REDUCING HEALTH INEQUALITIES

THE CHALLENGE OF PUBLIC HEALTH
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THE EQUALITY EXCHANGE
THINK PIECES

This is one of several essays written for Equality Exchange, a new forum for exchanging ideas, inspiration and skills relating to how public services can contribute to fairer, more inclusive and more equal societies. Equality Exchange was established by the British Council and takes place in the UK and four Nordic countries. Read more about the initiative and download this and other essays here: www.britishcouncil.org/denmark-projects-equality-exchange.htm

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John is our thought leadership expert, crafting our ideas on a whole range of topics related to public-service reform. He is our foremost expert on health innovation and leads our portfolio of health projects. Before joining us John was a policy advisor at the Cabinet Office. He led work on innovation at the Office of the Third Sector and worked at the Prime Minister’s Strategy Unit under the Labour Government.

www.innovationunit.org
Working extensively with public services around the world, we have seen what can be achieved when they operate at their best. They can stand for a world in which our common interests outweigh our competing interests. They can be just, as well as productive. They can provide inspiring visions of a better society, one in which much more so than today – the health and welfare of one person contributes to the health and welfare of others.

So how can we achieve this vision? Various approaches, which we will not go into here, have been tried and have failed. In the UK, inequalities have increased. Nordic countries face inequalities of a similar magnitude. Inequalities in health outcomes, in particular, remain strikingly and stubbornly high. In the UK, those living in the poorest neighbourhoods can expect to experience 17 years of poorer health and die seven years earlier than people from the wealthiest neighbourhoods. The risky behaviours (smoking, drinking excessive amounts of alcohol, eating fast foods) that lead to ill health are unequally distributed according to socioeconomic group.

We now know that unequal outcomes are not just a product of different income and occupation. Assets such as knowledge, networks and social norms matter too. But this is all too often ignored by public-service provision.

Public services at their best recognise these social assets. They do so by drawing heavily on the principles of co-production. Co-production assigns just as much value to those using services as to those delivering them. It draws on assets within individuals and communities so that they are supported to improve their own lives rather than being ‘done to’ by paternalistic services that encourage dependency. The ‘we’ll fix it’ attitude of health services almost exclusively focuses on curing and managing illness rather than supporting people to stay well. If health-service providers build on co-production, they can play a huge role in reducing inequality of outcomes.

The challenge from some is that the approach we advocate founders on the rich-get-richer principle: those who already have strong skills, knowledge and networks benefit most from services designed to work with and enhance these assets. If services are designed to work only with people’s existing assets this is true, which is why services need to actively build and support people’s skills and knowledge, helping to create new networks of which they can play a part. Not only is it possible to draw on these assets in the delivery of public services without exacerbating inequality, no attempt to reduce inequality should be taken seriously without it.

We have seen this operate successfully through our work in health and local government. We draw on the principles of co-production to work with and enhance the assets within people, between people and within communities.

**WORK WITH AND ENHANCE THE ASSETS WITHIN PEOPLE**

We have seen the transformative effect of empowering patients to take more control of decisions about their care. There are a multitude of tools that can support this but they only work if the relationship between the professional and the patient is truly one of equals.

Personal care plans in the UK are a great example. Patients use the information about their health, lifestyle and options for treatment or care to make decisions with their healthcare professional. It addresses people’s personal situation as a whole, recognising that they have needs – not just medical needs – that affect their total health and wellbeing. Our work on People Powered Health (more on this later) saw professionals use these plans to radically shift the focus of the conversation, but this relies on professionals and patients redefining the nature of the traditional doctor-patient relationship.

Services generally are not designed to harness patients’ capacity to look after themselves, but they are missing a trick. Take the wealth of health-related apps on the market that are helping people to look after their own health – they are enablers of healthy living that are being adopted with great effect. Some support people to self-diagnose, such as testing eyesight. Some support self-management, for example a diabetes app connected to an insulin pump. Others support people to improve their general health and wellbeing. Public-health teams could be working with health services, especially GPs, to better integrate comprehensive health and wellbeing services like TicTrac, which provides dashboards of personal data from different sources and helps to motivate people to achieve self-defined goals. Used with personal care plans, services like these can unlock the capacity people have to transform their own lives.

Equality of access to technology is a legitimate concern, but should not be used as a reason for inaction. Rather, it highlights the need for a concerted and systemic effort to both increase access to technology and support people to use it. The only way to help those least well off is to support them to access technology. We must also ensure that the technology, websites and apps used in public services are designed around the people and the outcomes we want. People first; technology follows.

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5. Cellnovo Diabetes app
6. www.tictrac.com
SUPPORTING PEOPLE TO HELP EACH OTHER

Public services mostly operate by connecting people to professionals but pay little attention to connecting people with their peers. Our research shows that professionals and professional settings can alienate the hardest to reach groups in society, who often miss out on vital support as a result. Peers are ‘people like us’, who can be the trusted first port of call to offer non-threatening and non-judgmental help, by providing basic information, signposting to services or directly sharing their own knowledge and skills. An added benefit is their capacity to spend more time with people than their professional counterparts, who are often limited in their resources.

Take pregnancy, for example. Our ethnographic research shows that mums-to-be can feel scared and confused by the mine of information with which they are presented, and are often socially isolated from sources of support to help them through this challenging period. We have worked with mums to offer pregnancy buddies as part of early-years services – peer mentors that support people from conception onwards. These new models overall resulted in an increased reach of 120 per cent, targeting the most vulnerable families, and reduced costs of on average 25 per cent.

