Report to Scrutiny

Item Number:

Contains Confidential or Exempt Information	No

Subject of Report: Health Inequalities

Meeting: Scrutiny Review Panel 1- Inequalities
19 January 2017

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Cabinet Responsibility: Councillor Hitesh Tailor - Health and Adult Services

Director Responsibility: Jackie Chin, Director of Public Health

Brief: This report provides the panel with information on health inequalities and provides details on life expectancy, level of development, childhood obesity, smoking, cardiovascular disease and sexually transmitted diseases in the borough.. Attached as Appendix 1 is the report from the Health and Adult Social Services Standing Scrutiny Panel's Review of Public Health in Ealing, which was considered by Cabinet in July 2016. One of the key questions for the review was, how do we ensure as a local authority that everything we do can achieve better health for our residents? Dr Chin will provide the Panel with a verbal update on the progress of the recommendations from that review.

Recommendations The Panel is recommended to :-

- Consider and comment on the report
- Note the progress of the recommendations of the HASSP Review of Public Health in Ealing 2016

1. What are Health Inequalities?

Health inequalities are **differences** between people or groups due to different factors including: social, geographical and biological. These differences **may result** in people who are worse off experiencing **poorer health** and **shorter lives.**

There are many examples of inequalities in health, analysed by geography, class, gender, ethnicity and other factors. For example, if you happen to be female and live within the borders of Guildford and Waverley in Surrey you will – on average – have 20 more years of healthy life than if you happen to be male and live within the borders of Bradford.

There are different views on how inequalities come about. There are views that it is the socio-economic circumstances of different groups, such as income, wealth or power, that ultimately cause inequalities in health. In contrast, behavioural theories see differences in lifestyles as the main cause of inequalities, with various claims for what is the 'top killer' or 'leading cause of inequality in health'. Some argue that there are cultural reasons for inequalities in health stemming from 'dependency cultures', which are inter-generational. This suggests wider problems linked to health can therefore be perpetuated through time in some groups and places, even when wider conditions become more favourable. There is also the hypothesis that poor health leads to changes in social status.

In addition, delivery of health care interventions such as blood pressure and cholesterol control, and smoking cessation support have the potential to reduce inequalities in health.

Income inequalities are a particular driver of health inequalities. Those from a socioeconomically deprived background are more likely to be impacted by harmful drinking and alcohol dependence, and are also more likely to smoke, and to be obese – all of which lead to associated negative health impacts:

- In 2013, alcohol related deaths for the most deprived decile were 53% higher than the least deprived.2
- 23% of those with an annual income of less than £10,000 are smokers, compared to 11% of those with an income of £40,000 or more.3
- 33% of women with no qualifications are obese, compared to 18% of women with a degree or equivalent level qualification.4

In the most deprived areas in the UK, men can expect to live 19 years less of their lives in good health, compared with the least deprived areas.

Health inequalities are also experienced by those who, for instance, have a mental illness, a learning difficulty, and those from particular ethnicities. For example, in London, the greatest health inequalities can be found in Bangladeshi, Pakistani, and mixed populations.

2. The Marmot Review

In 2010, The Marmot Review into health inequalities in England was published and proposed an evidence based strategy to address the social determinants of health as the conditions in which people are born, grow, live, work and age can lead to health inequalities.

The report, titled 'Fair Society, Healthy Lives', proposed a new way to reduce health inequalities in England post-2010. It argued that, traditionally, government policies have focused resources only on some segments of society. To improve health for all of us and to reduce unfair and unjust inequalities in health, action is needed across the social gradient.

The detailed report contained many important findings:

- People living in the poorest neighbourhoods in England will on average die seven years earlier than people living in the richest neighbourhoods
- People living in poorer areas not only die sooner, but spend more of their lives with disability - an average total difference of 17 years
- The Review highlighted the social gradient of health inequalities - put simply, the lower one's social and economic status, the poorer one's health is likely to be
- Health inequalities arise from a complex interaction of many factors - housing, income, education, social isolation, disability - all of which are strongly affected by one's economic and social status
- Health inequalities are largely preventable. Not only is there a strong social justice case for addressing health inequalities, there is also a pressing economic case. It is estimated that the annual cost of health inequalities is between £36 billion to £40 billion through lost taxes, welfare payments and costs to the NHS
- Action on health inequalities requires action across all the social determinants of health, including education, occupation, income, home and community

The Marmot Review looked at the differences in health and well-being between social groups and described how the social gradient on health inequalities is reflected in the social gradient on educational attainment, employment, income, quality of neighbourhood and so on. In addressing health inequalities the Review asserted that it is not sufficient just to focus on the bottom 10 per cent because there are poorer outcomes all the way down from the top. Universal action was needed to reduce the steepness of the social gradient of health inequalities, but with a scale and intensity that was proportionate to the level of disadvantage.

Key to Marmot's approach to addressing health inequalities is to create the conditions for people to take control of their own lives. This requires action across the social determinants of health. This placed renewed emphasis on the role of local government who along with national government departments, the voluntary and private sector have a key role to play.

The review set out a framework for action under two policy goals: to create an enabling society that maximizes individual and community potential; and to ensure social justice, health and sustainability are at the heart of all policies.

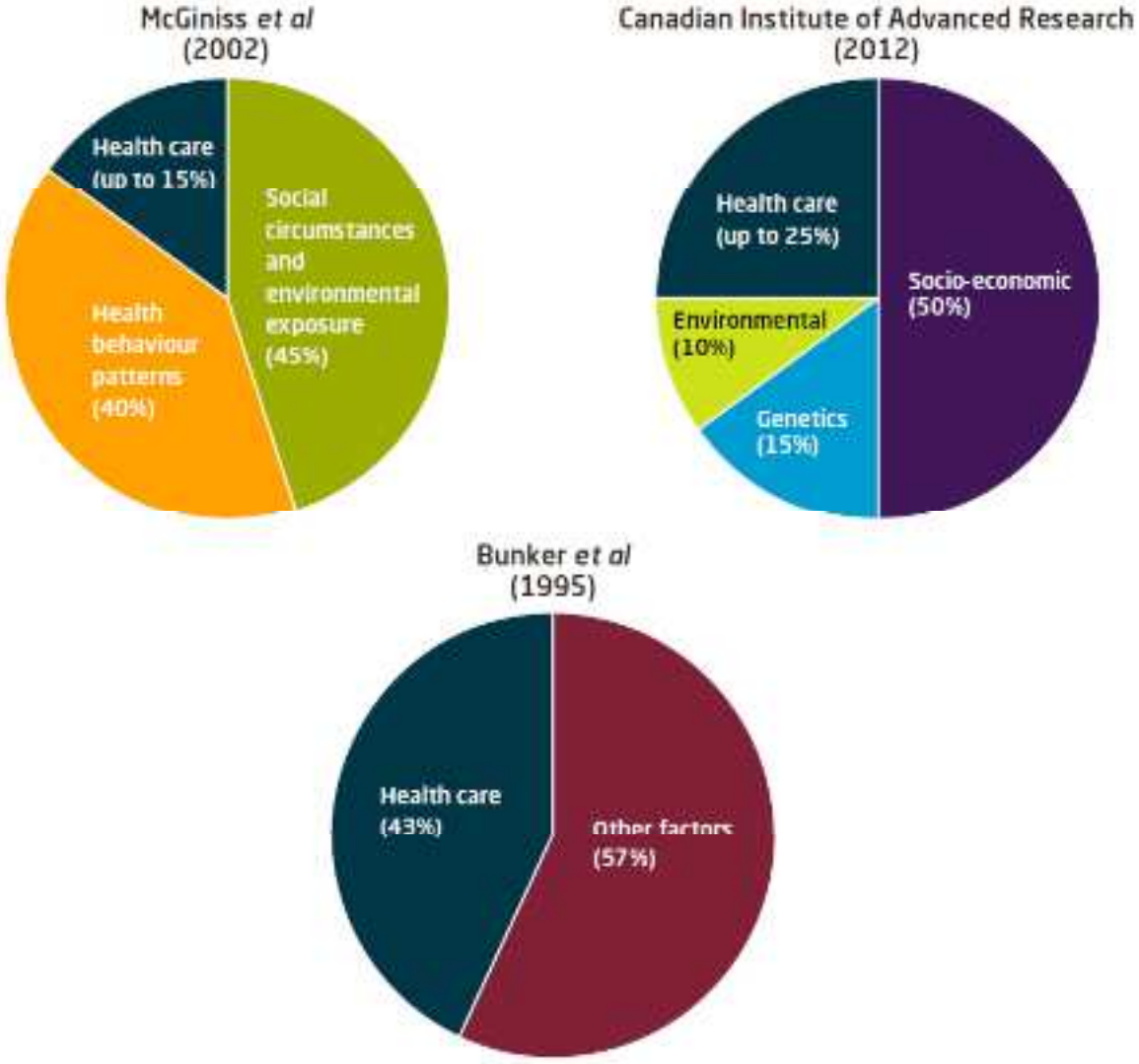
Central to the Review is the recognition that disadvantage starts before birth and accumulates throughout life. This is reflected in the 6 policy objectives and to the highest priority being given to the first objective:

1. giving every child the best start in life
2. enabling all children, young people and adults to maximize their capabilities and have control over their lives
3. creating fair employment and good work for all
4. ensuring a healthy standard of living for all
5. creating and developing sustainable places and communities
6. strengthening the role and impact of ill-health prevention.

