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Addressing the principle drivers and causes of health inequalities in the North East

Future of an ageing population: think piece

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Addressing the principle drivers and causes of health inequalities in the North East

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“The greatest future achievement in medicine will not be some new technological achievement, but if we can better support people to look after themselves.”

Ivan Illich

1. Introduction

The North East has the widest inequalities in income distribution and health of any English region. Michael Marmot has very eloquently outlined the evidence for the relationship between income inequality and health inequality and has made the economic and moral argument for addressing these inequalities. Put very crudely the argument is that the gradient in income distribution closely follows the gradient in poor health, as reflected in the gap in life expectancy and disability free life expectancy between the best and the worst (Marmot et al., 2010). The further conclusion he draws is that inequalities in health are largely socially determined and that access to high quality health services, which the North East, compared with some other regions has in abundance, have little impact on narrowing the gap.

The question for the North East is why are inequalities worse here than elsewhere in England. The answer is part historical and part geographical. Industrial development in the North East was based on the production and transport of raw materials. The mining of lead, coal and other minerals such as potash led to the development of railways to transport the raw materials to smelting plants and to ports for transport to manufacturing centres in distant parts. Shipbuilding on the Tyne and Wear and chemical industries and ironworks in Teesside were a direct consequence. At least initially these heavy industries were dependent on relatively unskilled manual labour. When the raw materials ran out, became too expensive to extract, or could be purchased cheaper elsewhere industrial decline set in. The geographical factor then comes into play because distance from the centres of power, influence and employment in London and the South East makes industrial decline in far flung parts less of a pressing priority.

Subsequently the decline in heavy industry resulted in a rise in the proportion of people employed in the public sector (Great Britain, Parliament, 2014): the North East has the highest level of public sector employment of any English region. It has also had what could be called an “Auf Wiedersehen Pet” effect (a popular 80s TV series about the exploits of a group of English migrant workers in Germany) in which the North East exported mostly younger and more skilled workers to wherever employment was available. The consequence of all of this has been a relatively unskilled workforce not best suited to the new knowledge based, high tech, bioscience industries. The addition to this historical perspective of the current economic down turn has been that the North East is at or near the top of a number of rather depressing league tables. These include the number of working-age people who are claimants of out-of-work benefits (18.4% in 2010, almost twice as many as in the South East) (The Poverty Site, 2014), the number of young people aged 16-24 not in education, employment or training (18.2% again almost twice as many as in the South East) (Great Britain, Parliament, 2014), and between 2008 and 2013 the North East had the biggest loss of employed jobs (156,000) and the smallest rise in self-employed jobs (23,000) of any English Region (Clark, 2014). Given all of the above it is perhaps not surprising that the North East has the highest rate of anti-depressant prescribing (Sedghi, 2014), and the highest number of people with limiting long term illnesses per head of population of any English region (The Poverty Site, 2014).

2. Addressing the determinants

Michael Marmot makes a strong argument for addressing the determinants of health inequalities in a universal but proportionate way, meaning that in order to lower the gradient between the best and the worst, we need to take action across the gradient but with more of a focus on those with the worst health. There is also an argument that we need to take action across the settings and contexts in which people live their lives, using the best available evidence for what works. These settings and contexts are multi-dimensional and need to include what can best be done at the level of individuals and families, local communities, regionally and nationally as well as more specifically educational establishments and the workplace.

There is also a need to focus on some agreed priorities. *Fair Society, Healthy Lives* (Marmot et al., 2010) suggests the following as priority policy objectives:

- Give every child the best start in life
- Enable all children, young people and adults to maximise their capabilities and have control over their lives
- Create fair employment and good work for all
- Ensure a health standard of living for all
- Create and develop healthy and sustainable places and communities
- Strengthen the role and impact of ill-health prevention

The weakness of this approach in the context of an ageing demographic is that the first two objectives focus predominantly on what could be called the developmental life cycle up until mid-life. Arguably in the developed world we now have two life cycles, a developmental life cycle from conception to mid-life and a mature life cycle from mid-life to end of life. If we are going to make more use of the assets that result from the developmental life cycle, we need a more pro-active, strategic approach to the mature life cycle. One option is to think about this as four stages (Drinkwater, 2012):

- Preparation for active old age
- Active old age
- Vulnerable old age
- Dependent old age

At present the Marmot team estimate that two in three Britons will fail to reach the planned retirement age of 68 free from disability unless action is taken to tackle inequalities. This means that if we want to stabilise or reduce the number of vulnerable and dependent older people we need to tackle the growing epidemic of long term conditions such as obesity, musculo-skeletal diseases, Type 2 Diabetes and the co-morbidity that often leads to general frailty, with much more of a focus on preparation for active old age and keeping people active.

3. Priorities for the North East

Thinking about this can be disempowering because the usual question is where on earth do you start and does the ability exist to deliver effective local change in an economic depression. There have been regional successes: Fresh, the first dedicated regional campaign to tackle smoking related illness, and the fact that the North East when compared with other regions has managed to narrow the gap in cardiovascular mortality (Townsend et al., 2012) between the best and the worst are both good examples. There is however a need to think more strategically about how to tackle the wider social and cultural determinants of inequalities. This means thinking about how we create and develop healthy and sustainable places and communities that create the conditions for people to have control of their lives.

