Public health and health inequalities: A (provocative?) view from the King's Fund

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2022

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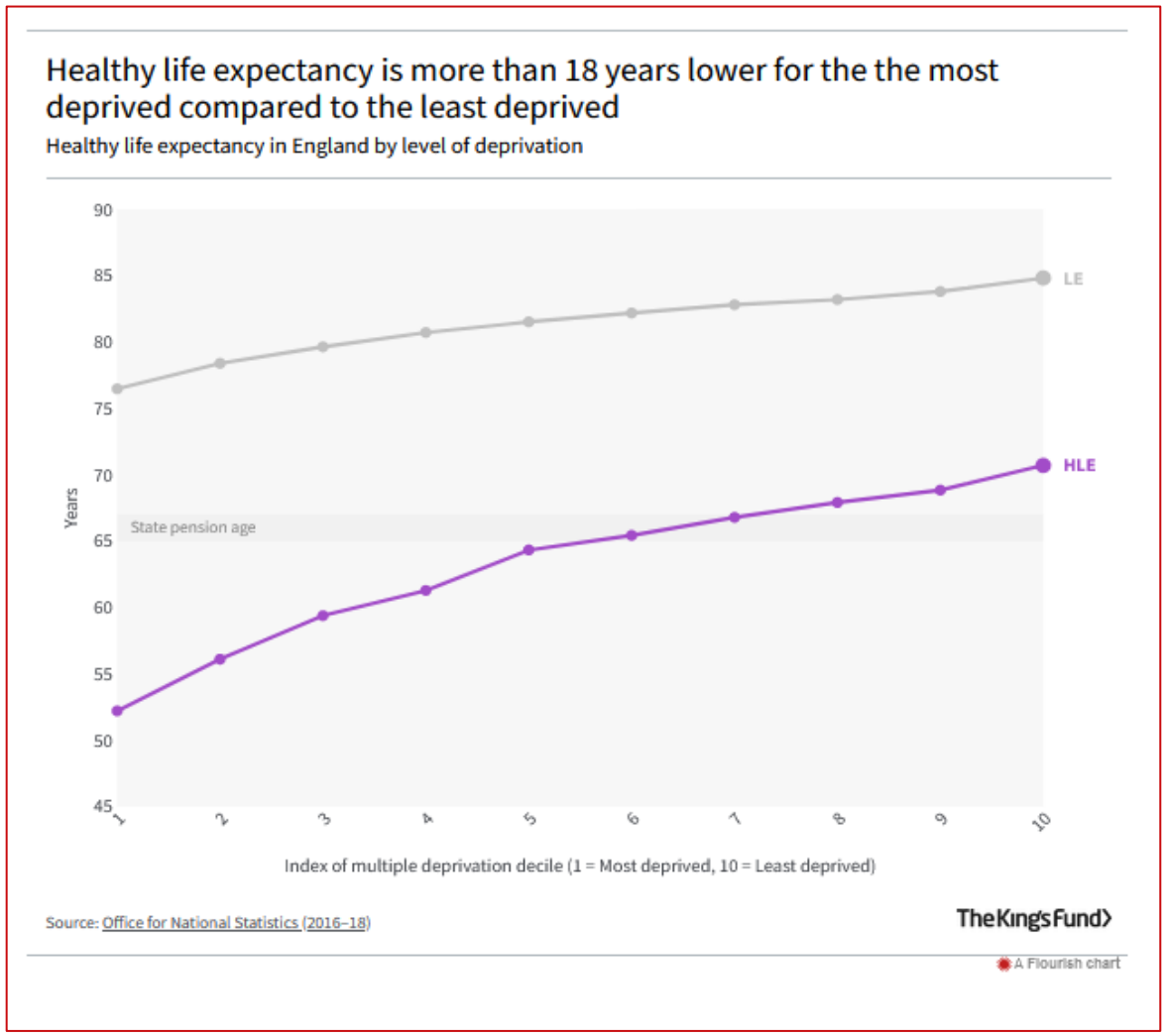
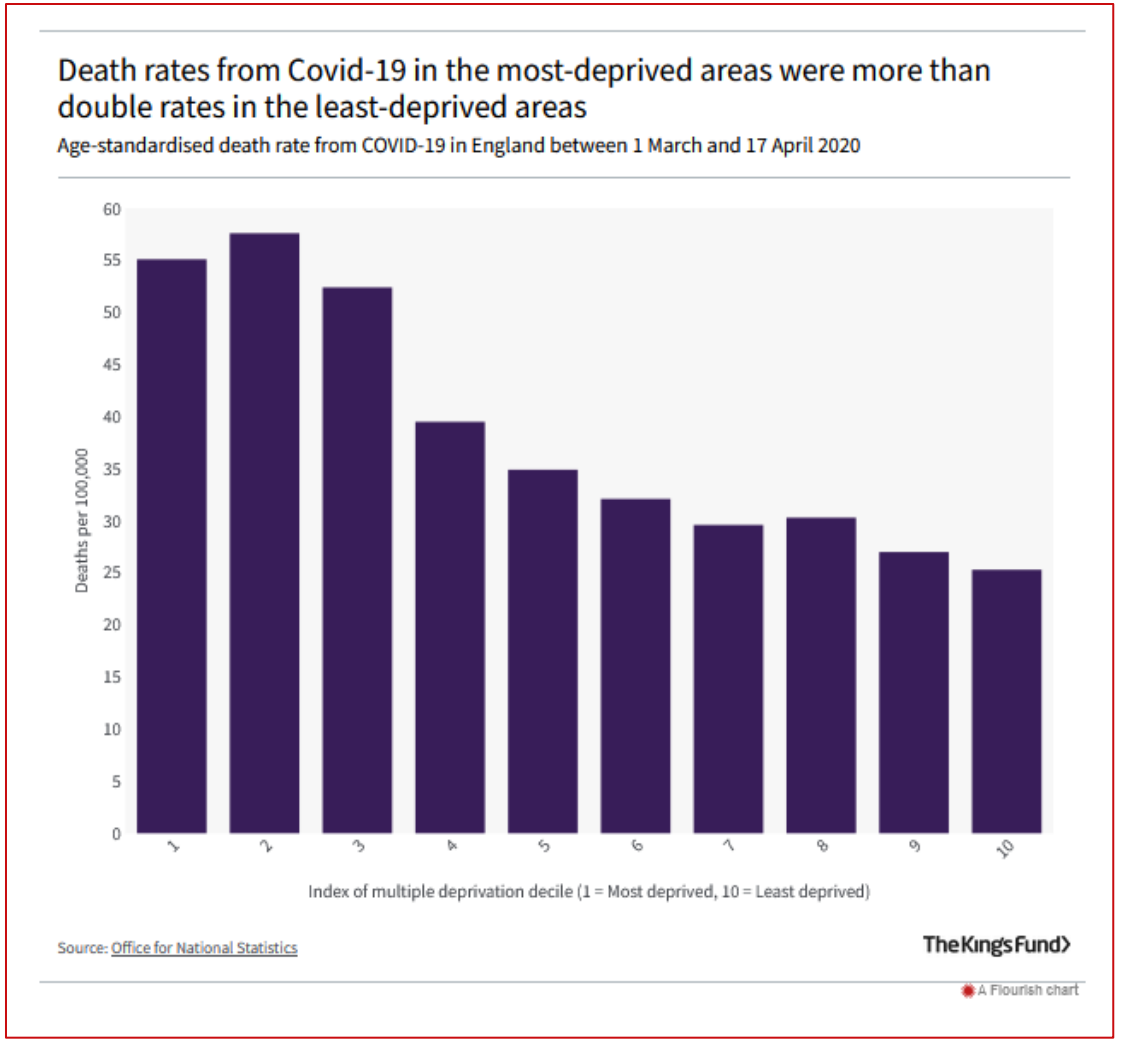
A summary

