Health Inequalities in west Hertfordshire

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Aims and Objectives

- Provide an overview of inequalities in health and in access to health care, including their causes
- Overview and interruption of local data

What are health inequalities?

- What is your understanding of health inequalities?

Introduction

- The distribution of health is determined by a wide variety of individual, community, and national factors.
- There is a growing body of evidence documenting inequalities in both the distribution of health (i.e. health outcomes) and access to health care both internationally and in the UK. Access to health care is a supply side issue indicating the level of service which the health care system offers the individual.

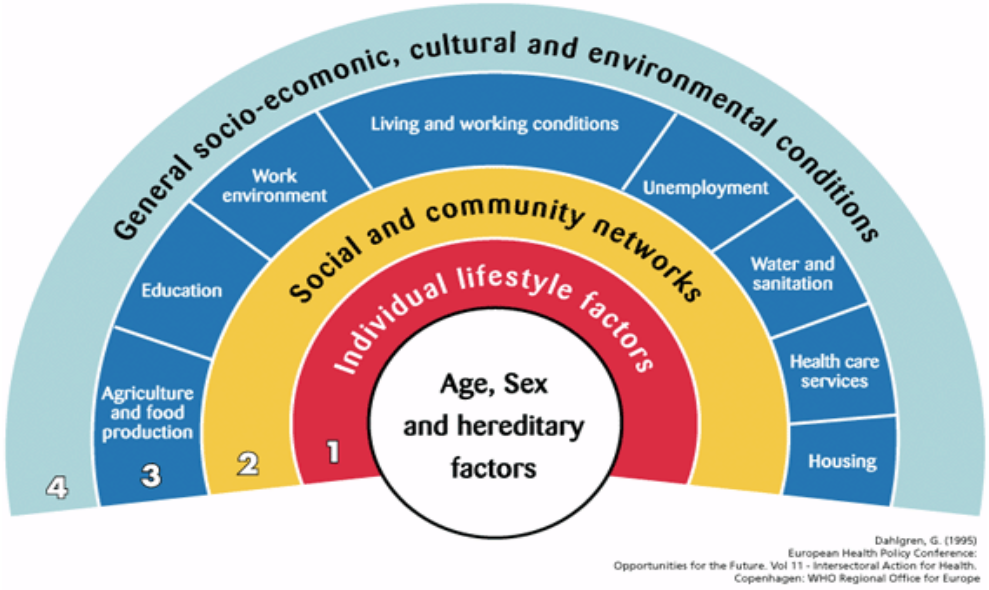


Figure 1: Determinants of health

Inequalities in the distribution of health

- Researchers have documented inequalities in the distribution of health by:
  - social class,
  - gender, and
  - ethnicity.
- Inequalities in health have been measured using many different outcomes including infant deaths, mortality rates, morbidity, disability, and life expectancy.

Social class (including income, wealth and education)

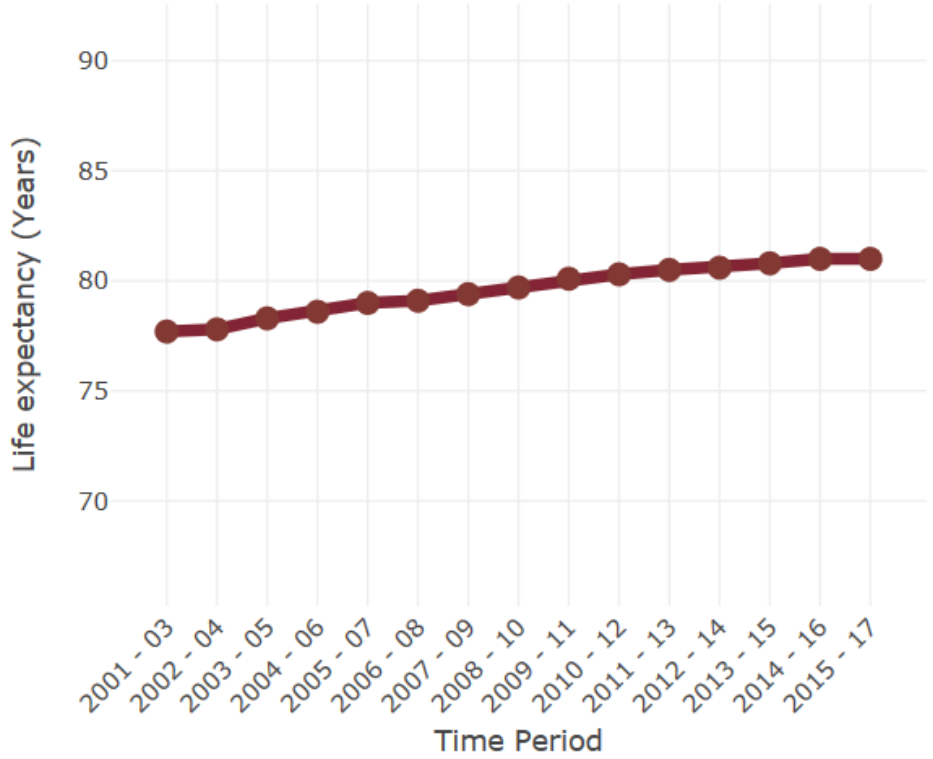
- Social class inequalities in the UK persist at every age and for all the major diseases.
- An analysis of health outcomes in England for the Global Burden of Disease study showed that males living in the most deprived region of England in 2013 had a life expectancy 8.2 years shorter than those living in the least deprived region, which was as large a difference as seen in 1990. Life expectancy for women living in the most deprived region in 2013 was 6.9 years shorter than for those in the least deprived region, an improvement since 1990 when the difference was 7.2 years. (Newton JN et al., 2015)

