Health Inequalities

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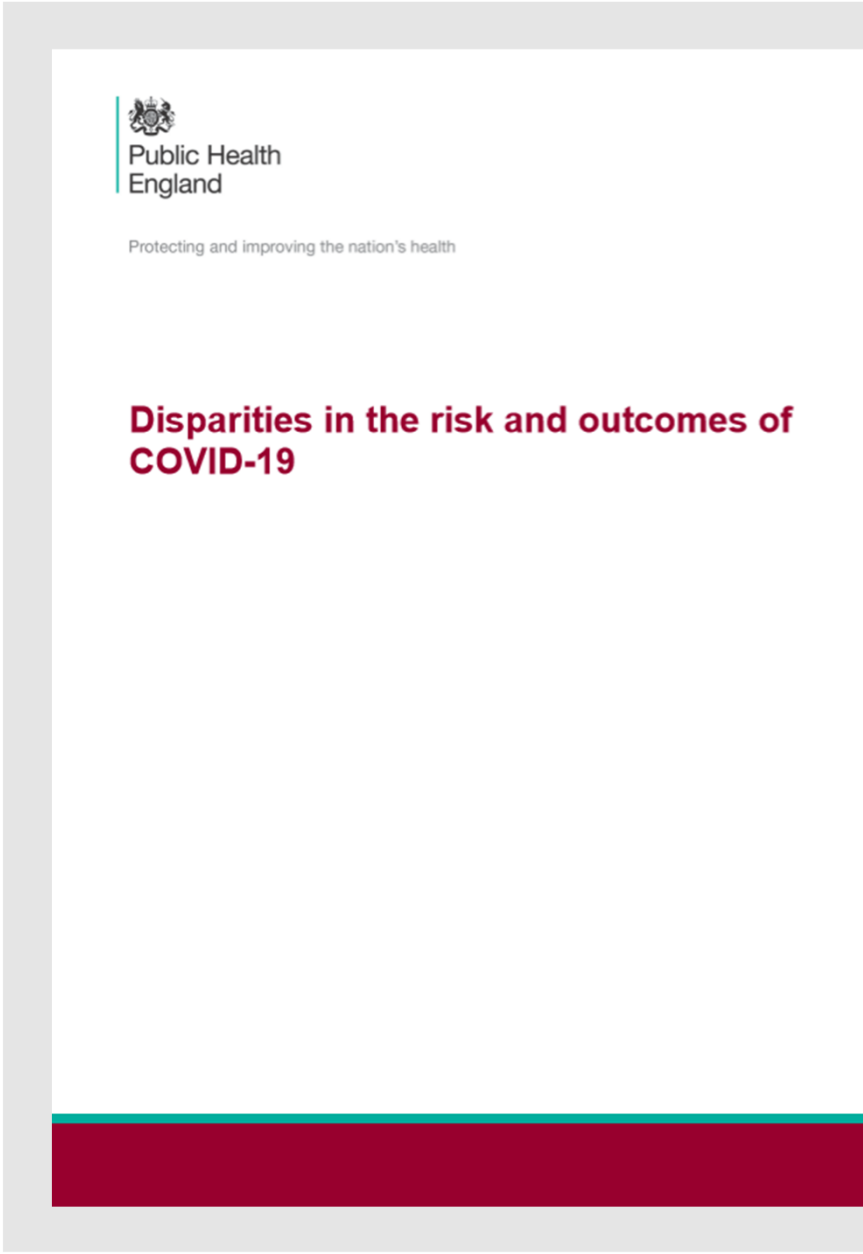
Director of Public health



The system approach

- Health inequalities are unfair and avoidable differences in health across the population, and between different groups within society. Reducing health inequalities is a system-wide priority, with all health and care services taking a lead role.
- People living in deprived circumstances experience poorer health and, on average, die earlier than people in the more affluent areas.
- We will embed health inequalities in strategy development, commissioning and service delivery and invest in communities and groups with the poorest outcomes focusing in the first place on those adversely impacted by COVID. Our inequalities symposium will provide the leadership forum for transforming this area of work
- Priorities for Integrated Care System:
    - Reducing the disparities impact of COVID through targeted and system wide work
    - reducing the gap in life expectancy between the most and least deprived areas through embedding focused work on tackling health inequalities in acute and community Trusts partnering with Local Authorities.
    - reduce mortality for people with severe mental illness or a learning disability and autism
    - development of trauma informed approaches across the system for all ages and reducing the impact of adverse childhood experiences which lead to poor health outcomes

