Rethinking “health inequalities” in the context of a healthy city

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1. Health inequalities is a minority sport. Something about “the poor”

2. Societal approach not a “health service issue”

3. Long experience tells us we are quick to reach into the biomedical toolbox.

4. This isn’t wrong, but it won’t provide a complete solution.
The 2\textsuperscript{nd} and 3\textsuperscript{rd} most important graphs in NHS and social care policy?
Why is there a gap in 2018

1) access to health care, esp primary care. Focus on services, not risks and populations
2) tobacco, alcohol, obesity etc
3) exposure to environmental and social issues – aka “the determinants of health”. NB austerity
4) Basic predominant belief in an economic system based on trickledown economics.

https://twitter.com/felly500/status/1014257191933698049
But......There is a “plan”. That will sort it surely.

- Says all of the right things – community development, CVD risk, lifestyle, work / health, differential resourcing
- Capacity to programme manage
- The council is a third smaller now than then.
Why has there been limited to no progress?

- no burning platform for the issue, in the right currency, that everyone aligns around.
- not seen as mission critical to the business
- differential resourcing is very difficult, politically and operationally;
- The wider context is exceptionally challenging
- Beyond austerity, the resource allocation formula itself has created inequality;
- Governance: the current challenge needs stable long term government.
What to do - evidence

• Marmot remains king
• 240 pages of evidence based recommendations. 5 main themes
What to do - approach

• Proportionate universalism still works
• But writing a “big plan” wont be enough. Capacity to process
• Step vs incremental change.
• Within and across silos.
• Coverage of effective interventions.
• Not just primary prevention. Prevent, reduce, delay.
• Actionable propositions – policy, environment, services, cohorts, geography
Short term AND long term are not mutually exclusive

Health Inequalities
Different Gestation Times for Interventions

- **A**: For example, intervening to reduce risk of mortality in people with established disease such as CVD, cancer, diabetes.
- **B**: For example, intervening through lifestyle and behavioural change such as stopping smoking, reducing alcohol related harm and weight management to reduce mortality in the medium term.
- **C**: For example, intervening to modify social determinants of health such as worklessness, poor housing, poverty and poor education attainment to impact on mortality in the long term.

[Figure 1: Health inequalities: different gestation times for intervention]
Default setting to tackling symptoms vs addressing causes

a spin on the downstream / upstream problem

• debt advice, cheap credit & welfare rights vs tackling low wage economy.

• Empowering people through community development vs involving people in shaping their built environment vs addressing air quality.
EACH of the “determinants” is a complex system. And is not fluffy. They all interact. And have a bearing on inequality.

NHS = £114bn
Welfare = £160bn
“social protection” = £250bn

We reach for the medical toolbox. Individual and NHS focused answers

- Lynch
  - danger of “medicalising” or individualising health inequalities:
    - medicalising is appealing, more so than addressing wealth inequality head on
- Marmot
  - evidence on “tackling” health inequalities tends to be focused on the biomedical model paradigm
  - “downstream” interventions covered in the scientific literature.
  - Methadone vs poverty.
  - There has been much less focus on structural interventions.

http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(17)32848-9/fulltext
Short term & biomedical DOES matter

Focused secondary prevention in primary care is the fastest way to reduce health inequalities

- Good treatment in primary care is the best way to quick wins in narrowing life expectancy gaps

Inequalities in life expectancy can be narrowed by at least 10% by good primary care


The King's Fund> Ideas that change health care
Ask of a DPH around NHS

• Health ≠ the NHS. Determinants ≠ inequalities. Inequalities ≠ public health
• Health, health need, health outcomes vs health care
• Pops not services, pathways and institutions
• Language - “health and social care” v “NHS and social care”
• Primary care. Differential resourcing.
• Risk management and population health
But the inequitable distribution of these things is as important as statins...... Discuss.
Services to improve outcomes vs changing the context in which people live

• We’ve got access to the best asthma drugs on the planet
• Umpteen immunologists and pulmonologists etc
• But we ignore the basics
  – **System** to deliver best quality care in a population
  – Primary care
  – Inhaler technique
  – Cigarettes
  – Air Quality
  – Poor housing

And that’s before we do inequity of risk and treatment, and multimorbidity
What is the currency.

- Getting from a conversation about Healthy Life Expectancy to use of resources.
- Is the currency £ or outcomes
- You can't trade your way out of a £ whole by focusing on deficit.
- New £ v bending existing £
- Current NHS £ in often in wrong places?
Health and well being board

- Health & Well being v NHS & Social Care integration
- Focus on stat responsibilities
- MAKE the Health and Well Being Board and strategy matter
- Hard power v soft power – partnerships struggle with the “how to make things actually happen”
- HWBBs do have actual powers (unusual), does it use
- Easy to agree strategy – hard part is seeing it through
- Must focus on population health. This is not the same as most of the same.
We can’t make progress. It’s too difficult

- Childhood leukemia survival
- Smoking prevalence
- CVD mortality reduction
- All once seen as “intractable”.
- Progress by doing the right things well, at scale over a long period.
- Progress WAS made in the past – see Barr (BMJ)

Barr - http://dx.doi.org/10.1136/bmj.j3310
3 reasons why it matters

1. We will not solve the NHS & Social Care problem till we make progress around population health
2. Will not address population health will we make progress in inequalities
3. Lack of attention to upstream leads to downstream demand in NHS and social care.
Debt is problematic vs low wage economy

- promote affordable credit options & reduce the cost of current forms of high cost credit
- mental health training is provided to employees + carry out mental health assessments before providing credit
- The FCA and ASA to prevent marketing of credit products to vulnerable individuals
- Better signposting to debt advice
How far upstream do you want to go

Causes of health
Inequitable spread of risk

Causes of causes
Inequitable spread of power

neoliberalism

Political origins of health inequities: trade and investment agreements
Joseph Stiglitz Says Standard Economics Is Wrong. Inequality and Unearned Income Kills the Economy
http://evonomics.com/joseph-stiglitz-inequality-unearned-income/
Ha-Joon Chang | The economic argument against neoliberalism -
Economic power of big anchors

• underplayed.
• reconsider this in context of inequality.
• aspiration into work and learning – what are the streams into employment and learning.
• What role can anchor institutions play in this?
• Anchor – role to connect aspiration to opportunity
• Create a single approach as a city.
Place, services, context

• All matter.
• Providing the right environment as well as supporting people
• Localism isn’t helping (see the attempt to pin responsibility for poor air quality on severely asset stripped local govt with limited to no levers)
The impact of a deliberate strategy

• See Barr et al – impact on life years

• NB times of plenty. Need to do the same now in a colder climate.

http://dx.doi.org/10.1136/bmj.j3310
6 problems to be mindful of

1. Counting stuff vs having faith
2. Focus on the visible and short term vs the long term and less tangible
3. Coherent response and “a programme” vs building a culture.
4. Can't address in silos, but that will be the default. Complex adaptive systems. No single idea, no single leader
5. We quickly default to the policy or service area we are closest to. There is a great deal going on, that we as individuals might not know about
6. Austerity