Gender

- In the UK, mortality is greater in males than in females at all ages.
- In youth and early adulthood, males are more likely to die from motor vehicle accidents, other injury (such as fire and flames, accidental drowning and submersion), and suicide, contributing to higher mortality rates among young men and boys.
- Across the whole of adult life, mortality rates are higher for men than women for all the major causes of death including cancers and cardiovascular disease. However, women have much higher rates of disability than men, especially at older ages. Women have more morbidity from poor mental health, particularly those related to anxiety and depressive disorder (Acheson, 1998).
- WHO (2008) suggests that gender differences in health are a result of both (1) biology and (2) social factors (distinct roles and behaviours of a men and women a given culture, dictated by that cultures gender norms and values).

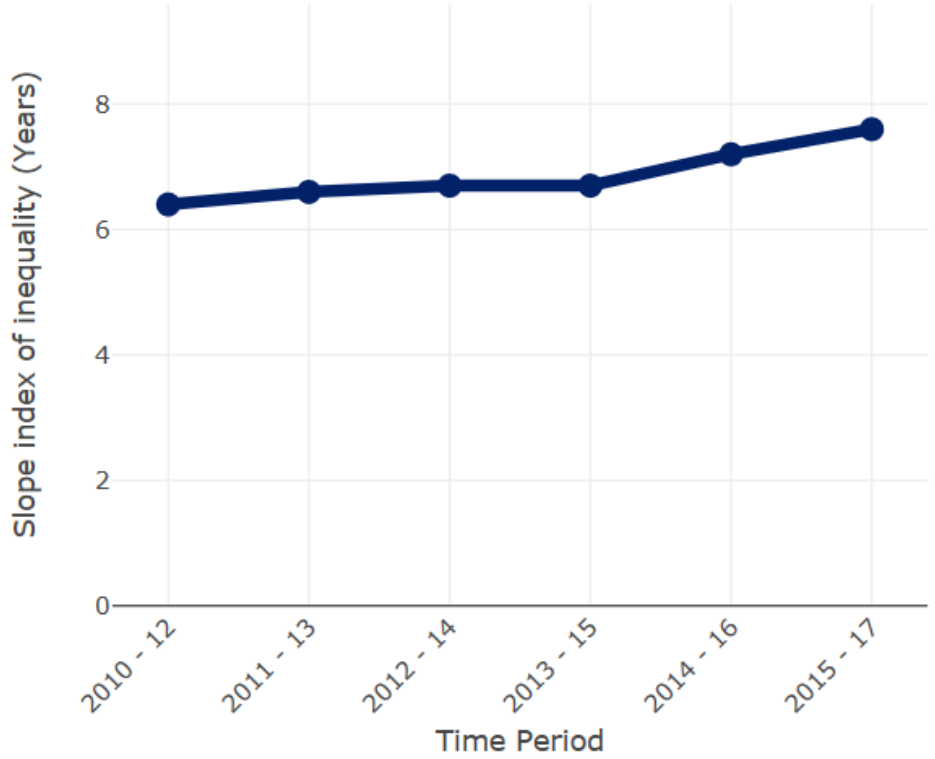
Life expectancy at birth-Male

Hertfordshire

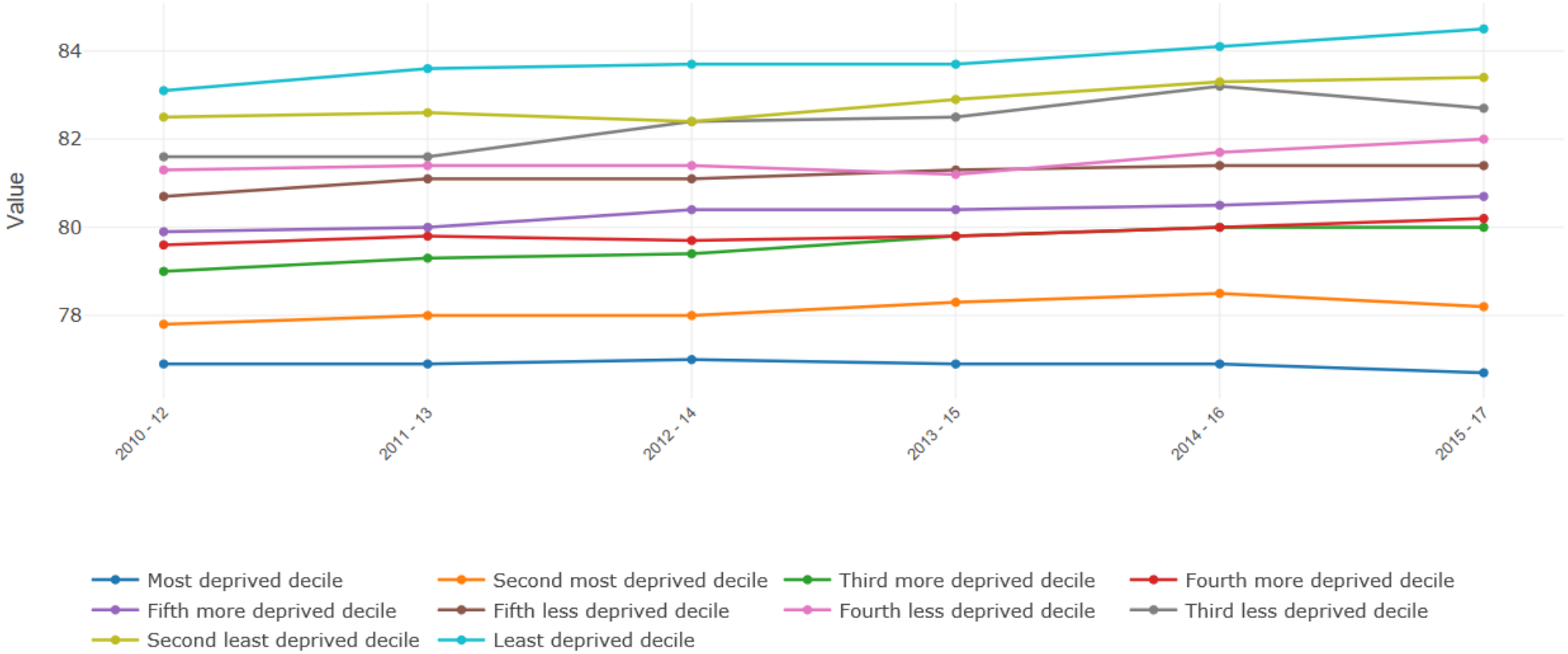


Inequality : Life expectancy at birth-Male

Hertfordshire : Slope index of inequality

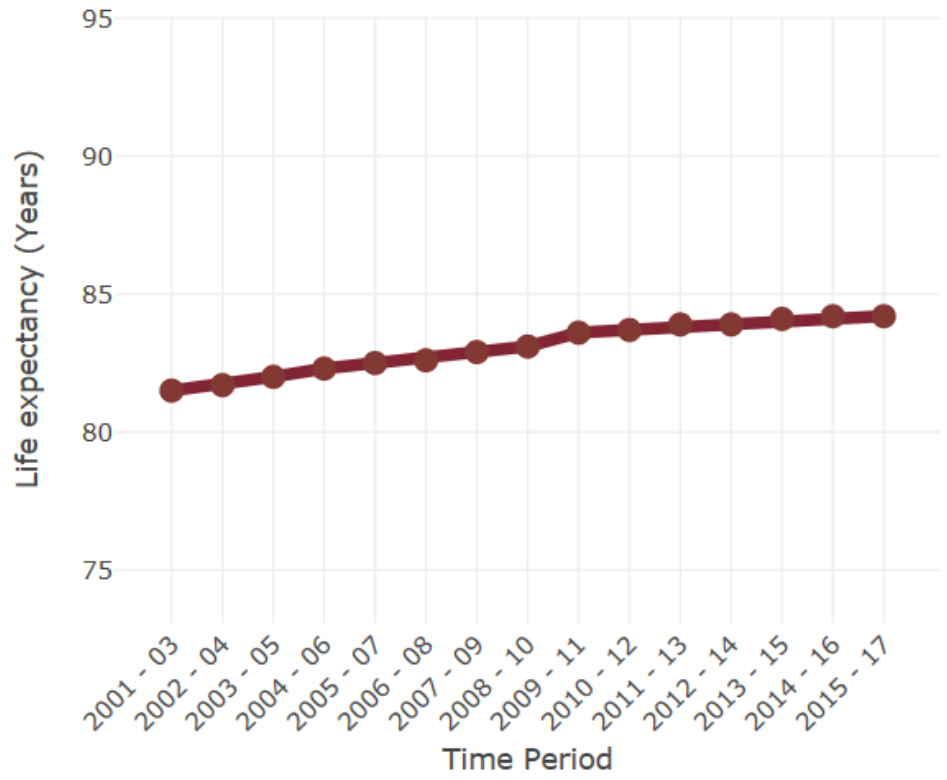


Life expectancy at birth – male
Lower Super Output Area (LSOA) deprivation deciles in west Hertfordshire