1. **Health inequalities policy is lacking at national level, despite there being good evidence of what works and England having 'done this before'** – institutional amnesia and a lack of political will. NHS England has a new approach through the NHS, and with partners – this is necessary but not sufficient.
2. **The public health system has not been protected** financially, partly because it sits in local government not the NHS, despite public health spending being 3-4 x as cost-effective as NHS spending in producing health
3. **The action is at regional and local level**. ICSs hold promise **IF** they focus on population health, not simply the integration of care services. The latter depends on deep collaboration with the public health family, most of this expertise sits outside the NHS and is in local government; and the NHS putting the money in – local government is close to bankruptcy. Bridging that gap is key – there are cultural, funding and incentive barriers to overcome – this depends on leadership and commitment from 'both sides'.

Health inequalities

Health inequalities are wide, and have been exacerbated through covid-19





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England had an effective cross-govt policy up to 2010

1997-2010: a concerted and systematic attempt at health inequality reduction?

It took time for the Labour government to take concerted action on health inequalities. However, the government's strategy emerged more strongly in the early 2000s, building on health action zones (area-based initiatives focused on community approaches to tackling health inequalities), and set out in a cross-government strategy. This had a dual focus on meeting short-term national targets while pursuing longer-term challenges relating to the underlying causes of health inequalities.

The strategy was operationalised through a public service agreement between the Department of Health and HM Treasury, which included 82 cross-government commitments.

Did this approach work?

In 2010, the National Audit Office reviewed progress on the life expectancy element. It suggested that, despite great efforts, critical work had started late and the targets were unlikely to be met. Subsequent independent studies have used a wider range of more up-to-date data to show that these efforts had a positive effect on reducing health inequalities against a number of measures:

- the relationship between income inequalities and health inequalities got weaker over the period and there was a reduction in amenable mortality in deprived areas consistent with how funding had been allocated
- inequalities in life expectancy between deprived and non-deprived local authorities narrowed
- there were reductions in inequalities in infant mortality.

- England had a cross-govt national health inequalities strategy until 2010, before then inequalities were widening, they narrowed around the strategy period, and widened again afterwards.
- Policy weakened post-2010, targets and support were dropped, and more was expected of local and regional systems, effort drifted.
- Covid-19 has increased interest again, with some but not enough change.