The Marmot Review was a timely reminder of the continuing social and economic cost of health inequalities. It presented a robust and well-evidenced business case for national and local action to address health inequalities through concerted action. The report identified local government as a pivotal partner in addressing the social determinants of health inequalities.

It’s worth remembering the estimates of the relative contribution of factors to our health as set out in Figure 1 below.

Figure 1 Estimates of the relative contribution of factors to our health



Source: The King's Fund 2013

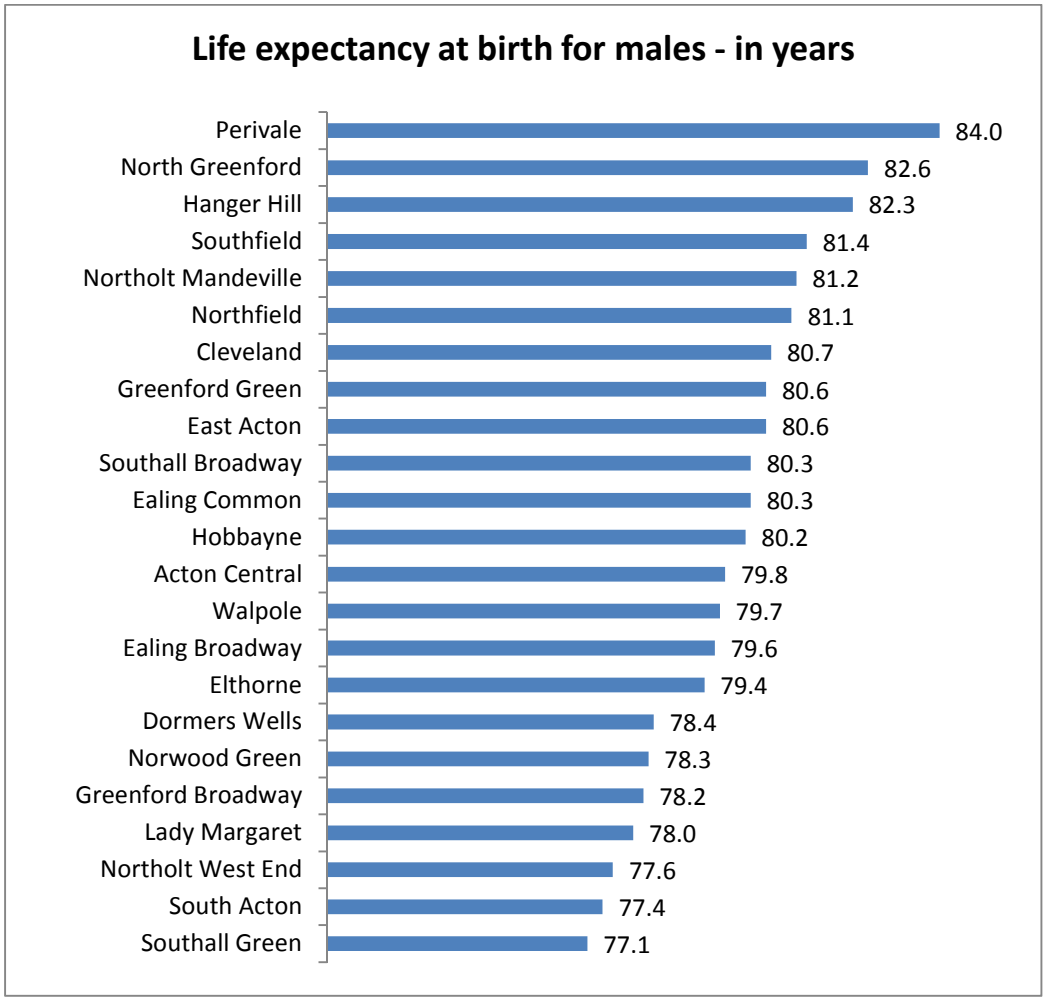
The Panel has already considered inequalities in relation to housing, income and welfare reform. This paper will provide a descriptive analysis of some of the health inequalities in life expectancy, good level of development, childhood obesity, smoking, cardiovascular disease (CVD) and sexually transmitted illnesses (STIs).

3. Life Expectancy

There are wide variations in life expectancy across London. From birth in Ealing, men can now expect to reach 80.6 years compared to 84.2 years for women – a **gap of 3.6 years**, in London this gap is 4.1 years. Further details by ward are set out in Figures 2, 3, 4 and 5.

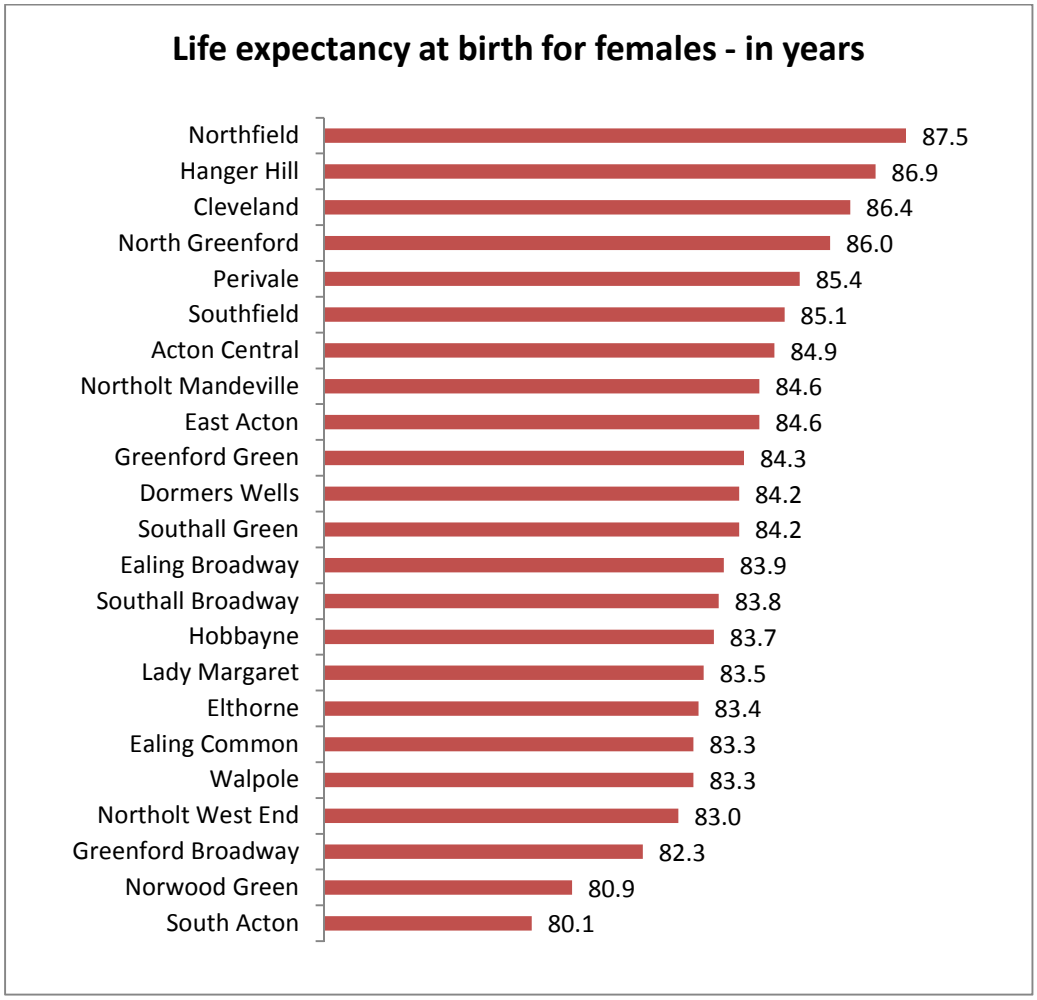
We know that for every 10 per cent increase in older people suffering deprivation, life expectancy falls by six months; for a 10 per cent increase in employment deprivation (those involuntarily unemployed), life expectancy is a year lower. In contrast, for every 10 per cent more fruit and vegetable consumption, life expectancy is seven months greater whereas for every 10 per cent increase in binge drinking, life expectancy is four months lower.