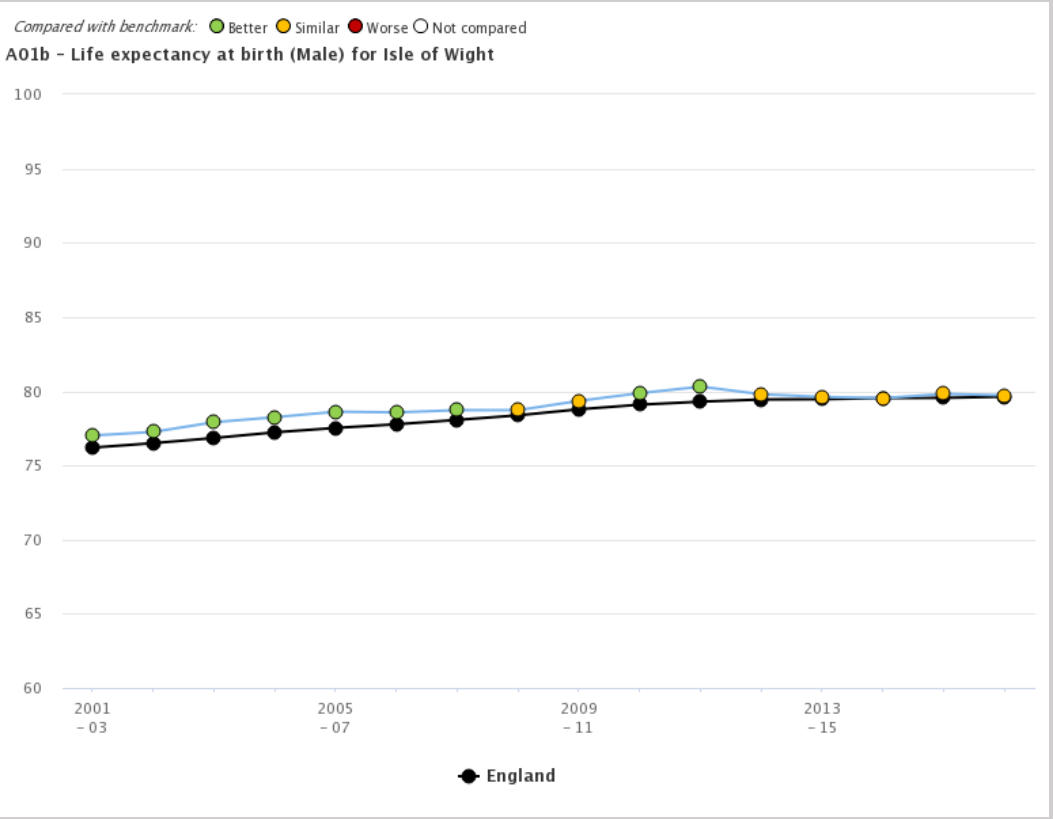
Health and Wellbeing strategy

‘Hampshire is a great place and generally our population is healthy with good life expectancy. However, outcomes are not as good for some people as they could be. A key feature of this strategy is our ambition to continue to narrow the gap between those with the best and worst health and wellbeing. This means paying attention to the ‘wider determinants of health’, such as housing, education, employment, community safety, and the physical environment just as much as we do to traditional health and care services’

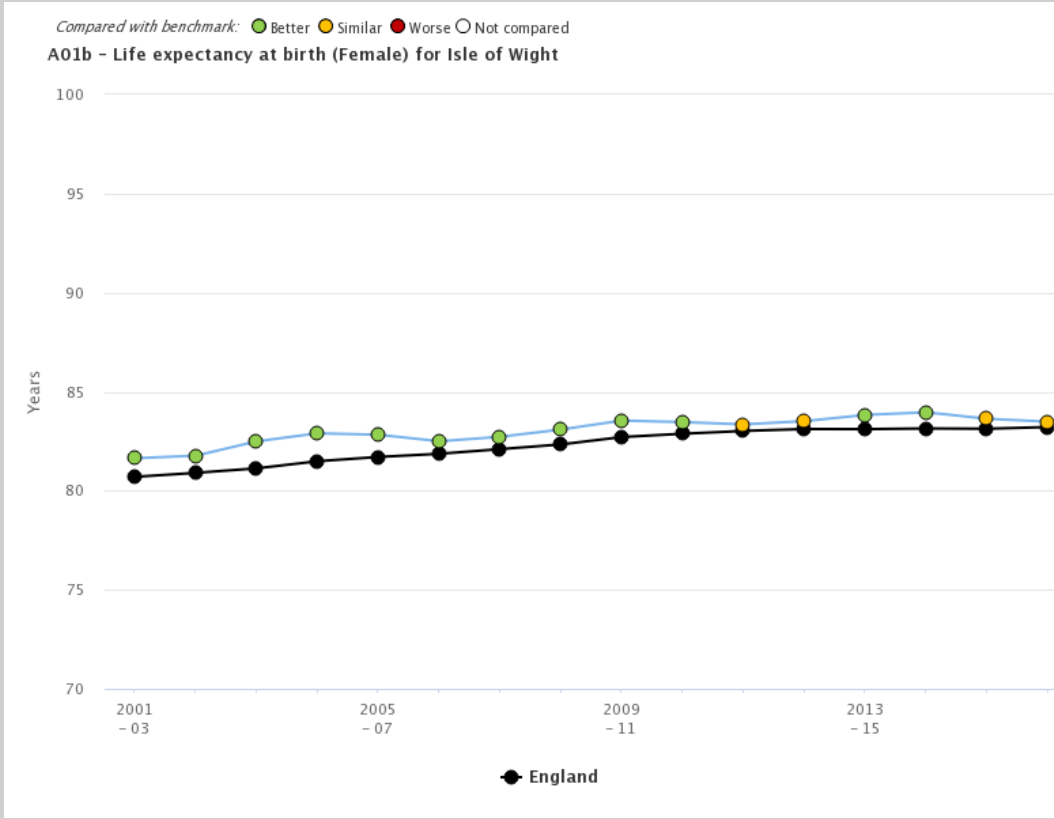
The Health and Wellbeing Board’s vision is to enable people in Hampshire to live long, healthy and happy lives, with the greatest possible independence. We want to narrow the gap in life expectancy and improve healthy life expectancy. In simple terms, we want to ensure that those living longer are also healthier for longer