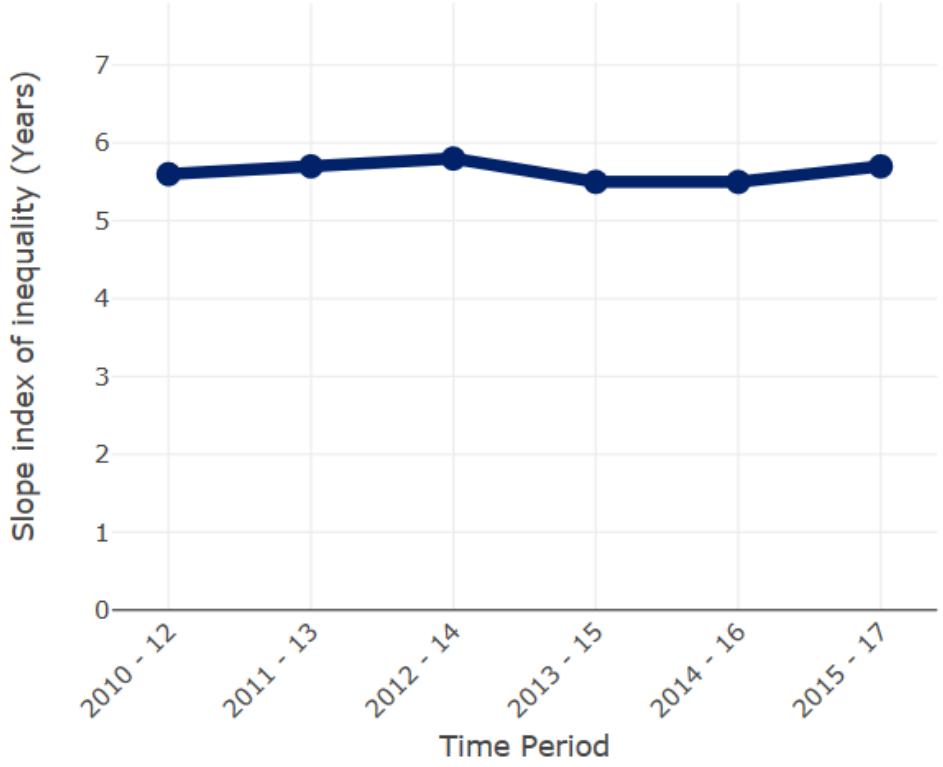
Life expectancy at birth-Female

Hertfordshire

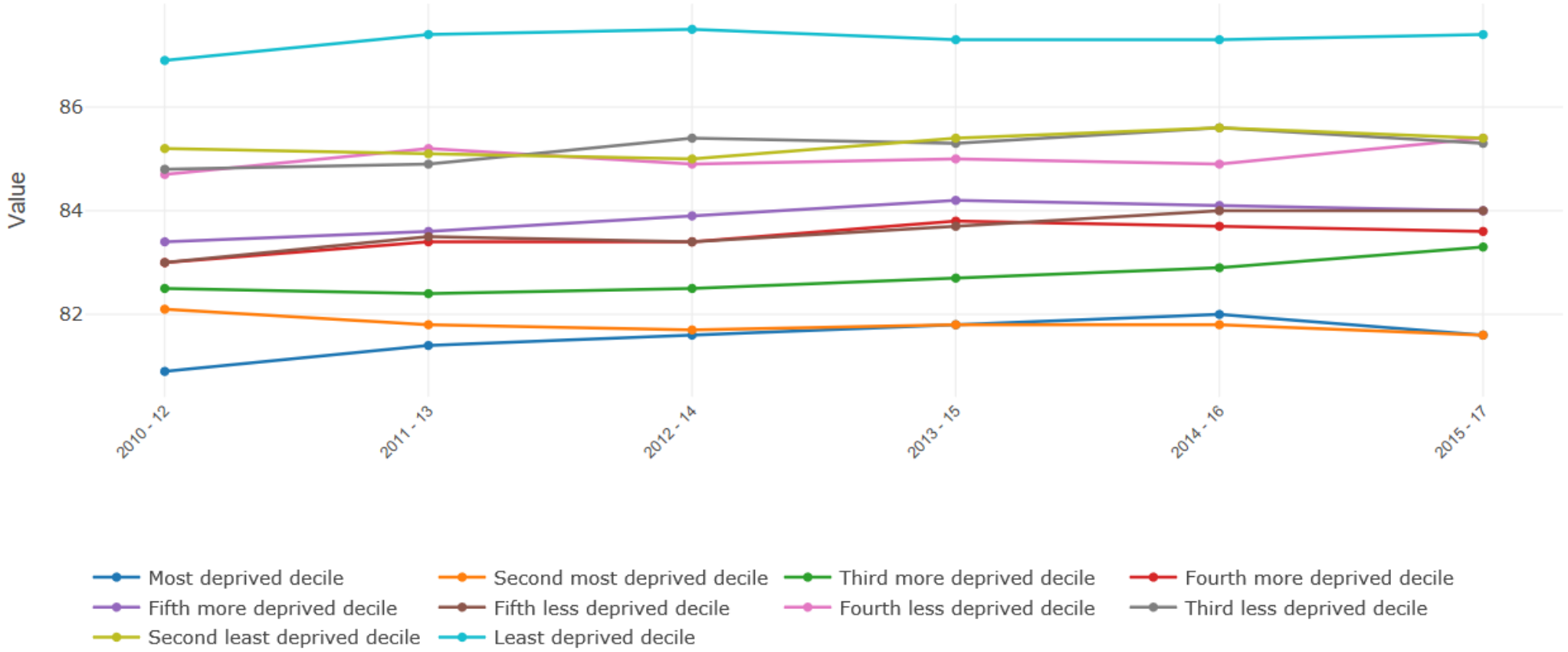


Inequality : Life expectancy at birth-Female

Hertfordshire : Slope index of inequality



Life expectancy at birth – female
Lower Super Output Area (LSOA) deprivation deciles in west Hertfordshire



Ethnicity and Culture

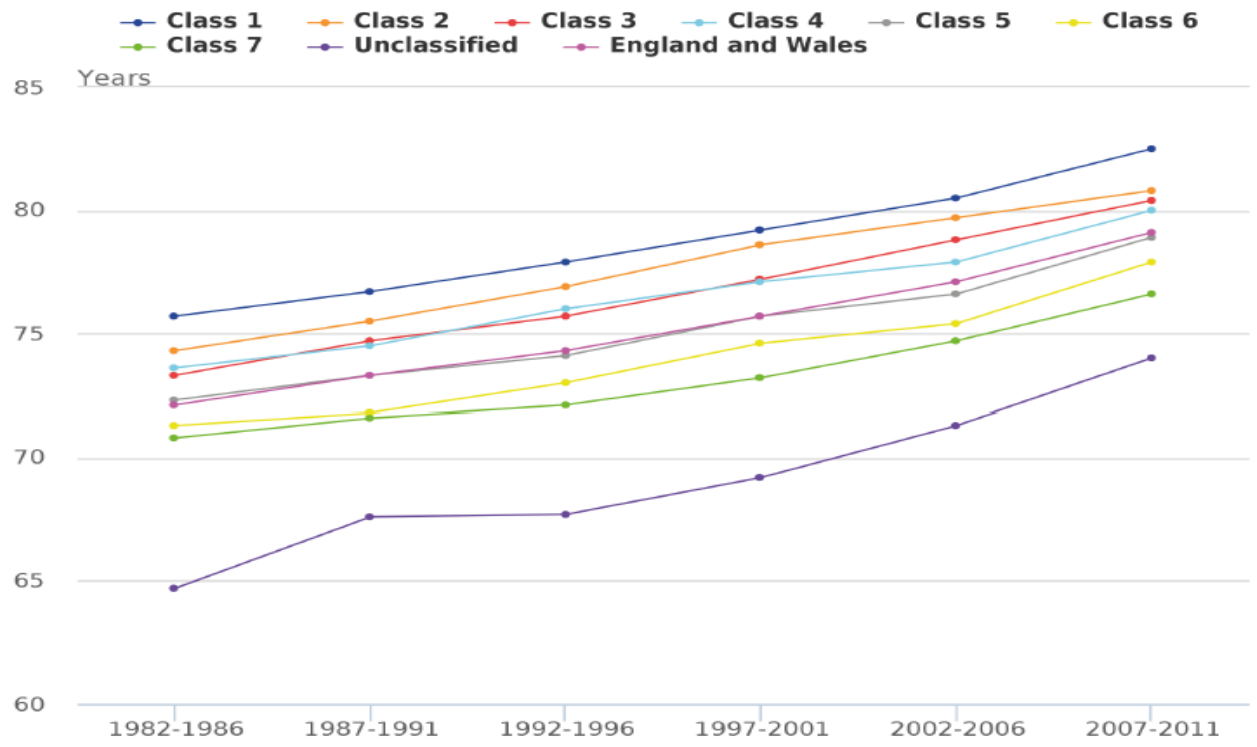
- There is a growing body of evidence documenting ethnic inequalities in health outcomes in the UK, and internationally, despite difficulties with the conceptualisation and measurement of ethnicity as an epidemiological variable.
- Ethnicity is not recorded on UK death certificates, and mortality data uses country of birth as a proxy, thus failing to identify ethnic minorities born in the UK.
- There are some repeatedly documented findings on ethnic inequalities in mortality:
  - Men and women born in the Caribbean have high rates of mortality from stroke. Men born in the Caribbean have low rates of mortality overall and low rates of mortality from coronary heart disease.
  - Individuals born in West/South Africa have high overall mortality rates, high mortality rates from stroke, but low mortality rates from coronary heart disease.
  - Individuals born in South Asia have high mortality rates form coronary heart disease and stroke.
  - Non-white migrant groups tend to have lower mortality rates from respiratory disease and lung cancer but higher mortality rates for conditions relating to diabetes.