Figure 2 Life expectancy at birth for males



Source; PHE Local Health 2015

Figure 3 Life expectancy at birth for females



Source; PHE Local Health 2015

Figure 4 Life Expectancy at birth in females 2010-2014

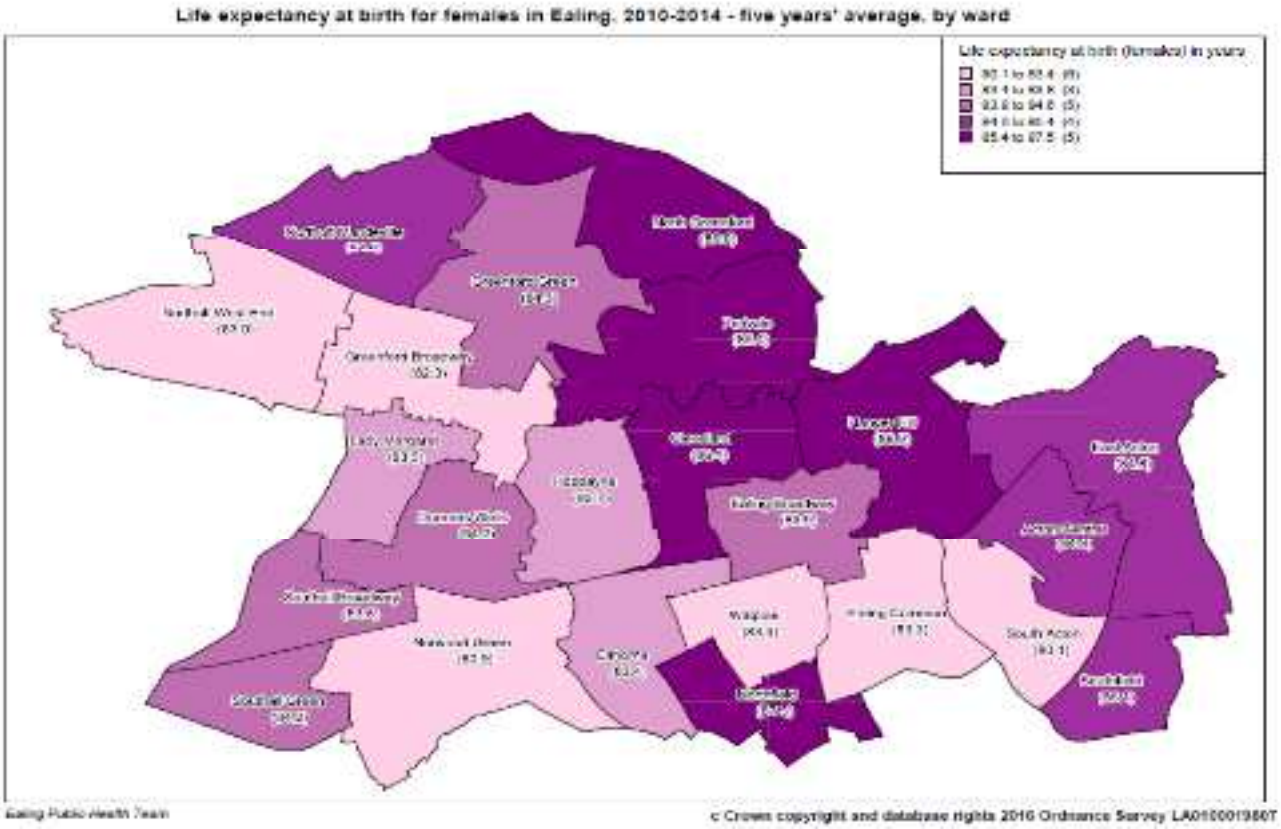
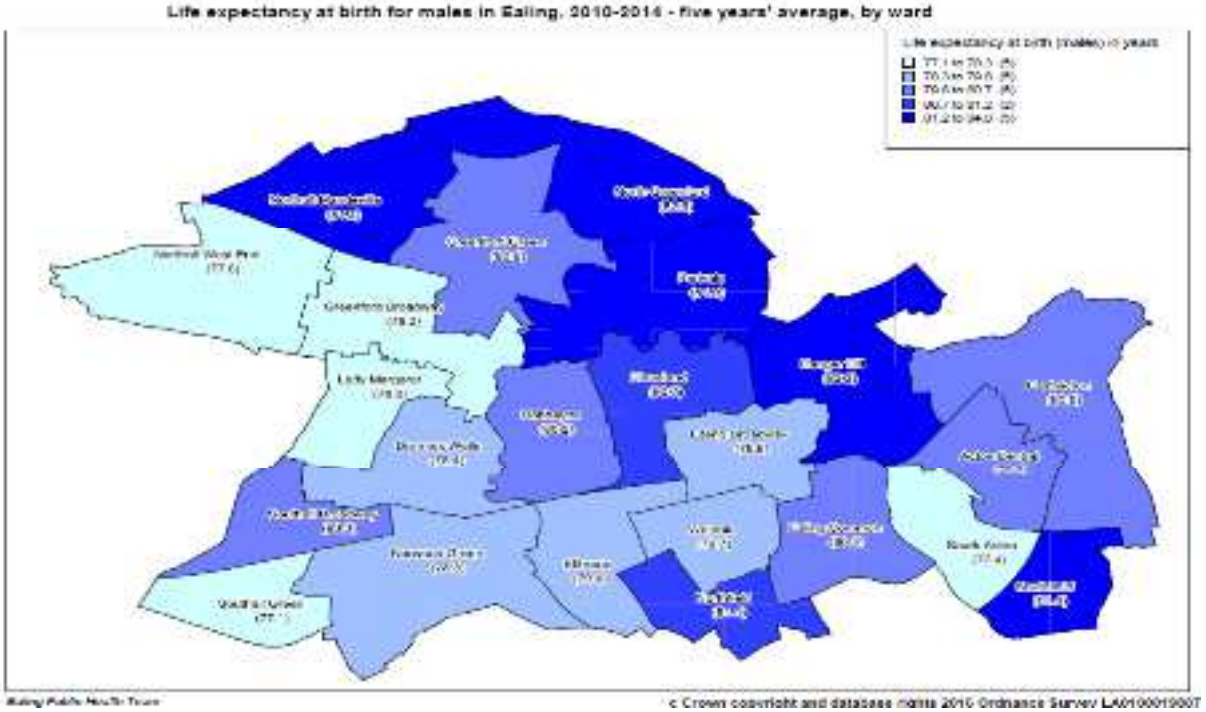


Figure 5 Life Expectancy at birth in males 2010-2014



4. Healthy Life Expectancy

Healthy life expectancy at birth, according to the ONS estimates 2012-14, Ealing's males can expect 62.9 years of healthy life and females 62.6 years,