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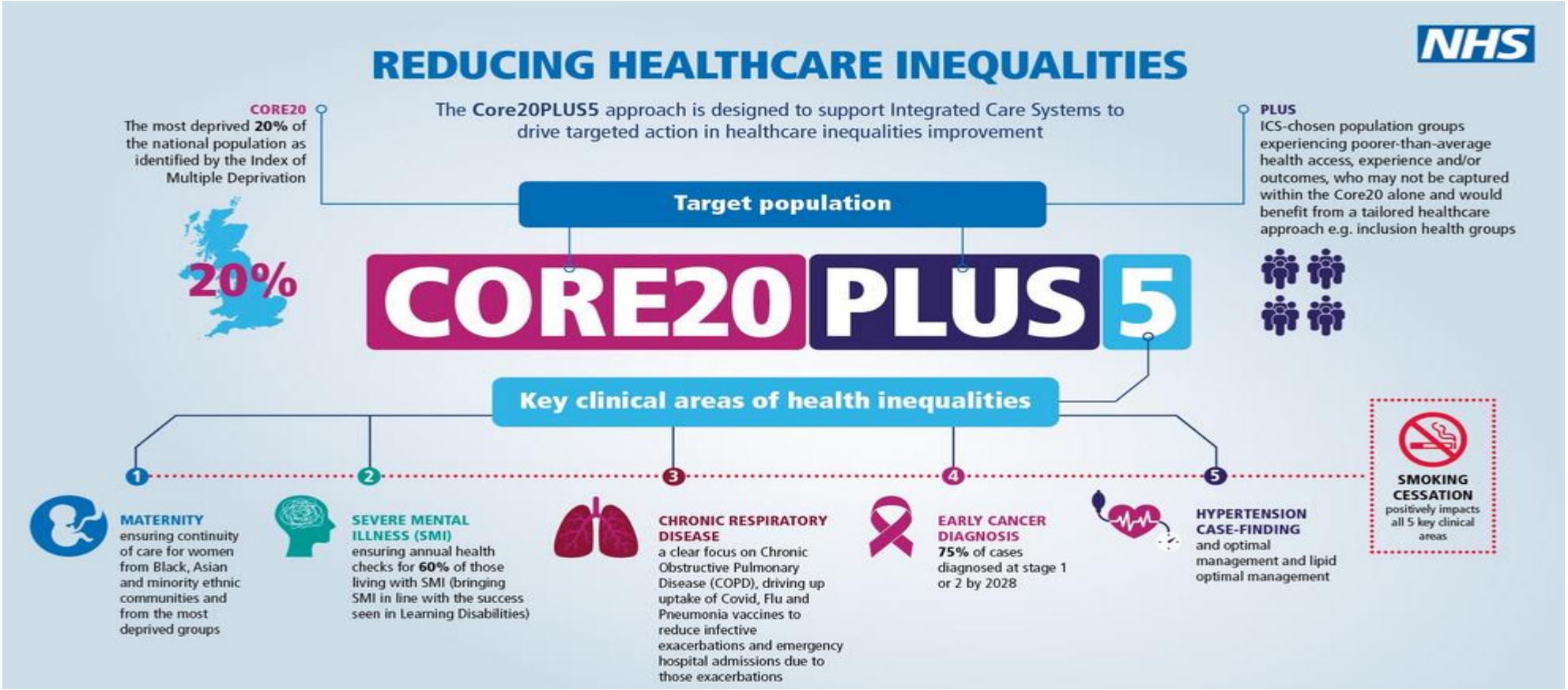
The NHS has a new approach – 'core20plus5'

1. Partly as a response to covid-19 experience, NHS England has strengthened its focus on health inequalities in three ways



Public health: £ and system

Integration then fragmentation of organisations

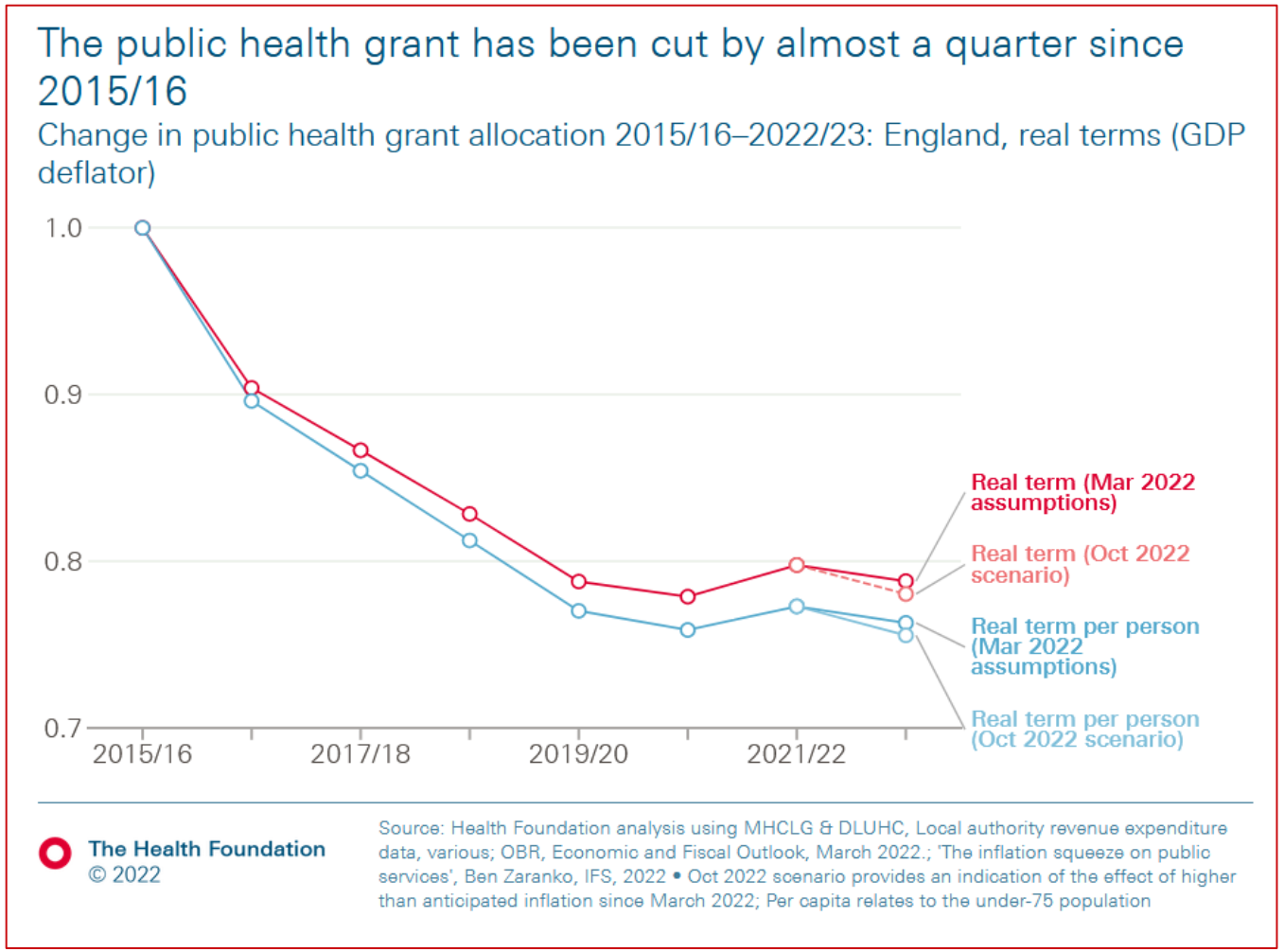
- New executive agency national body. Public Health England set-up, bringing together 70+ existing organisations – to provide synergy, policy advice, data/surveillance
- Locally, most of NHS public health people and funding moved to local government, where judged could have a greater impact on health.
- Funding transferred, and distributed by formula. No assessment of whether the overall level was enough.
- Some clinical services remain e.g. screening and immunisations in the NHS