Inequalities in health care and its access

- The concept of equity in access to health care (horizontal equity) has been a central objective of the NHS since it began, inequalities in health care access persist. The inverse care law states: The availability of good medical care tends to vary inversely with the need for it in the population served.
- Hard-to-reach groups vary widely: BAME groups, the homeless, asylum seekers, adolescents with eating disorders, not in employment, education or training (NEETs), the elderly, people with medically unexplained symptoms, people with advanced cancers, those with sensory impairments, people with learning disabilities, people with mental health or substance misuse problems, and older people with a variety of physical, sensory, intellectual and mental health difficulties.
- Goddard and Smith (2011) outline reasons for variations in access to health care:

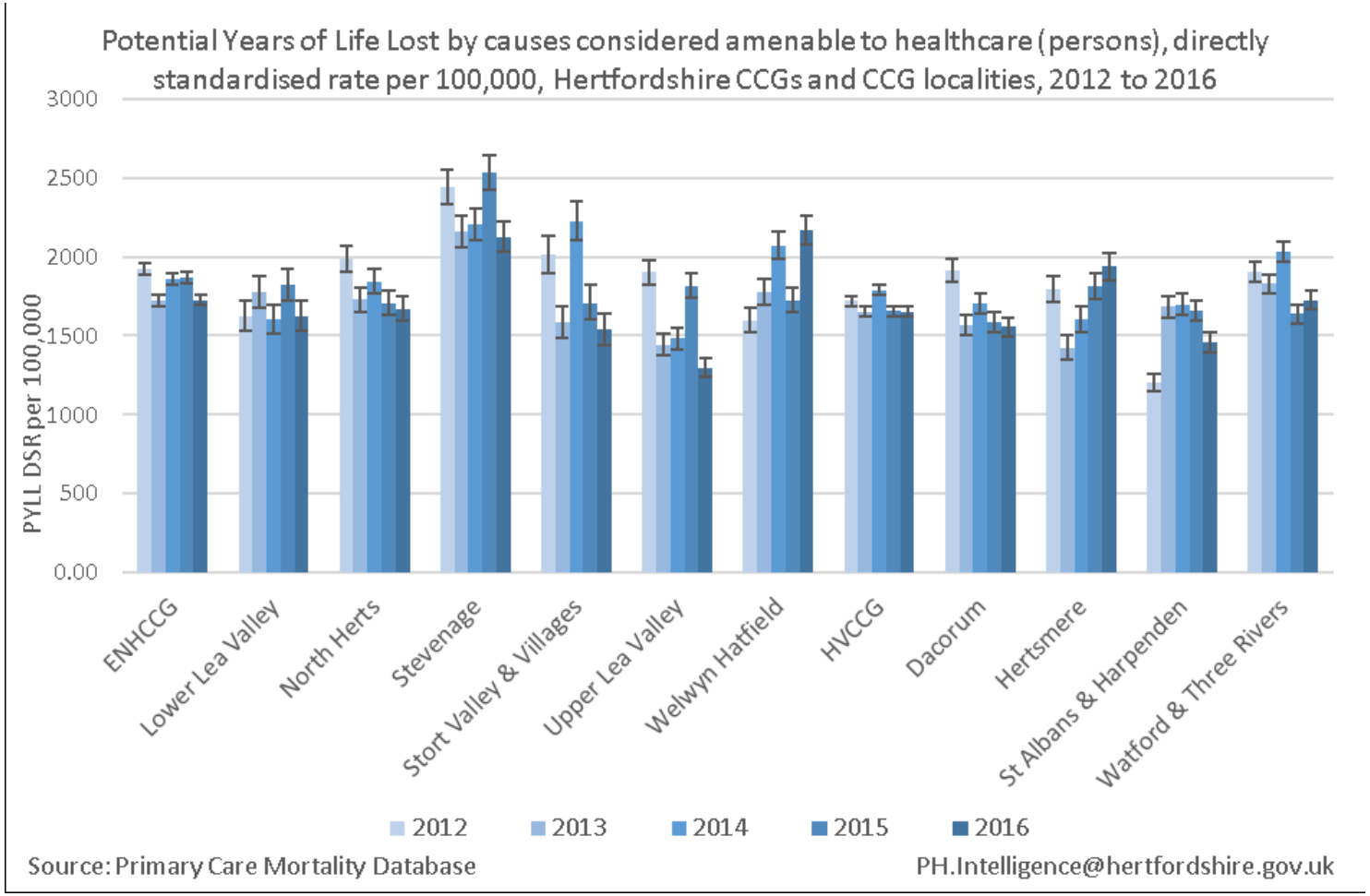
  - **Availability:** Some health care services may not be available to some population groups, or clinicians may have different propensities to offer treatment to patients from different population groups, even where they have identical needs.
  - **Quality:** The quality of services offered to patients may vary between population groups.
  - **Costs:** The health care services may impose costs (financial or otherwise) which vary between population groups.