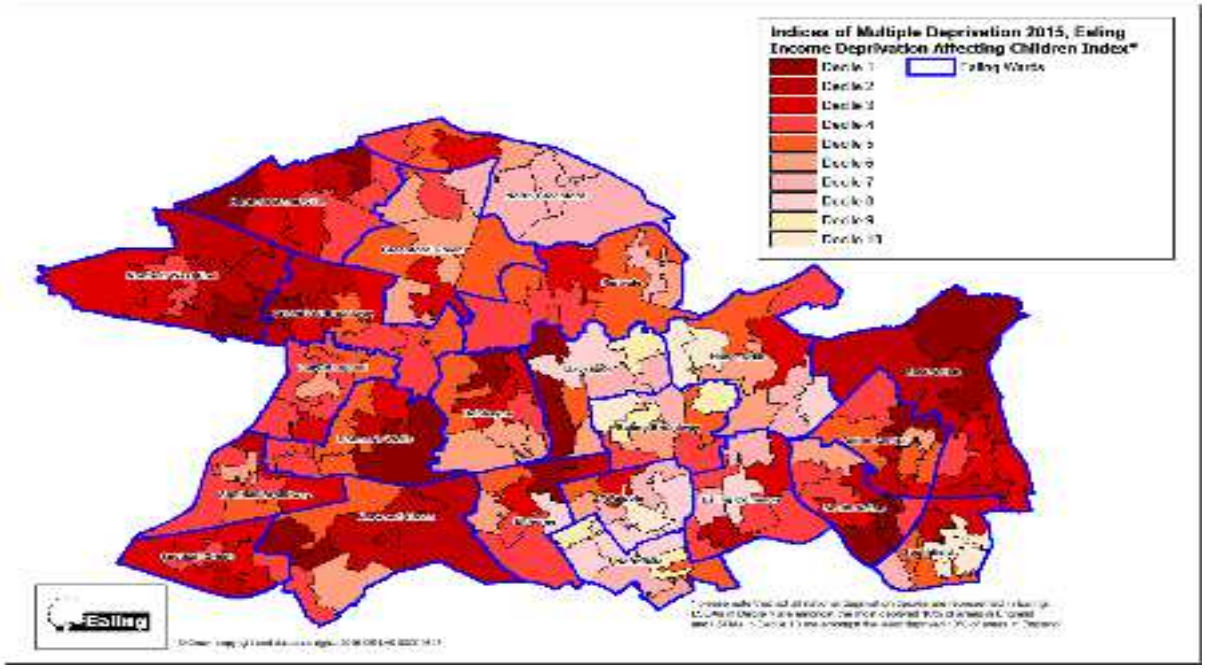
5. Children

Health inequalities have a particularly striking effect on children, putting them at a disadvantage which will continue into later life. For example, three in five (60%) of the most deprived boys aged five to eleven are predicted to be overweight or obese by 2020, compared to 1 in 6 (16%) of boys in the most affluent group. Child poverty and adverse childhood events can influence the brain development of children, heightening their chances of risk of death in adulthood from a broad range of conditions

income, employment and quality of housing, exert significant impacts on social, educational and health outcomes. For example, children living in poverty are more likely to have health problems such as asthma, obesity and mental health problems, and lower educational attainment, than their more affluent peers.

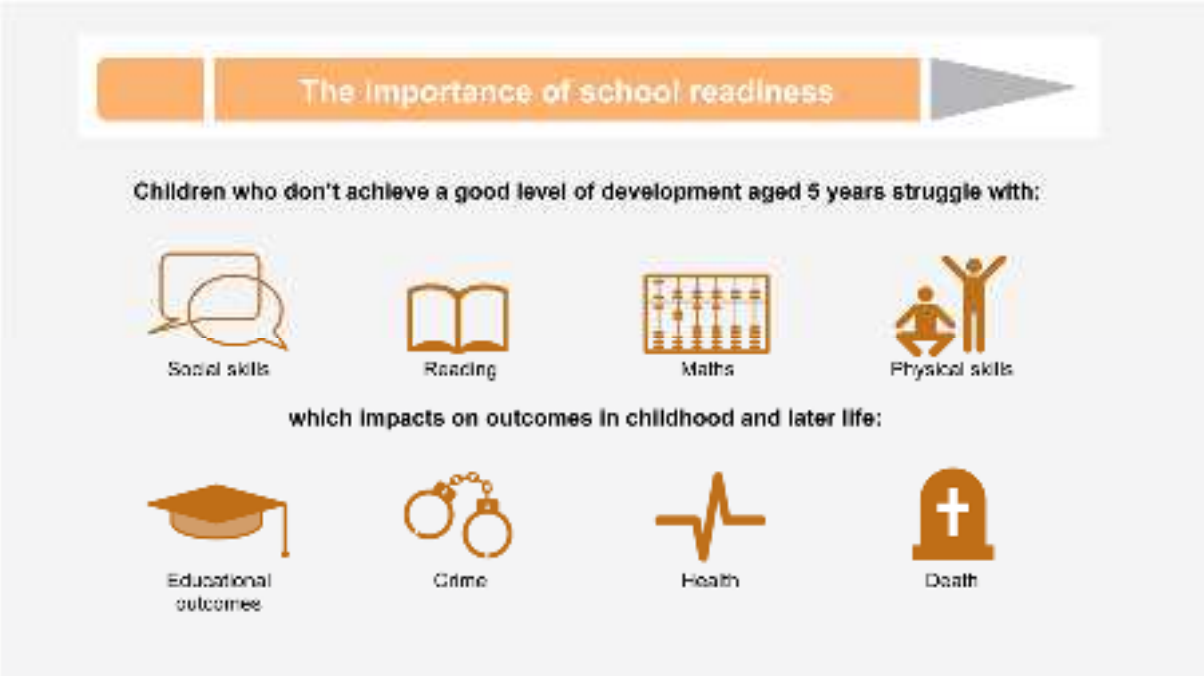
The **Income Deprivation Affecting Children Index (IDACI)** is a subset of the Income Deprivation domain of the IMD, showing the proportion of children in each lower super output area who live in families that are income deprived (in receipt of Income Support, income-based Jobseeker's Allowance, Pension Credit Guarantee or Child Tax Credit below a given threshold). The 2015 figures show that 23% of Ealing's children lived in income-deprived families, an improvement from 2010 (32.5%).

Figure 6. Income Deprivation Affecting Children Index (IDACI), Ealing LSOAs, 2015



5.1 Good Level of Development

Ensuring children are able to get the best from school is vital. Educational attainment is one of the main markers for wellbeing through the life course and so it is important that no child is left behind at the beginning of their school life.



School readiness is a strong indicator of how prepared a child is to succeed in school cognitively, socially and emotionally. To assess how 'school ready' a child is, we use a measure called the good level of development (GLD). Evidence shows that those who do not reach a GLD by age five, will go on to struggle with key skills such as communication, language, literacy and mathematics.

Levels of school readiness links to educational attainment, which impacts on life chances; it has been shown to impact on health, future earnings, involvement in crime, and even death.

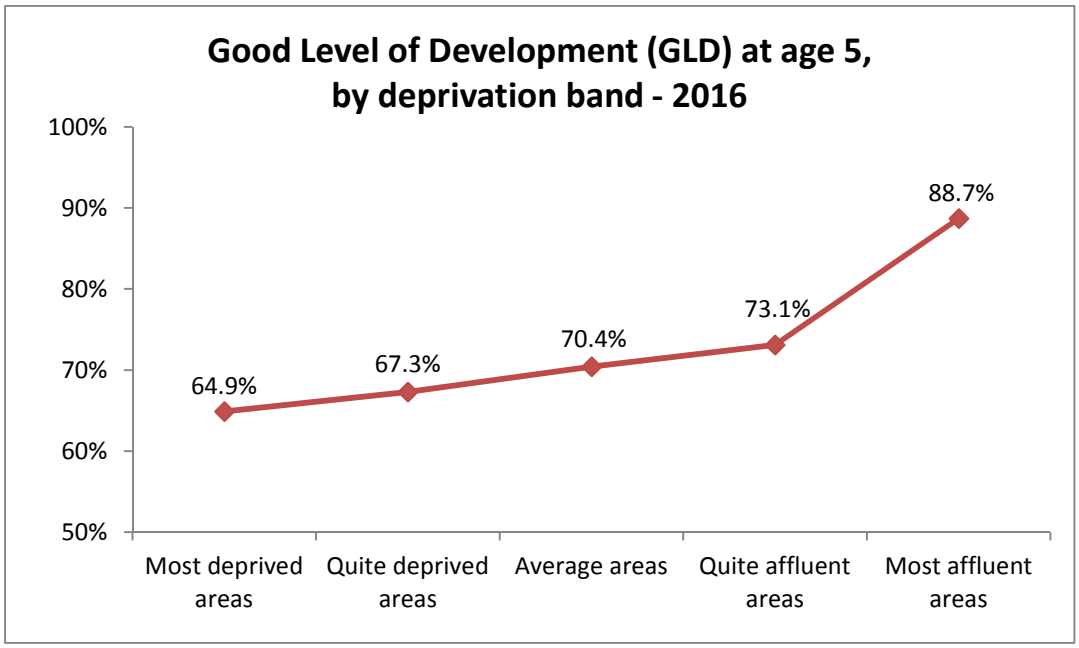
In London, (2013-14) 2 in 5 children do not achieve a good level of development. There are wide variations in the proportion of children who are school ready