- Govt announces PHE will be abolished, to be replaced by a health protection organisation (United Kingdom Health Security Agency) and a health improvement body (the Office for Health Improvement and Disparities); some functions back to NHS England.
- Both bodies live in October 2021. OHID has struggled to influence nationally, working well regionally. UKHSA managing transition to post-covid health protection model.

2013

2020

Falling expenditure despite being cost-effective



- Local government receives a grant from central government to fund public health services.
- This has been falling in real terms since 2015-16, as local govt has faced cuts which the NHS has not. These cuts have been bigger in more deprived areas with greater need.
- Evidence shows the services funded through the grant are 3-4 times as cost-effective in improving health as putting the same money into the NHS baseline

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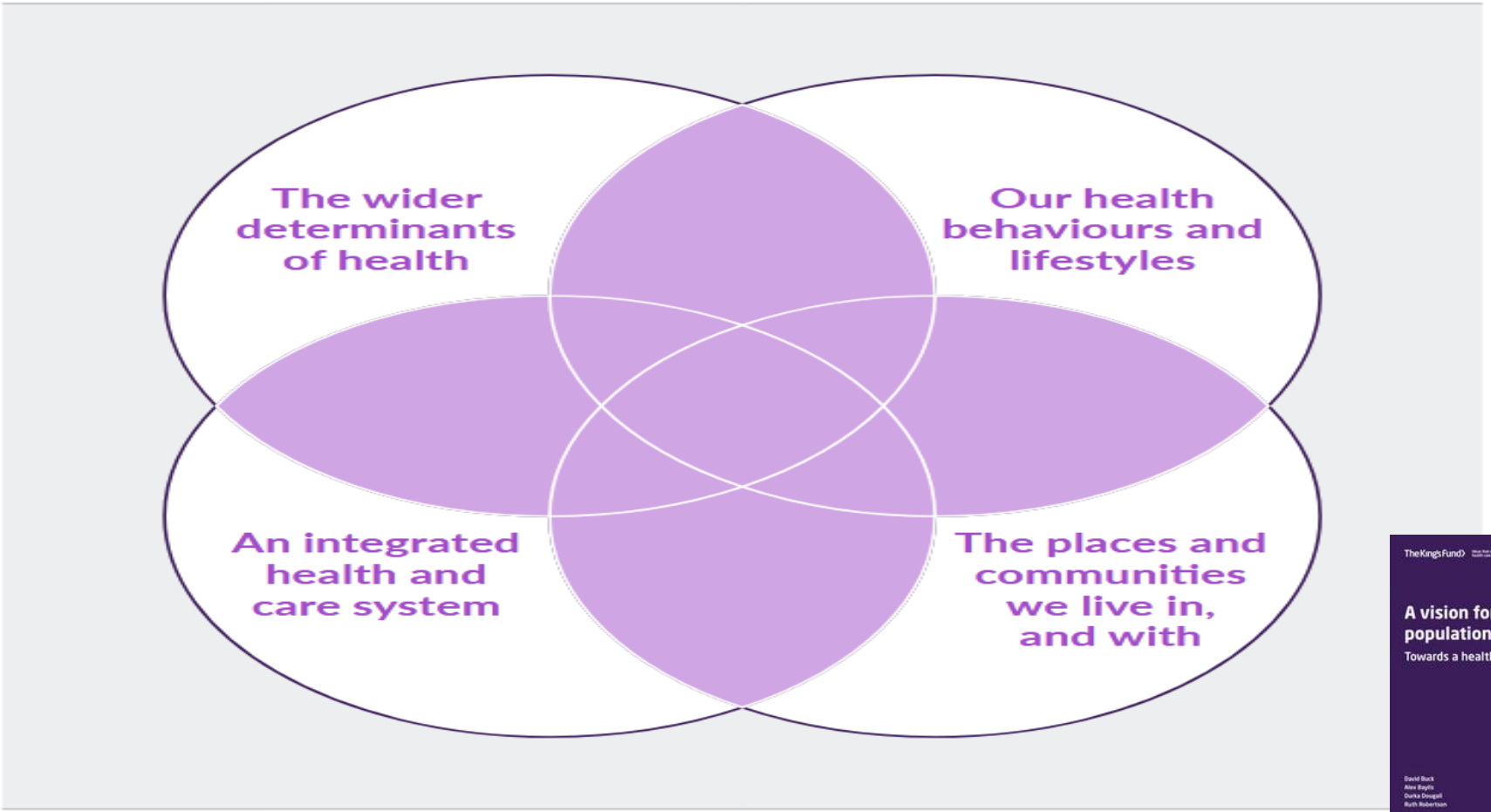
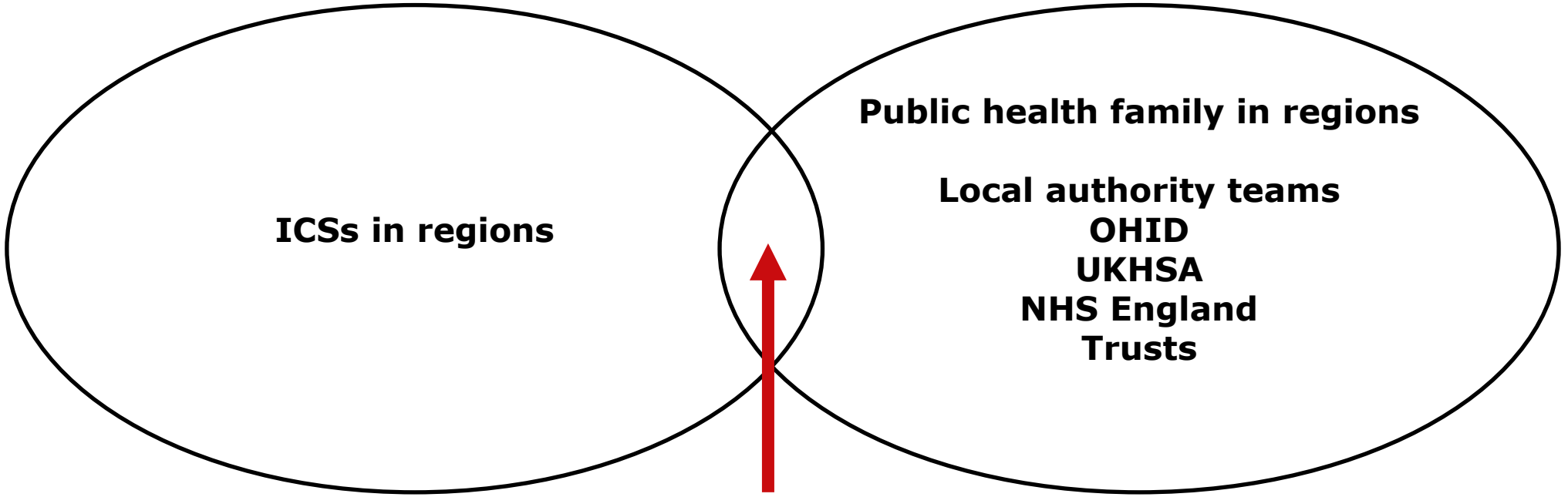
The promise of ICSs and public health collaboration

