other patients to see'. You feel like a nuisance.

Expectation in the community is very low, we don't demand.

Health Profile of England

A comprehensive picture of the state of the public's health across England



NHS Health Trainers
National agenda – local delivery

- Personalised strand of Choosing Health
- 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
- Early Adopter phase – Sept ’05 – Mar ’06

  78 partnerships nearly half the NHS

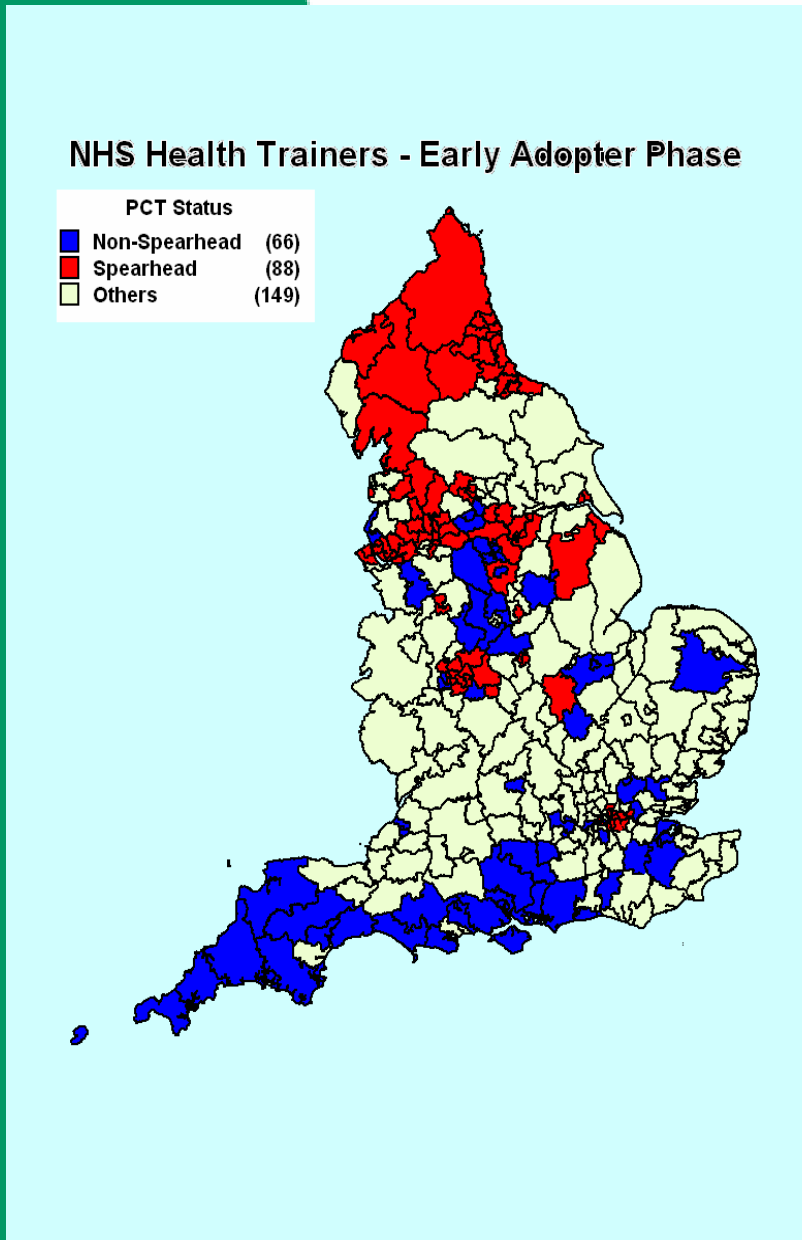
  Other participants – Army, Prison and Initial

NHS Health Trainers where we are now

Department of Health

Phase 2

- Implementation team comprising 15 hubs around the country
- Share workload, knowledge, expertise and learning
- Monthly meeting with DH
- 1200 Health Trainers likely by ’07
- NHS
- Voluntary
- 3rd parties – Army, Prisons, Initial
- Engaging other 3rd parties –
  - The FA Premier League
  - Royal Mail
  - Fire Brigade



NHS Health Trainers
April ’06 on – NHS Lifecheck

- ‘Our Health, Our Care, Our Say’ commits Lifecheck at three key stages in life
  - Early years
  - Early adolescence
  - Mid life
- Primary delivery role for mid-life is assigned to Health Trainers
- Development phase for NHS Lifecheck will focus on Spearhead areas
- Builds on existing programmes
- Involvement of stakeholders and users during design and development phase
- Roll out January 2007 onwards

Achieving Balance