In Ealing, data for Good Level of Development (GLD) for (2015/16) shows the following inequalities:

- Girls significantly outperform the boys (75.7% v 63.5%) – Ealing's overall score is 69.4% (for all pupils achieving GLD), the figures for London are 71.2% and England 69.3%
- 5 year olds of Mixed/Dual ethnic background had the highest achievement rate for GLD – 76.0%, whilst pupils of Other ethnic heritage had the lowest – 63.6%;

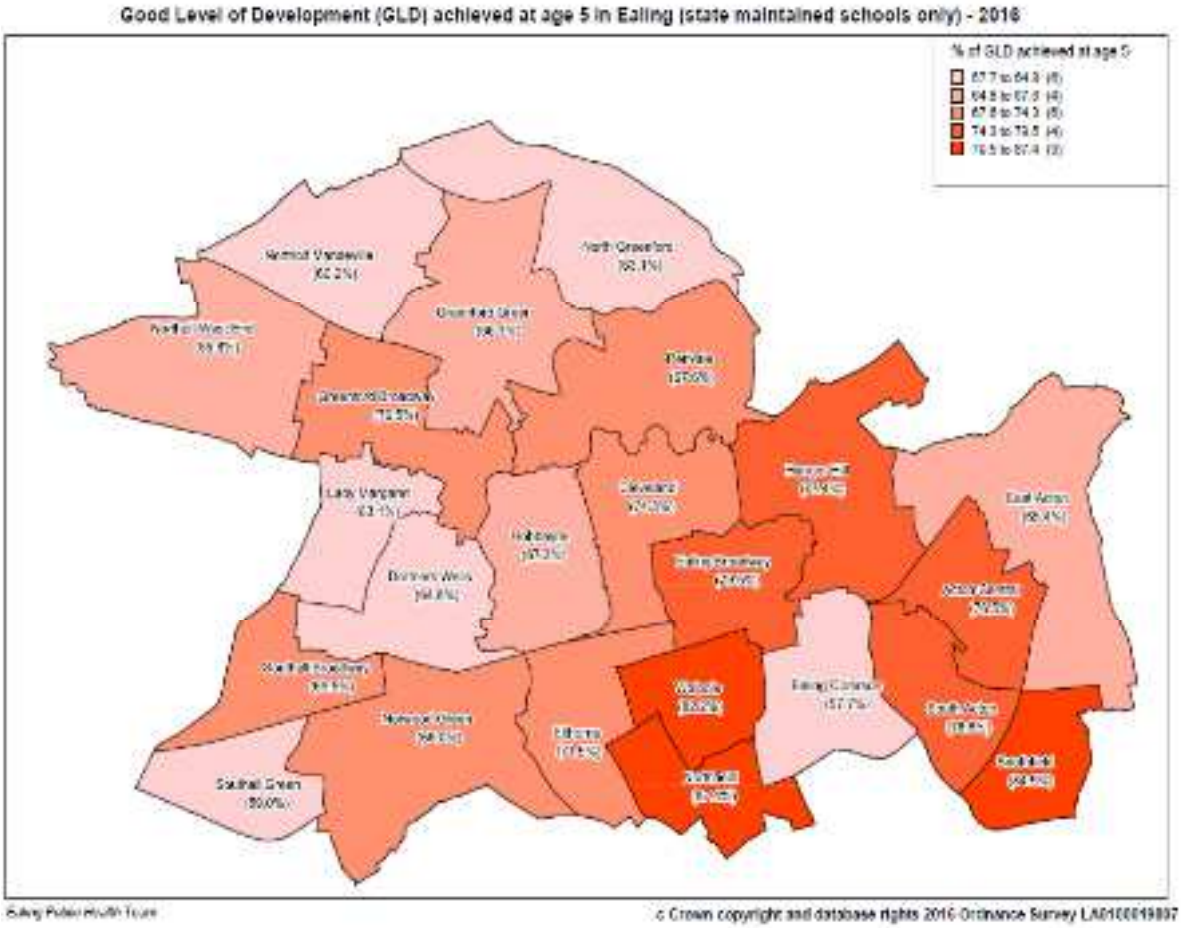
- Pupils entitled to FSM were significantly less likely to achieve GLD – in 2016, 57.2% of them reached or exceeded the expected level of performance in comparison to those without the FSM entitlement, where 71.1% achieved GLD;
- There is a strong correlation between the attainment of GLD and the level of deprivation in which the child lives: from the pupils in the most deprived areas 64.9% achieved GLD, whilst 88.7% of those living in the most affluent areas of the borough did the same. Figures 7 and 8 illustrate this for Ealing.

Figure 7 Good level of development age 5 by deprivation band 2016



Source: Ealing Public Health

Figure 8 Good level of Development age 5 in Ealing 2016



Good level of development at age 5 and good level of development at age 5 with free school meals

Children eligible for Free School Meals in Ealing in the early years do well against their national counterparts and have continued to improve over time, with a 9% rise in outcomes from 2013 to 2016. Though in 2016 there was a drop in EYFS Profile outcomes for this group, they continue to attain 4% higher than England (Table A), with a significantly smaller gap between those eligible for Free School Meals and all others than England, and in line with the London average (Table B).

Table A: EYFS Profile outcomes 2013 to 2016 for those children attaining a Good Level of Development who are eligible for Free School Meals

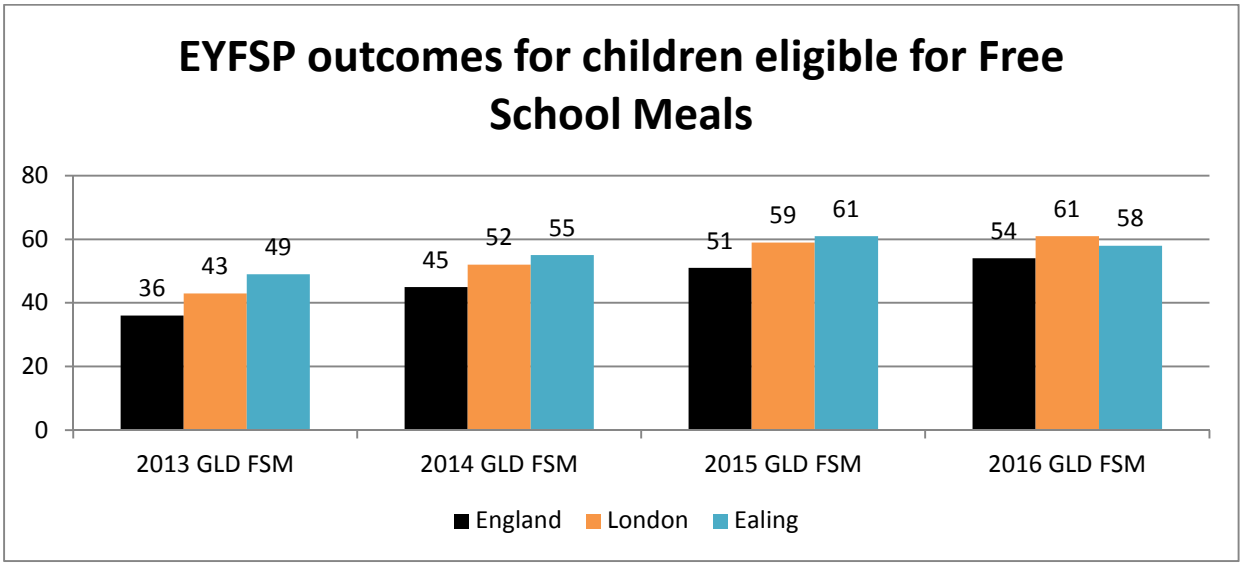
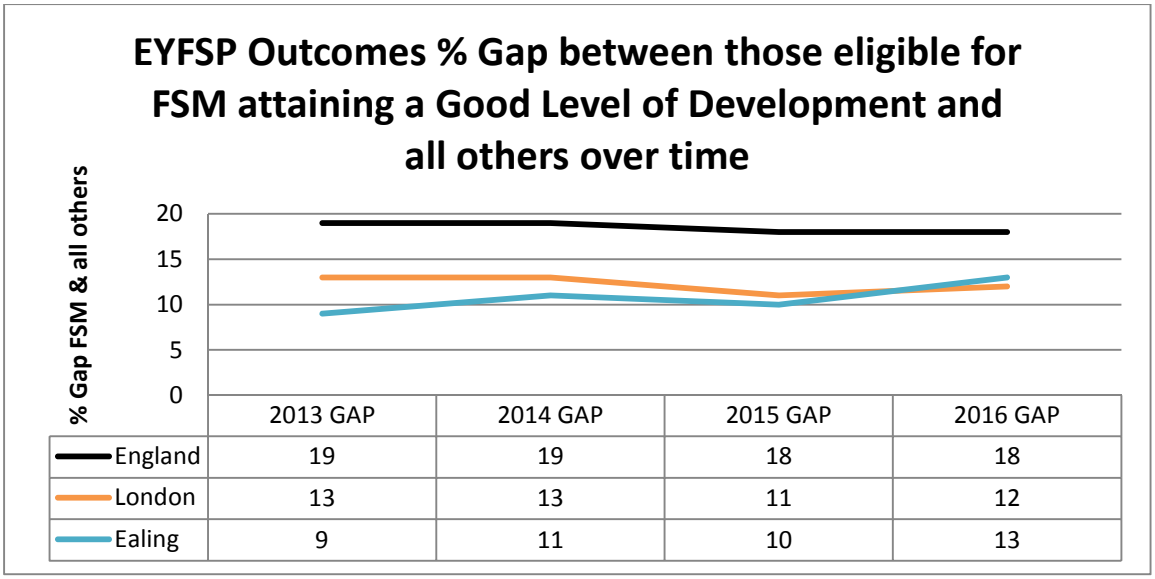