Male life expectancy at birth for expanded NS-SEC including the unclassified, 1982-6 and 2007-11



Source: ONS Longitudinal Study

I. Class 1: Higher Managerial and Professional; Class 2: Lower Managerial and Professional; Class 3: Intermediate; Class 4: Small Employers Own Account Workers; Class 5: Lower Supervisory and Technical; Class 6: Semi-Routine; Class 7: Routine


Potential Years of Life Lost by causes considered amenable to healthcare (persons), directly standardised rate per 100,000, Hertfordshire CCGs and CCG localities, 2012 to 2016
PYLL DSR per 100,000
3000
2500
2000
1500
1000
500
0.00
ENHCCG
Lower Lea Valley
North Herts
Stevenage
Stort Valley & Villages
Upper Lea Valley
Welwyn Hatfield
HVCCG
Dacorum
Hertsmere
St Albans & Harpenden
Watford & Three Rivers
2012
2013
2014
2015
2016
Source: Primary Care Mortality Database
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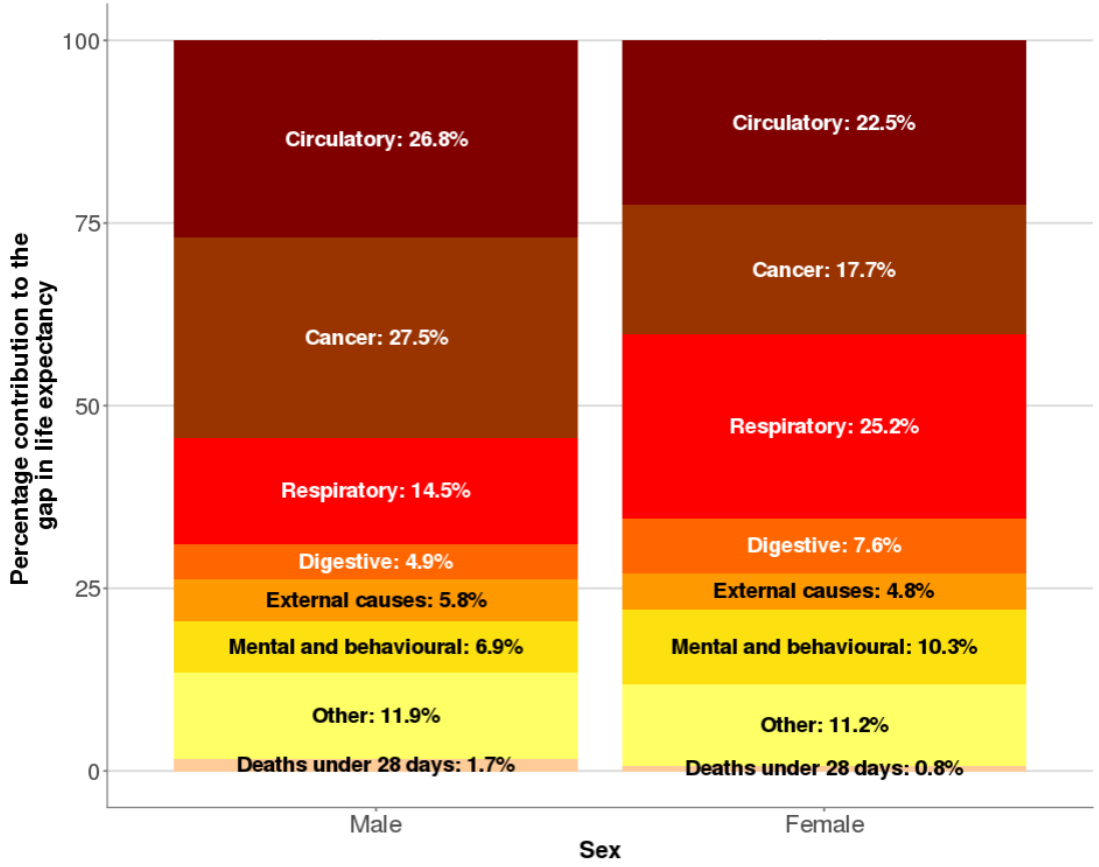
Scarf chart showing the breakdown of the life expectancy gap between the most deprived quintile and least deprived quintile of Hertfordshire, by broad cause of death, 2015-17



Inequalities between areas

- Watford and Three Rivers experienced the poorest outcomes across the selected emergency hospital admission and mortality indicators, whilst St Albans and Harpenden experienced the best. Watford and Three Rivers has the highest overall level of deprivation.
- CCG rates of emergency admissions for acute conditions (considered avoidable), emergency admissions for children with lower respiratory tract infections and potential years of life lost (PYLL) from cerebrovascular and respiratory diseases have all seen statistically significant increases over time, whilst emergency re-admissions within 30 days, PYLL from ischaemic heart disease and premature mortality from cardiovascular disease have all decreased.
- Hypertension (12.5%), obesity (8.1%) and depression (8.4%) have the highest prevalence of the 20 GP QOF registers, in line with national trends. Dacorum has the highest GP recorded prevalence for these indicators.