Complex population health and health inequalities problems require balanced action in the four pillars and, critically in partnership, where they overlap

Figure 11 A population health system that recognises and maximises the activity in the overlaps between the pillars



A population health approach requires ICS-public health family collaboration



Success depends on these coming together

Most funding lies here, principally NHS organisations

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Most expertise/knowledge on population health lies here in the public health family, splintered across organisations; many not in the NHS

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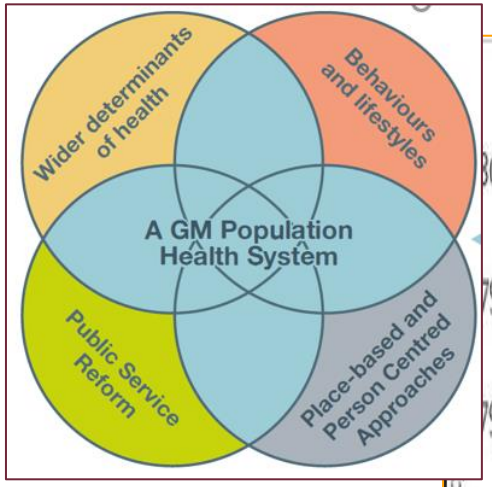
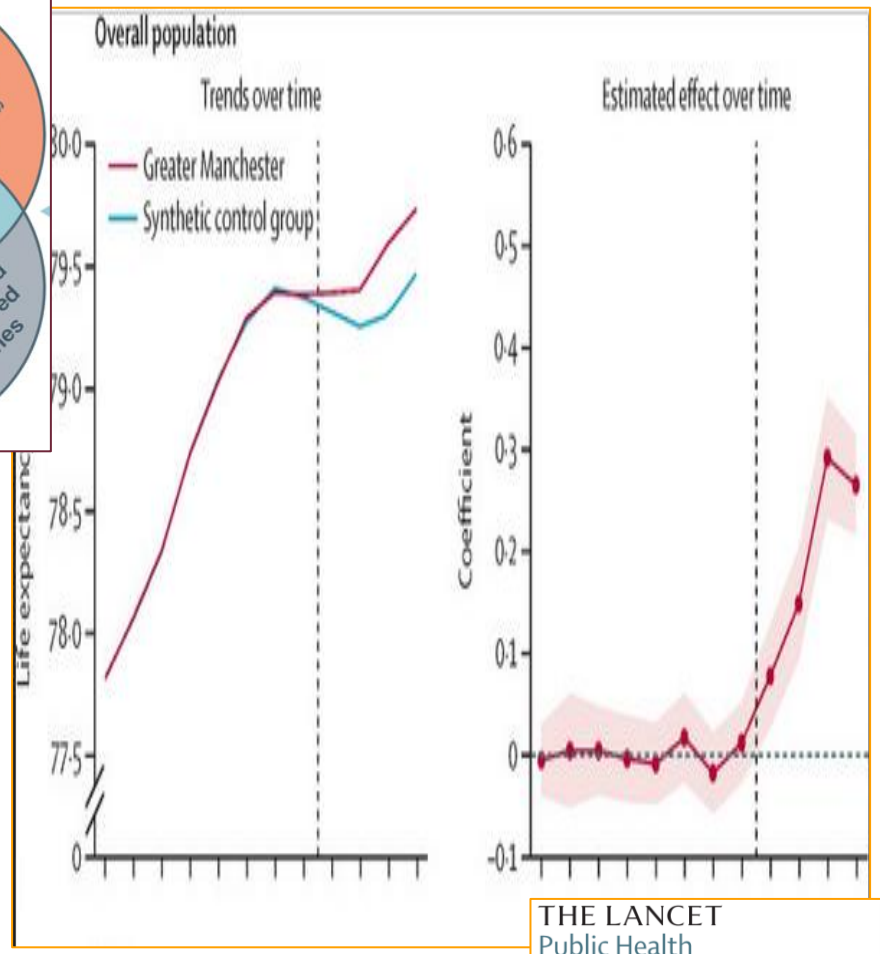
GM, perhaps it is starting to work…?