Table B: EYFS Profile outcomes 2013 to 2016 gap between those children attaining a Good Level of Development who are eligible for Free School Meals and all others



	2013 GAP	2014 GAP	2015 GAP	2016 GAP
England	19	19	18	18
London	13	13	11	12
Ealing	9	11	10	13

5.2 Childhood Obesity

The latest results from the NCMP showed that obesity prevalence has risen significantly in England since 2014/15 in both Reception (9.3% from 9.1%) and year 6 (19.8% from 19.1%), with the proportion of children aged 10 to 11 in England who are overweight and obese now the highest on record. The deprivation gap continues to widen, and

there are also inequalities for some Black and Minority Ethnic communities. Obesity prevalence was higher for boys than girls in both age groups. Obesity prevalence for children living in the most deprived areas in both age groups was more than double that of those living in the least deprived areas. The deprivation gap as measured by the differences in obesity prevalence between the most and least deprived areas has increased over time.

In 2014/15, obesity prevalence in Reception is 10.6% and 23.9% for those aged 10-11 in Ealing. The pooled data for 2012/13-2014/15 by ward is shown below.

Figure 9: Obese and overweight pupils in reception year, NCMP, 3 year pooled data 2012/13 – 2014/15

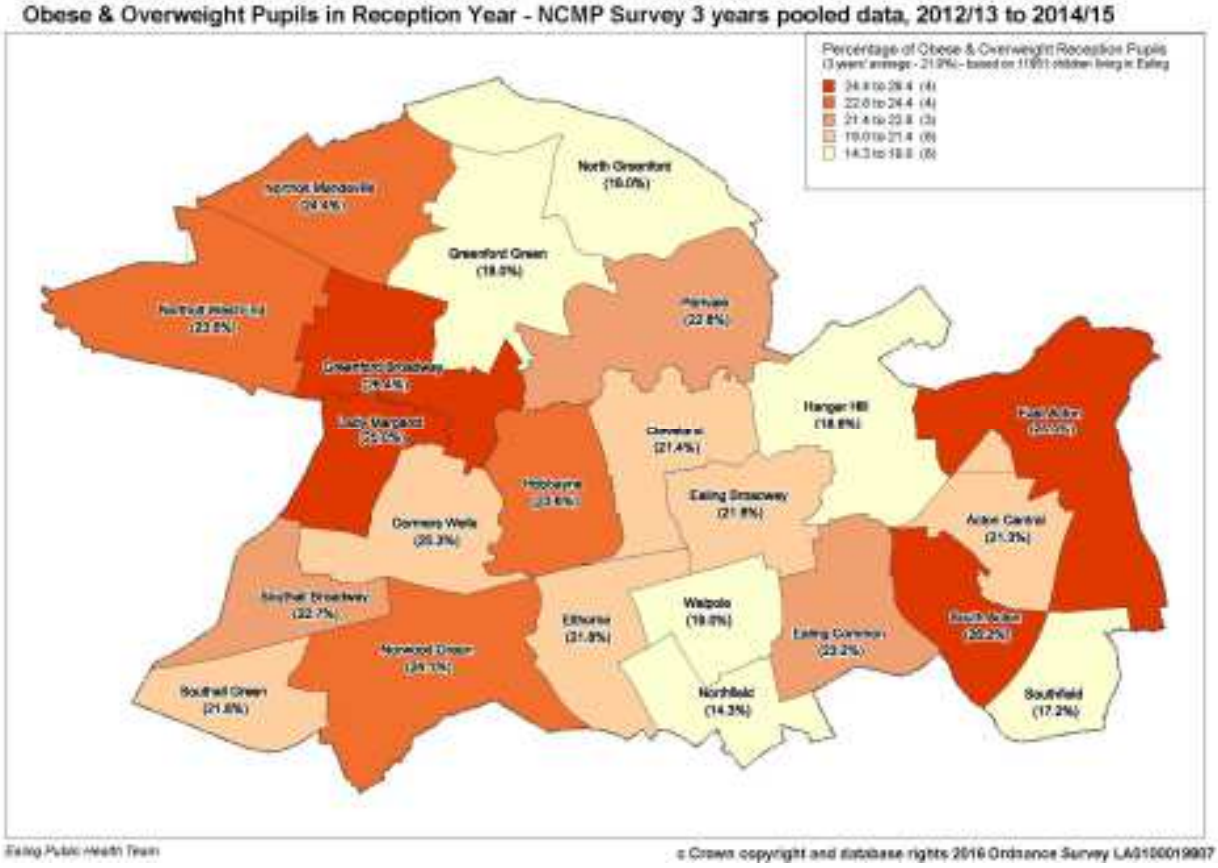
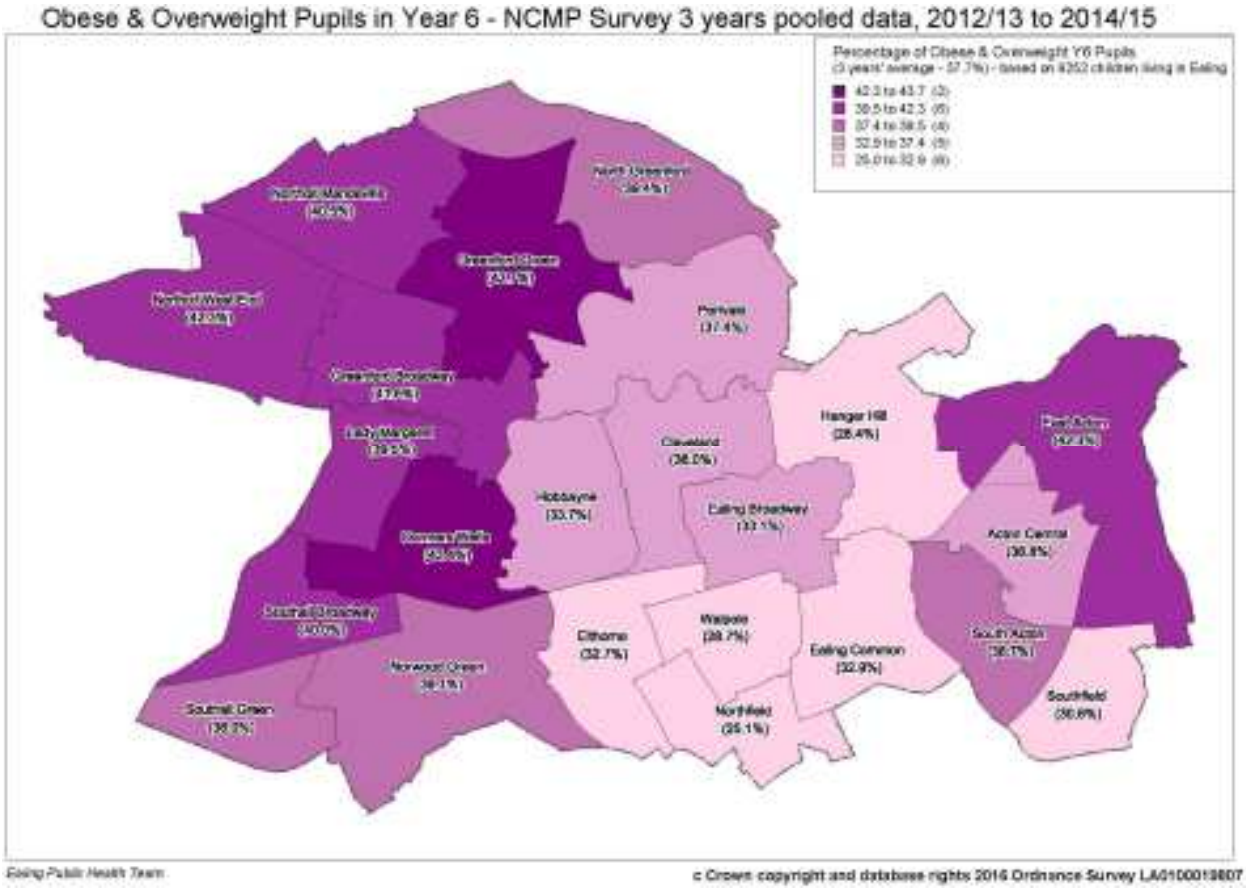