Similarly, we used group appointments and an online social-networking tool to connect mums in London as part of MumsPower, building on the lessons from CenteringPregnancy™. CenteringPregnancy™ is a model of group antenatal care that prepares women and their partners for all the physical, psychological and emotional facets of both pregnancy and parenthood. Its content is shaped by mums and their partners so they get exactly what they need. Sessions are interactive rather than didactic, with midwives as facilitators of discussion rather than leaders. In this model of care everyone’s opinions and experiences are valued and listened to. It is particularly effective for mothers who need additional support during their pregnancy, including single mothers and women from more deprived backgrounds.

In Sweden, Koll på Läkemedel is tackling the problems caused by multiple prescriptions for older people. Some 20 per cent of Swedish people over the age of 75 take ten or more different doses of medicine daily. This programme connects them, so they share their experiences and knowledge with each other and receive formal training together. They learn to handle their medication and are empowered to challenge doctors, ensuring they receive appropriate prescriptions and aren’t exposed to unnecessary risks. The programme continues to be successful in reducing medication problems. It is calculated to have saved billions of Swedish krona – hundreds of millions of pounds.

Connecting peers who face similar health challenges is particularly powerful in reducing health inequalities. This can generate much better outcomes and save health services money. The age of professionals as the only source of advice and support is over.

NURTURING ASSETS WITHIN COMMUNITIES

As well as building on capabilities within and between people, public services need to utilise and build on existing community assets. This encompasses formal and informal provision, including church groups, community organisations and voluntary centres, many of which will already provide the sorts of services we talk of here. So much remains untapped in local communities. Public services should be actively shaping the market to encourage their survival, strengthening them as well as knitting them into the local services offered.

This is especially relevant in health, where GPs are the point of contact when first interacting with the health service in the UK. They have been recently urged to tackle inequalities in health by using social prescribing to community resources. The problem is that GPs don’t always have this attitude on resources available.

Frontline workers, including GPs, would benefit from live asset maps that record the local community assets that support healthy lifestyles. The more effectively and simply that this information gets communicated to frontline staff, the more likely they are to use the information with people seeking to improve their health. In Newcastle, a city-wide scheme of social prescribing, using local community assets to help people with long-term conditions has been implemented to great effect.

THE POWER OF COMBINING THESE APPROACHES

These examples demonstrate how harnessing assets within people, connecting them to one another and drawing on resources in communities can each be beneficial, but public services that do all three achieve radically better outcomes.

We worked with Nesta to support six localities around the UK to do just this for people living with long-term health conditions and named it People Powered Health. In the UK, long-term conditions such as Chronic obstructive pulmonary disease (COPD), diabetes and depression affect more than 15 million people and disproportionately affect some of the poorest and most vulnerable people. To see success in reducing health inequalities it is essential we transform how we care for those living with long-term conditions. If People Powered Health innovations were scaled up across England, patients’ quality of life, experience and health outcomes would improve. It is estimated that the NHS would save £4.4bn a year.

To analyse how to put in place these types of approaches to reduce health inequalities in the UK we need first to think about the context in which we are operating – whose responsibility is it?
ALL CHANGE IN ENGLISH HEALTH SERVICES

The Health and Social Care Act 2012 caused a massive and contested upheaval in the organisation of health services. There have been substantial changes to the way the NHS in England is organised. Control has been decentralised so groups of GP practices and clinical commissioning groups (CCGs) receive budgets to buy care on behalf of their local communities.

Within these reforms, responsibility for public health has moved from the monolithic National Health Service to local government. Some functions, including setting national priorities, have remained under central government control via the new national agency, Public Health England (with similar functions to the National Institutes for Public Health in Nordic countries). The majority of funding, £2.7 billion a year, is now under local government control. So who holds the remit for reducing health inequalities?

Within local government, public-health teams have been tasked by Public Health England to achieve the following outcomes: (1) increasing healthy life expectancy and (2) reducing differences between communities in health outcomes.

This change represents a significant opportunity. Local public-health teams will be closer to the levers that can affect social determinants of health, including education, leisure and housing services. However, these vast structural reforms across the NHS and local government that move budgets and decision making closer to communities will have no impact if they are not accompanied by widespread cultural change that sees professionals place more confidence in those communities; if they do they have the capacity to pull on these levers in a powerful way.

However, this change presents a significant challenge. ‘Health’ in its various guises will be spread over two separate sectors, which historically have struggled to integrate. It is essential that public-health teams integrate with traditional health services given that most people’s primary relationship will still be with their GP. Organisations will need to work together in a systematic way, creating networks and consortia to ensure care is connected.

Health and Wellbeing Boards are the UK’s new forums where key leaders from the health and care systems work together to improve the health and wellbeing of their local population and reduce health inequalities. However, if they operate in traditional ways – far removed from the needs of their communities – they are unlikely to succeed where others have failed. To scale models that draw on co-produced approaches they need to themselves operate in this way.

We have worked with Lambeth Health and Wellbeing Board to support them to adopt co-produced and co-designed approaches for their forum. Instead of the traditional model of ivory-tower, board-room decision making, Lambeth are ensuring communities are fully involved in setting the health agenda and taking action to deliver improvement. This approach is key to making a real impact on health outcomes for everyone, especially in the most deprived communities.

Public services today do a great deal to care for people in distress or in trouble; they could do a great deal more to help them improve their lives and help them avoid times of distress and trouble. Public services that build and utilise the assets within people, connect people and foster flourishing communities are the kind that build better societies.