THE LANCET
Public Health
Volume 7, Issue 10, October 2022, Pages e844-e852

Articles

The effect of devolution on health: a generalised synthetic control analysis of Greater Manchester, England

Philip Britteon PhD *, Alfariany Fatimah PhD *, Yiu-Shing Lau PhD *, Laura Anselmi PhD *, Alex J Turner PhD *, Stephanie Gillibrand MA *, Paul Wilson BA *, Prof Kath Checkland PhD *, Prof Matt Sutton PhD *

- GM's life expectancy has diverged positively since devolution (end of 2014 to 2019) compared to control populations – on average by about +2 months over that period.
- Effects bigger for men than women, and in some places rather than others.
- Overall, effects were larger in the most deprived areas compared to the least deprived.

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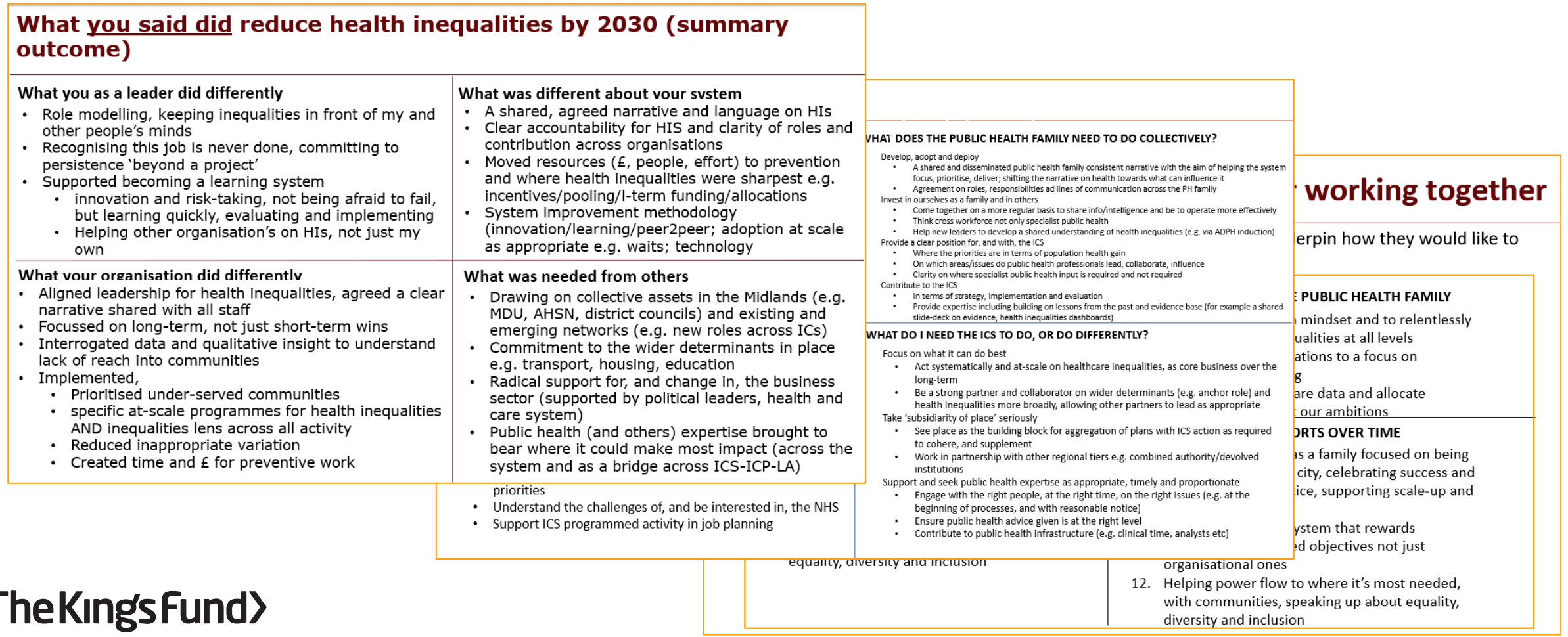
Beyond GM, need for explicit principles and behaviours

- Many systems seeking to establish collaborative principles between public health community, ICSs and regional bodies. Every one different, lots of common ground.