Figure 10 : Obese and overweight pupils in year 6, NCMP, 3 year pooled data 2012/13 – 2014/15



6. Adults

6.1 Smoking

There were 418,170 registered people with Ealing's 79 GP practices in 2014/15. From this number, 339,509 were aged 15 and over. In this age group, 54,958 were listed as current smokers (16.2%)[1]. This is a slight increase since 2013/14, when 16% of population aged 15+ were smokers. In London, smoking prevalence in 2014/15 was 18.1% and in England 18.6%, so Ealing's figure is significantly lower.

Figure 11 shows the smoking prevalence in 2014 at ward level population in Ealing, based on Integrated Household Survey (IHS). The distribution of smokers varies in different parts of Ealing, with prevalence ranging between 14.2% and 19.0% for all the wards, but these differences are not statistically significant. The highest rates of prevalence, equal to or above 17.5% were seen in 5 wards of Southall (Dormers Well, Lady Margaret, Southall Green, Southall Broadway and Norwood Green). Northolt West End (17.9%) was another ward with a similar rate.[2]

[1] Source: QOF, HSCIC, 2016. Please note: from 2014/15 the published data no longer contains the field SMOK001 which was previously used to calculate this indicator. All data has therefore been recalculated using the estimated list size (15+) as the denominator (QOF).

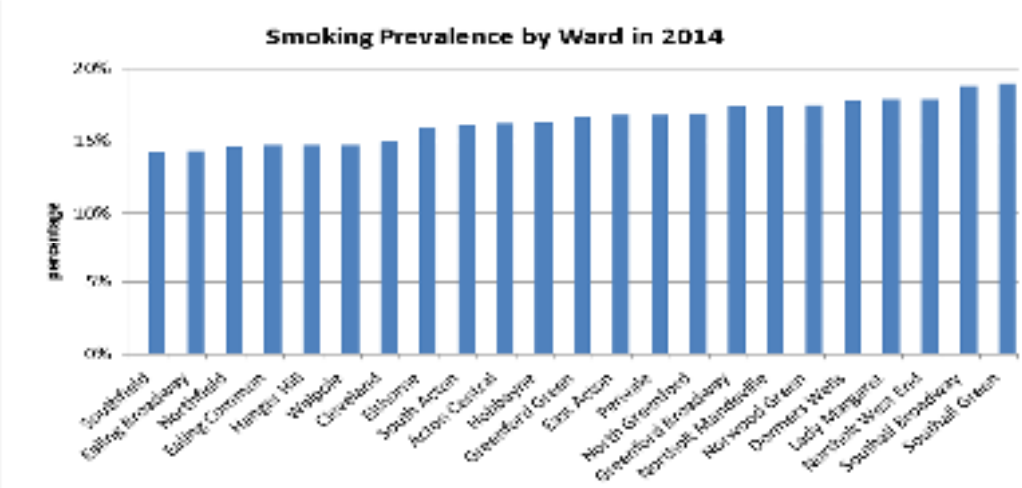
[2] *ASH Ready Reckoner, Dec 2015 Update*

The lowest levels of smokers are based in wards in Central Ealing with a prevalence of under 15% (Southfield, Ealing Broadway, Northfield, Ealing Common, Hanger Hill and Walpole). There are many more smokers among the most disadvantaged in the population and reflect the significant health inequality issue caused by smoking.

Inequalities in smoking prevalence

- Approximately 1 in 5 men are smokers compared to 1 in 6 women,
- 25-29 year olds are 1.4 times more likely to be smokers compared to 55-59 year olds
- People in the routine and manual group are 2.2 times more likely to be smokers compared to those in professional groups

Figure 11: Smoking Prevalence (%) at Ward Level in 2014



Source: ASH Ready Reckoner, Dec 2015 Update

6.2 Cardiovascular Disease

Cardiovascular disease (CVD) is an overarching terms that describes a family of diseases including coronary heart disease, stroke, and kidney disease sharing a common set of risk factors.

- 4.9 million people aged 16 or over in England have CVD, which is 11.7% of the population.
- CVD is responsible for 200,000 deaths per year- 1 in 3 deaths in UK.
- Every hour in England and Wales 4 people under 75 years die from CVD
- The combined cost of cardiovascular disease to the NHS and UK economy is estimated at £30 billion.

Preventing cardiovascular disease may also reduce the burden on social care, families and carers by preventing long-term illness and disability from heart attacks, strokes and other conditions caused by cardiovascular disease.

The prevalence of CVD increases with deprivation and is more common among people from black and minority ethnic groups, including South Asian, African and African-Caribbean descent.