Hertfordshire Public Health Evidence & Intelligence

Hertfordshire Health Evidence

hertshealthevidence.org

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Significantly Better	Significantly Worse	May Not Be Significantly Different	Significantly Lower	Significantly Higher
Low				High

Hertfordshire districts compared to Hertfordshire

Indicator	Sex	Age	Unit	Period	England	Hertfordshire	Broxbourne	Dacorum	East Hertfordshire	Hertsmere	North Hertfordshire	St Albans	Stevenage	Three Rivers	Watford	Welwyn Hatfield
	Not Compared	Data Unavailable	Where applicable see target for shading details	Produced: 15/07/19 Data as of: 15/07/19	Area Compared To											
Life Expectancy at birth	Females	All ages	Years	2015 - 17	83.1	84.2	85.1	84.3	85.2	84.1	83.5	84.7	82.6	84.2	82.7	84.6
Life Expectancy at birth	Males	All ages	Years	2015 - 17	79.6	81.0	81.2	81.4	81.7	81.4	81.4	81.7	78.4	81.7	79.2	80.7
Premature mortality from all causes	Persons	<75 yrs	per 100,000	2015 - 17	331.9	280.3	275.9	273.0	249.7	288.1	267.1	262.0	372.4	261.2	331.6	286.8
Under 75 mortality rate: cardiovascular	Persons	<75 yrs	per 100,000	2015 - 17	72.5	58.9	63.5	57.3	50.7	58.0	53.0	52.5	80.2	53.7	77.1	62.3
Under 75 mortality rate: cancer	Persons	<75 yrs	per 100,000	2015 - 17	134.6	120.8	108.9	124.6	107.8	116.9	118.3	124.8	155.7	121.8	121.5	121.3
Suicide rate	Persons	10+ yrs	per 100,000	2015 - 17	9.6	7.0	7.5	7.8	5.4	7.9	6.9	6.0	5.3	7.0	9.0	8.7
Killed and seriously injured on roads	Persons	All ages	per 100,000	2015 - 17	40.8	36.1	27.2	32.8	29.4	50.5	43.5	36.0	30.6	35.2	33.1	42.1
Hospital stays for self-harm	Persons	All ages	per 100,000	2017/18	185.5	105.9	88.3	100.9	65.0	127.0	141.6	103.8	131.7	119.9	119.2	97.6
Hip fractures in people aged 65 and over	Persons	65+ yrs	per 100,000	2017/18	577.8	563.7	543.0	596.6	578.1	595.2	615.2	488.2	555.9	529.0	543.9	546.3
Cancer diagnosed at early stage	Persons	All ages	%	2017	52.2	54.6	52.2	58.1	57.0	50.4	55.8	55.9	53.0	52.4	56.0	51.3
Estimated diabetes diagnosis rate	Persons	17+ yrs	%	2018	78.0	73.1	74.8	70.6	67.1	73.1	73.6	64.7	79.1	78.2	93.2	70.3
Estimated dementia diagnosis rate (aged 65+)	Persons	65+ yrs	%	2018	67.5	65.2	50.5	62.8	57.5	67.9	72.3	59.0	75.0	73.8	83.9	62.9
Admission episodes for alcohol-specific conditions	Persons	<18 yrs	per 100,000	2015/16 - 17/18	32.9	20.9	26.1	24.4	16.4	26.1	17.2	20.3	16.8	23.7	25.7	13.4
Hospital stays for alcohol-related harm	Persons	All ages	per 100,000	2017/18	632.3	567.3	579.6	583.9	461.7	607.3	526.5	559.6	592.7	628.2	709.4	537.6
Smoking Prevalence in adults	Persons	18+ yrs	%	2018	14.4	12.0	18.2	14.3	9.9	11.1	8.8	11.0	15.7	14.7	7.4	12.1
Enough physical activity: % of population age 19+	Persons	19+ yrs	%	2017/18	66.3	67.1	59.5	68.3	70.9	63.2	64.4	73.7	60.4	69.8	60.5	73.4
Percentage of adults (aged 18+) classified as overweight or obese	Persons	18+ yrs	%	2017/18	62.0	60.4	70.2	60.7	54.0	60.5	63.2	48.9	64.0	56.9	67.0	63.2
Under 18 conceptions	Females	<18 yrs	per 1000	2017	17.8	11.0	15.6	13.2	7.8	14.0	11.3	8.6	16.3	8.1	6.9	11.5
Smoking status at time of delivery	Females	All ages	%	2017/18	10.8	7.1	8.7	5.8	8.7	5.8	9.2	5.8	8.7	5.8	5.8	8.7
Breastfeeding initiation	Females	All ages	%	2016/17	74.5	77.6	75.1	74.9	80.8	78.2	80.4	84.1	72.6	-	73.9	78.1
Infant mortality	Persons	< 1 yr	per 1000	2015 - 17	3.9	2.8	0.80	3.5	2.5	2.3	2.8	2.6	3.9	1.9	5.0	2.6
Obese children (Year 6)	Persons	10-11 yrs	%	2017/18	20.1	15.2	22.5	16.9	12.0	15.3	13.9	10.6	18.5	15.1	17.2	15.1

Any questions?