The North East has the highest number of Lower Super Output Areas which are within the 30% most deprived (Rogers, 2011). Characteristically, what you find in these areas are a higher than average proportion of people who have multiple unhealthy behaviours, that include smoking, poor diet, lack of physical activity and high alcohol consumption (Buck & Frosini, 2012). You can also map onto these areas high numbers of people with limiting long term illnesses, high numbers claiming out of work benefits, high levels of anti-depressant prescribing and high levels of use of unscheduled hospital care, including A&E services. What is often neglected is the fact that these areas also have assets: resilient people, voluntary sector providers, community groups, buildings and open spaces. But rather than build on these assets, the usual response is that we need to provide or target services more effectively. This can then be compounded by the fact that services tend to be operated and delivered in silos which inevitably results in a fragmented approach, so that someone who is out of work, in debt, depressed, smoking and drinking too much ends up with a variety of service options, none of which address the need to take an integrated approach to all these issues.

One of the reasons there has been consistent recent support for the voluntary or civil sector to play a bigger role in the provision of publically funded services (HM Government, 2014) is that public services, as currently constructed and managed, have found it very difficult to break out of a framework which is about doing things to people in a fragmented and often paternalistic way, rather than doing things with people in the context in which they live their lives. The voluntary sector has a strong record of working effectively with marginalised and disadvantaged groups and communities. They often have greater reach, trust and credibility than public services and they are more likely to use innovative approaches that are about empowering and developing people, for instance as peer to peer volunteers or as local champions. The sector is also more likely to take a holistic approach to individuals and to their social circumstances.

Examples of these approaches can be found in recent work from NESTA on the ways in which social action and engagement can change lives, and in the work of Save the Children on developing Children's Zones for England. The report from NESTA (Clarence & Gabriel, 2014) argues that mobilising people should be a core organising principle for public services and their justification for this is that it will:

- Increase the resources available to achieve social goals
- Give public services access to new expertise and knowledge
- Reach people and places that public services cannot reach

- Lead to a fundamental change in the way we respond to social needs and challenges

- Create better services and reciprocal value for the people who give their time.

The work of Save the Children on adapting the Harlem Children's Zone model to England (Dyson et al., 2012) is based on the view that "*despite the best efforts of successive governments, many areas in England are marked by concentrated poverty and social deprivation. This puts children and young people at a serious disadvantage, particularly in terms of how well they do at school"* and in terms of health outcomes. Their proposal is that although evidence based age specific interventions are important they are more likely to achieve successful outcomes if they are located within a "*framework that supports children throughout their lives, from cradle to career (with a strategically planned pipeline of services), and supports the whole child, addressing a wide range of family and community factors, which may prevent their doing well".* The model also proposes that zones should "*develop governance and leadership structures that ensure a degree of autonomy to enable them to respond to local circumstances"*.

Similar long term holistic models need to be developed for the mature life cycle. The focus should be on long term conditions which are largely responsible for the gap in healthy life expectancy and are also estimated to account for 70% of NHS costs. Type 2 Diabetes where poor diet, obesity and inactivity are important contributory factors is a good example. There is a clear social and cost gradient, both in terms of who develops the disease and the costs to society in terms of outcomes. At one end of the spectrum someone with social, psychological and financial resources, including a good understanding of health only needs a little nudge and they will do all that needs to be done to cope with the condition. At the other end someone who is depressed, unemployed and in debt will need considerable support if they are to begin to take control of their condition.

One possible approach to this problem is Ways to Wellness, which in partnership with Voluntary Organisations Network North East (VONNE) and Newcastle West CCG has been developing a social impact bond (SIB) model for social prescribing of a range of tailored activities for people with long term conditions. The operational model is about recruiting and training people from local communities as Link Workers who will work with geographical clusters of general practices and will accept referrals of people, aged 40-74, who need support in coping with their long term condition. The Link Worker using motivational skills and knowledge of their local community will be responsible for providing and supporting a personalised action plan which will be all about engaging in activities that build a range of supportive social networks, including peer-to-peer support, to improve the confidence of individuals in self-care. The length of the support required will also be tailored to the needs of individuals with some people needing more input than others.

Apart from improving the quality of life of individuals with long term conditions, the ultimate challenge will be demonstrate that this approach, rather than being an additional cost pressure, produces tangible savings in terms of reduced demand for NHS and social care services. Working through how to demonstrate that savings have been achieved and over what time scale are very challenging, partly because current information systems are set up to capture outputs rather than outcomes and partly because people are looking for short term rather than long term returns on investment.

4. Conclusion

Three possible approaches have been suggested: social action to mobilise people as active participants, support from cradle to career using the Children's Zone concept, and social prescribing to address the social determinants of long term conditions. All of these are complex whole systems approaches to complex problems which challenge the expert professional model of services. In the current fiscal climate and in the face of changing disease and demographic patterns there are increasing concerns that existing models of public services are unsustainable. We urgently need to move to new models in which co-production of value with service users and better use of all available assets becomes the norm. These approaches will require culture change and some investment using social impact bond models. There will also need to be robust evaluation of these models so that there is clarity about the processes and interventions used so that learning can be shared and a clear focus on the social and financial returns on investment.

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