What you said did reduce health inequalities by 2030 (summary outcome)

What you as a leader did differently

- Role modelling, keeping inequalities in front of my and other people's minds
- Recognising this job is never done, committing to persistence 'beyond a project'
- Supported becoming a learning system
  - innovation and risk-taking, not being afraid to fail, but learning quickly, evaluating and implementing
  - Helping other organisation's on HIs, not just my own

What was different about your system

- A shared, agreed narrative and language on HIs
- Clear accountability for HIS and clarity of roles and contribution across organisations
- Moved resources (£, people, effort) to prevention and where health inequalities were sharpest e.g. incentives/pooling/l-term funding/allocations
- System improvement methodology (innovation/learning/peer2peer; adoption at scale as appropriate e.g. waits; technology

What your organisation did differently

- Aligned leadership for health inequalities, agreed a clear narrative shared with all staff
- Focussed on long-term, not just short-term wins
- Interrogated data and qualitative insight to understand lack of reach into communities
- Implemented,
  - Prioritised under-served communities
  - specific at-scale programmes for health inequalities AND inequalities lens across all activity
  - Reduced inappropriate variation
  - Created time and £ for preventive work

What was needed from others

- Drawing on collective assets in the Midlands (e.g. MDU, AHSN, district councils) and existing and emerging networks (e.g. new roles across ICs)
- Commitment to the wider determinants in place e.g. transport, housing, education
- Radical support for, and change in, the business sector (supported by political leaders, health and care system)
- Public health (and others) expertise brought to bear where it could make most impact (across the system and as a bridge across ICS-ICP-LA)

priorities

- Understand the challenges of, and be interested in, the NHS
- Support ICS programmed activity in job planning

WHAT DOES THE PUBLIC HEALTH FAMILY NEED TO DO COLLECTIVELY?

Develop, adopt and deploy
- A shared and disseminated public health family consistent narrative with the aim of helping the system focus, prioritise, deliver; shifting the narrative on health towards what can influence it
- Agreement on roles, responsibilities ad lines of communication across the PH family

Invest in ourselves as a family and in others
- Come together on a more regular basis to share info/intelligence and be to operate more effectively
- Think cross workforce not only specialist public health
- Help new leaders to develop a shared understanding of health inequalities (e.g. via ADPH induction)

Provide a clear position for, and with, the ICS
- Where the priorities are in terms of population health gain
- On which areas/issues do public health professionals lead, collaborate, influence
- Clarity on where specialist public health input is required and not required

Contribute to the ICS
- In terms of strategy, implementation and evaluation
- Provide expertise including building on lessons from the past and evidence base (for example a shared slide-deck on evidence; health inequalities dashboards)

WHAT DO I NEED THE ICS TO DO, OR DO DIFFERENTLY?

Focus on what it can do best
- Act systematically and at-scale on healthcare inequalities, as core business over the long-term
- Be a strong partner and collaborator on wider determinants (e.g. anchor role) and health inequalities more broadly, allowing other partners to lead as appropriate

Take 'subsidiarity of place' seriously
- See place as the building block for aggregation of plans with ICS action as required to cohere, and supplement
- Work in partnership with other regional tiers e.g. combined authority/devolved institutions

Support and seek public health expertise as appropriate, timely and proportionate
- Engage with the right people, at the right time, on the right issues (e.g. at the beginning of processes, and with reasonable notice)
- Ensure public health advice given is at the right level
- Contribute to public health infrastructure (e.g. clinical time, analysts etc)

working together

erpin how they would like to

PUBLIC HEALTH FAMILY

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ORTS OVER TIME

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ystem that rewards
d objectives not just

equality, diversity and inclusion

organisational ones

12. Helping power flow to where it's most needed, with communities, speaking up about equality, diversity and inclusion

The national… economy inactivity and the election

Economic inactivity and Labour testing the waters

Health is wealth?

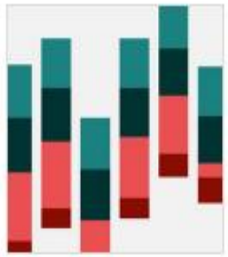
REAL Challenge annual lecture

Wednesday 9 November 2022, 11.00-12.30

About 1 mins to read

Event | COVID-19 | Inequalities | Social determinants of health | REAL Centre

Copy link



Download the slides and watch the video below

Watch the recording

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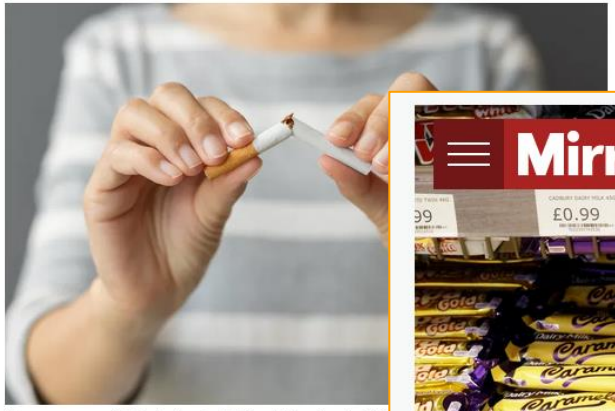
Labour Could Phase Out Sale Of Cigarettes, Says Wes Streeting

Shadow health secretary says NHS needs "fresh radical thinking".

By Ned Simons

08/01/2023 02:22pm GMT



Close up young woman holding broken cigarette in hands. Happy female quittin
Stop smoking cigarettes, health care concept. No smoking campaign.

Labour could ban cigarettes sales if it wins the next electio

Buy one get one free deals were due to come to an end under Tory plans which are likely to be scrapped (

Image: Christopher Furlong/Getty Images)

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Labour's Wes Streeting vows to scrap junk food deals ban like the Tories

The Shadow Health Secretary said it would be 'tin eared' to axe cut-price deals on unhealthy snacks while Brits are struggling

