Local conversations on health inequalities

Summary of findings of research undertaken by TNS BMRB

About Public Health England

Public Health England's mission is to protect and improve the nation's health and to address inequalities through working with national and local government, the NHS, industry and the voluntary and community sector. PHE is an operationally autonomous executive agency of the Department of Health.

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Background

Public Health England (PHE) is the national public health body with a remit to protect and improve the public's health and to reduce inequalities. PHE commissioned TNS BMRB to undertake research with local communities to understand how the general public identify and describe health inequalities and to identify potential opportunities for innovation in communication and action. TNS BMRB is one of the largest and most established social research organisations in the UK (www.tns-bmrb.co.uk).

The research approach

This research was conducted in two phases.

Phase One involved interviews with 19 public health stakeholders recommended by PHE. These included Directors of Public Health, local authority councillors with a health inequalities remit, and voluntary sector representatives. Stakeholder interviews explored area-specific health issues, the solutions being implemented or considered to address these issues, and the wider barriers and facilitators to addressing health inequalities.

Phase Two involved paired workshops (ie two workshops held in each area with the same people about two weeks apart) with 87 members of the public across five locations: Newquay, Hackney, Walsall, St Helens and Hull. Participants were selected to reflect a diverse range of individuals within each local area. The first workshop involved a relatively open discussion of the causes of poor health followed by activities and information to help members of the public to engage with health inequalities as an issue. This included introducing some of the findings (in particular looking at the gradient of life expectancy/healthy life expectancy) and recommendations of the Marmot Review (2010). The second workshop (held two weeks later) took more of an asset based approach, using local statutory and voluntary sector stakeholders to help facilitate conversations around the determinants of health inequalities.

Key findings

Everyone is a stakeholder in their local community; some have an expert or professional view, others report their lived experience. However, in order to distinguish between the two groups, in this toolkit, we refer to the latter as members of the public or participants and to the former as stakeholders.

Public health stakeholders

- **Public health stakeholders** defined health inequality by the measurement of differences in life expectancy (and healthy life expectancy) outcomes between different sections of society. Typically the gap between the most affluent and the most disadvantaged parts of a locality are used to illustrate health inequality, however inequalities can be seen across every social class.

- Health inequality was seen by stakeholders as resulting from social inequality/injustice - an inequality of opportunity, choice and voice with consequences across the range of domains for which public sector services and policies are accountable (eg employment, education, housing, the environment).

- Stakeholders thought members of the public would have a different understanding of health inequality to that of health professionals because it requires people to actively compare and contrast their health with that of others in different circumstances. This is something that most people were felt not to have the opportunity or need to do.

Members of the public

- **Participants** in the workshops found it hard to engage with the concept of 'health inequalities' – 'inequality' was something that happens to you and is out of your control. Inequality was directly linked to income and employment rather than health and was largely framed by participants as inequality of opportunity of key areas affecting the quality of their lives – employment, education, and housing.

- Where connections were made, these were between socio-economic drivers of health inequality (including employment, education/skills, local environment/community and housing) and unhealthy behaviours and lifestyle choices. Subsequently, through discussion in the second workshops participants began to make links between health conditions/illness/disease resulting directly or indirectly from the socio-economic drivers of health inequality)

- Members of the public acknowledged the challenge facing decision-makers in how and where to allocate resources. When asked to make a decision on how resources could be spent locally to address health inequality there was an even split between those who wanted equality of health outcome and those who wanted equality of resource allocation between more and less advantaged segments of a community. There was a desire for fairness to guide decision-making and a strong sense of

discomfort in making an allocation which led to some members of a community not receiving equality in resource access or outcomes.

- While health outcomes were linked to broader areas such as the environment and income, they were more commonly associated with unhealthy eating, levels of physical activity, smoking, alcohol and drug use. These outcomes were seen to be within the control of individuals, therefore making 'inequality' redundant. Instead, inequality in relation to health was seen in terms of access and availability of health services within the community. Variations were acknowledged in the distribution of services but not in terms of inequality of health outcomes eg life expectancy and likelihood to develop health conditions in their local area. There was surprise at the comparative differences in the severity of health outcomes (in terms of life expectancy between different areas) when presented with local data, but less surprise about the levels of unhealthy behaviours.

- Discussions in the second workshop further explored what people felt might impact on their health as well as whether they or their communities had assets they could offer that might help reduce the impact of the things they identified.

- A lack of education/training opportunities was felt to impact on qualifications and the development of life skills. The former has a direct impact on employment and income while the latter has more of a direct impact on people's ability to make healthy lifestyle and links to risky/disruptive behaviour (eg crime and antisocial behaviour).

- A lack of employment opportunities (and regular employment at a living wage) was regarded as a key driver of poor health. Unemployment, led to limited financial resources and lack of structure in people's life. Employment had its own issues which included: work life balance; zero contract hours; limited availability of local jobs; seasonal employment; and choice and diversity of employment sectors available. Both employment and unemployment could lead to time and financial constraints which in turn create stress, reduce opportunity and motivation to eat healthily and engage in exercise and healthy activities, these behaviours in turn can lead to mental health issues and health conditions.

- Limited affordable housing and the quality and condition of available housing were believed to be related to poor and unsafe living conditions, social isolation/lack of community integration and increased likelihood of anti-social behaviour. These in turn could contribute to health conditions (eg respiratory illnesses), stress, social isolation and mental health issues.

- Issues with the local environment/community were the least obvious in their connection with health issues though limited awareness, access or provision of

community resources, poor transport infrastructure, a lack of open space, and unsuitable commercial outlets (eg fast food, betting shops) were all seen to have a direct impact on people's lifestyles. A greater concern for most people was the lack of any sense of community and concerns around social isolation which was identified in all areas.

- There was very limited awareness of local assets (eg support structures, local services, economic assets and cultural assets) and a lack of understanding of how these assets could be leveraged and utilised to promote good health outcomes. Assets were often discounted based on negative current experiences (eg Jobcentres), this was further compounded by a general feeling of disempowerment both among members of the public and stakeholders attending. Decisions that have a direct impact on health inequalities were often believed to be undertaken centrally either within local or central Government.

- In linking public priorities to the Marmot Review's policy objectives, there was a general consensus that health inequalities should be tackled through a combination of education and early intervention, fair employment opportunities and ensuring a healthy standard of living for all. In summary, priorities for local areas included:
  - Enough jobs for all
  - A living wage (not just minimum wage) to have enough money to live close to employment
  - The opportunity for everyone to have their own home
  - Affordable, comfortable and secure accommodation
  - Clear guidelines and enforcement around anti-social behaviour within social housing
  - Good quality apprenticeships and vocational available to young people to reduce issues around youth disengagement and providing a clear purpose in life. These opportunities should also be available to adults to up skill and promote structured and skilled employment
  - Cheaper child care
  - Education to improve healthy eating awareness/capabilities
  - Access to parental skills education to support awareness and knowledge of key life skills
  - Opportunities to build community relationships and social relationships within the local area and communities eg buddying/mentoring/volunteering
  - Grants and subsidies for education/skills/training
  - Good transportation to access services and activities across a local area
  - Local hubs and spaces offering opportunities to meet other people, access to resources (eg internet access) and training, community and physical activity
  - Community regeneration and redevelopment of empty housing, helping to create vibrant spaces for meeting others.

References

Marmot, M. (2010) Fair Society, Healthy Lives. Strategic Review of Health Inequalities in England post-2010