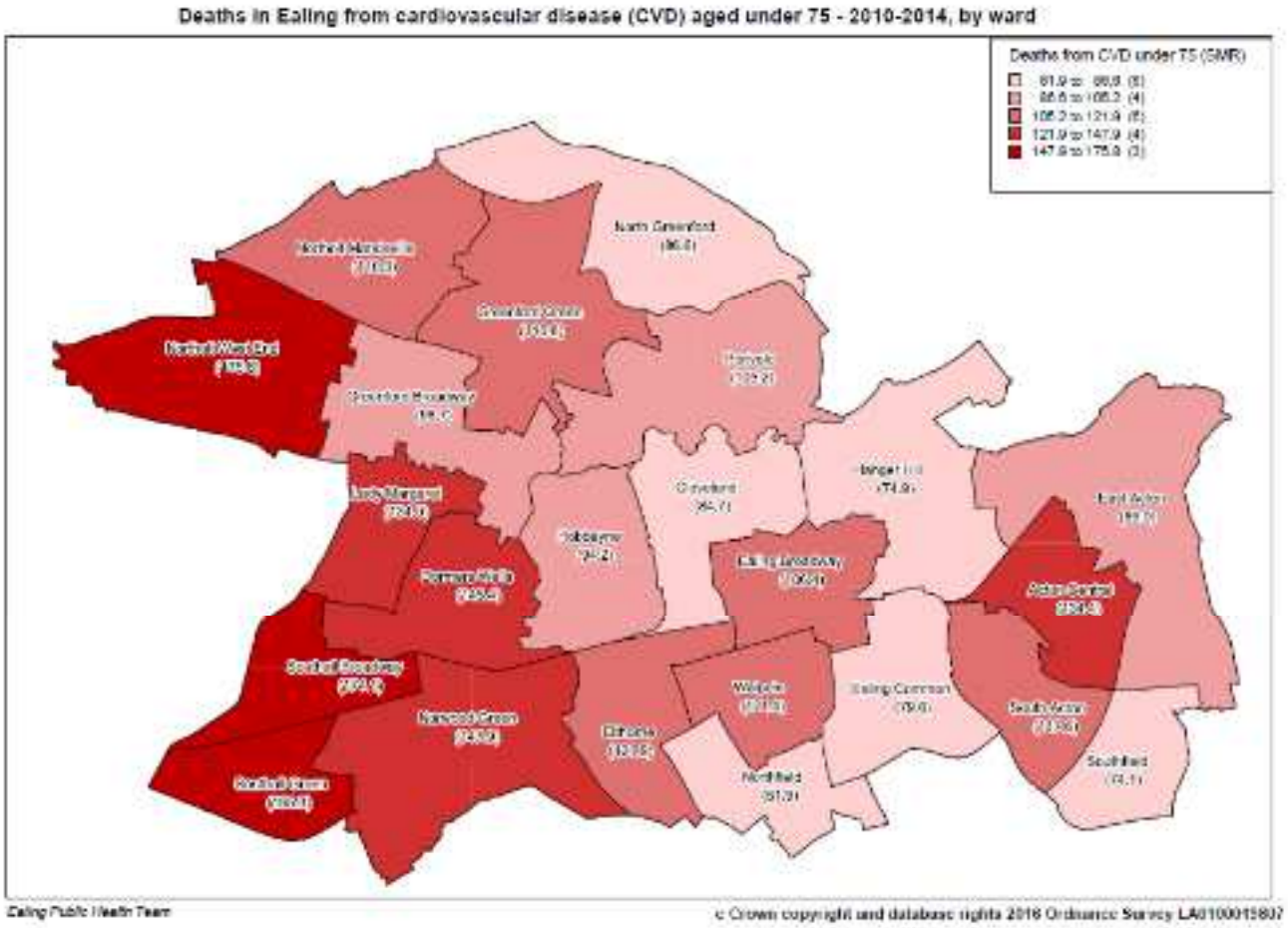
The main risk factors for death from CVD are:

- Smoking
- Raised blood pressure
- Diabetes
- Obesity
- Lack of physical activity

All of these risk factors are associated with living in a deprived area.

People in the most deprived decile in England are 1.7X more likely to die from cardiovascular disease under 75 years compared to people in the least deprived decile. Figure 12 shows deaths in Ealing from CVD in those aged under 75 from 2010-2014.

Figure 12 Deaths from CVD aged under 75 - 2010-2014



Obesity is a major cause of cardiovascular disease. Currently 1 in 3 adults and children are overweight or obese. By 2050 these figures are projected to rise to 9 in 10 adults and 2 in 3 children, at a cost of £50 billion per year.

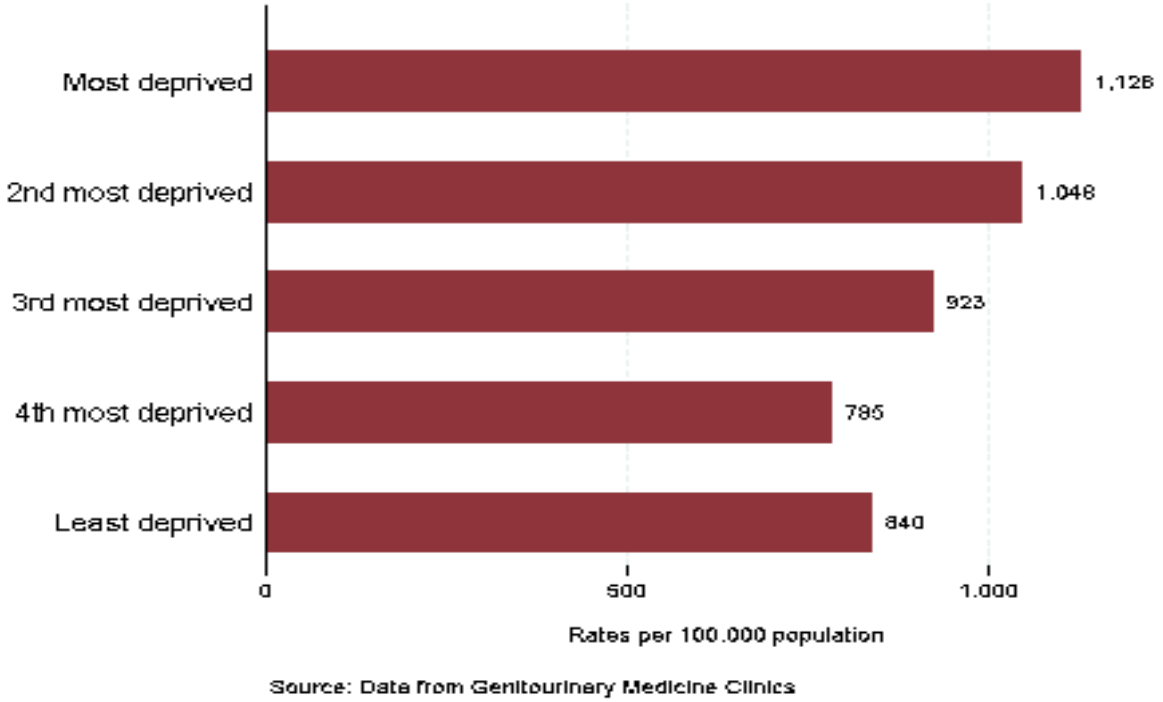
There are also significant issues for different equality groups in the population. For example people with mental health problems have a much higher incidence of CVD, and poorer outcomes. Depression has been associated with a four-fold increase in the risk of cardiovascular disease, even when other factors are controlled.[3]

6.3 Sexually Transmitted Infections (STIs)

There are inequalities amongst certain groups in relation to STI's and HIV. Nationally, young people aged 15-24 years, men who have sex with Men and Black Caribbean ethnic groups have higher rates of acute STI's. MSM and Black African communities have higher rates of HIV. Public Health England recommends targeted intervention aimed specifically at these different groups to improve sexual health outcomes.

As with wider health-related issues, there is also a strong link between areas with higher social deprivation scores and STI's. In Ealing, there are higher rates of STI's in Lower Super Output Areas associated with deprivation. Due to the sensitive nature and confidentiality protocols, this data is not presented. The graph below shows the association between deprivation and STI's amongst Ealing residents.

Figure 13 : The rate per 100,000 of acute STIs by deprivation category in Ealing: 2012



Source: Data from Genitourinary Medicine Clinics

[3] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/217118/9387-2900853-CVD-Outcomes_web1.pdf

7. LEGAL IMPLICATIONS

The Health and Social Care Act 2012, which came into force on the 1 April 2013, transferred responsibility for local public health services to local authorities.

It placed a duty on local authorities to take such steps as they consider appropriate to improve the health of people in their area. It also placed on Local Authorities a responsibility for a number of other public health functions

Local authorities fulfil their duties in a range of ways by commissioning services from a variety of providers from different sectors, working with clinical commissioning groups and other partners. Local authorities can also fulfil this duty in the way they operate the planning system, policies on leisure and key partnerships with other agencies.

The responsibility to improve and protect our health lies with government, local communities and with ourselves as individuals. There are many factors that influence public health over the course of a lifetime. Integrating public health into local government allows that to happen with services planned and delivered in the context of the broader determinants of health, like poverty, education, housing, employment, crime and pollution.

In all they do, local authorities should ensure the health needs of disadvantaged areas and vulnerable groups are addressed, as well as giving consideration to equality issues. The goal should be to improve the health of all people, and to improve the health of the poorest, fastest.

8. FINANCIAL IMPLICATIONS

There are none arising directly from this report.

9. OTHER IMPLICATIONS

There are none.

10 BACKGROUND INFORMATION

Inequalities in life expectancy- Changes over time and implications for policy. Kings Fund 2015

Health Inequalities in London – PHE 2015

Fair Society, Healthy Lives

Pre-publication sign-off

Name	Department	Date sent	Date response received	Comments appear in report paragraph:
Internal				

Report History

Decision type:	**I. Urgency item?**
Non-key decision	No

Authorised by Cabinet member:	Date report drafted:	Report deadline:	Date report sent:
Not applicable			
Report no.:	Report author and contact for queries:		
	Jackie Chin chinj@ealing.gov.uk		