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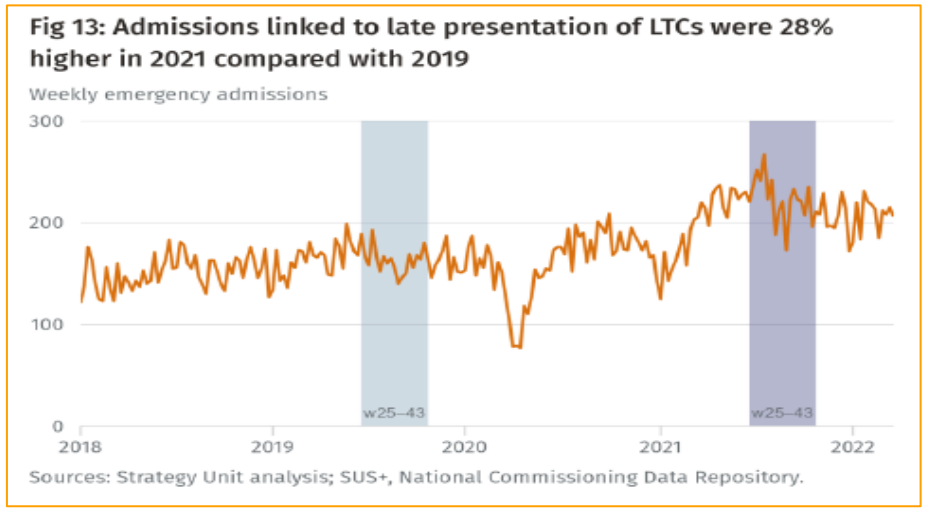
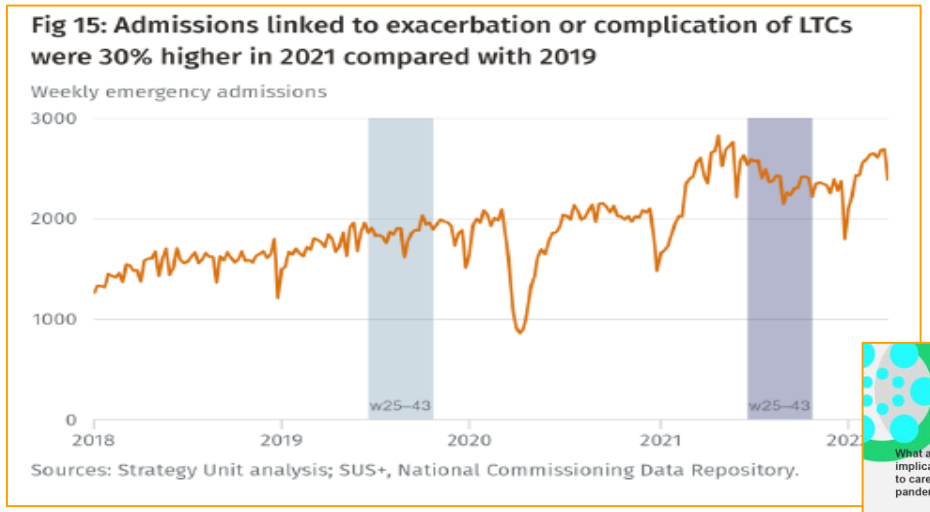
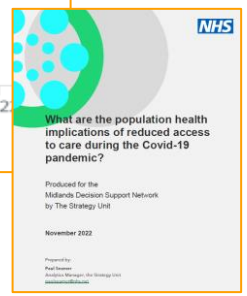
Still coming… covid legacy and cost of living wave

Covid legacy, complex dynamics







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e.g.

Impact on LTCs late presentation and exacerbation, management of secondary prevention being seen in the data now

Long-run(?) complex changes to behaviours and mental health

Article | Full-text available

Health behaviors and subsequent mental health problems during the COVID-19 pandemic: A longitudinal analysis of adults in the UK

January 2023 · Frontiers in Public Health 10
DOI: 10.3389/fpubh.2022.1064677
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Kenisha Russell Jonsson · David C. Taylor-Robinson · Viviane Schultz Straatmann · Show all 5 authors · Nicholas Kofi Adjei

Do we know the shape, dynamics of poverty/CoL wave?

> The Joseph Rowntree Foundation estimated in early 2022 that more than 1 in 5 of the United Kingdom population were living in poverty, which equates to 14.5 million people, including 4.3 million children.

- We know poverty affects health, and decision-making, in multiple ways – narrowing and tunnelling people's lives – as well as direct effects.
- Cost-of-living challenges draw in a much wider population group than have faced these challenges before. We will see deepening and broadening of challenges.
- Where in systems (national, regional, local), are these 'waves' being modelled in terms of connections to s/m/l-term effects on health and demand for services?
- Local government can teach the NHS a lot in this space

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The question… how are you maximizing your joint assets in facing these challenges and opportunities?

The West Midlands (and wider Midlands) has great assets, are you making the most of each other?

Community cohesion:
Teams talked about how they rely for insight and for delivery on organisations, leaders, individuals and trusted locations within neighbourhoods

Academic rigour:
Either via ARCs or as individual universities, there is credible local research expertise in Leicester, Keele, Birmingham etc. It is not clear how those talents are being marshalled to collective benefit

Analytical support:
A network of support to local analysts is led by the Midlands Decision Support Network: this not only raises standards but seeks to produce multi-disciplinary insight with decision making tools and rapid reviews of key evidence

Innovation support:
AHSNs, and the Midlands Engine, have capabilities to connect public services to industry and tech, bringing new ideas and approaches into work on inequalities

These assets need to be mapped, and their role in the work of systems and the region clarified, in order to have maximum impact inside organisations and avoid unplanned duplication or tacit competition

Leading edge practice:
Local work is cited in national publications and guidance, but is not adopted region wide as yet – e.g. UHCW wait list algorithm, LLR primary care funding rebasing

Professional networks:
Networks exist or are forming across sub-regions – Chief Medical Officers, directors of population health, health inequality leads, directors of public health etc. Most are split east/west midlands.

Public health expertise:
Well-connected knowledge and professional insight exists within UKHSA, OHID, local authorities, academic bodies, Trusts, and ICBs – despite workforce pressures in the discipline

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Source - workshop discuss 28/7/22

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