fe expectancy

Males

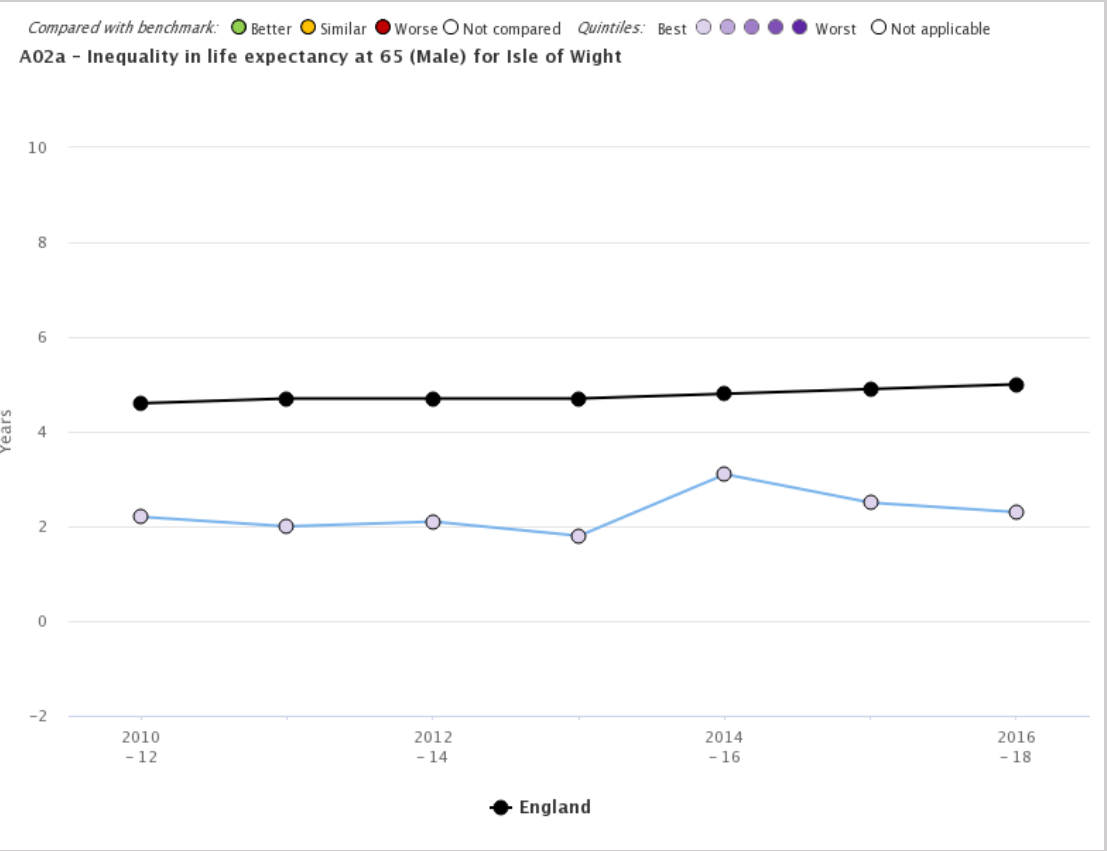


Females

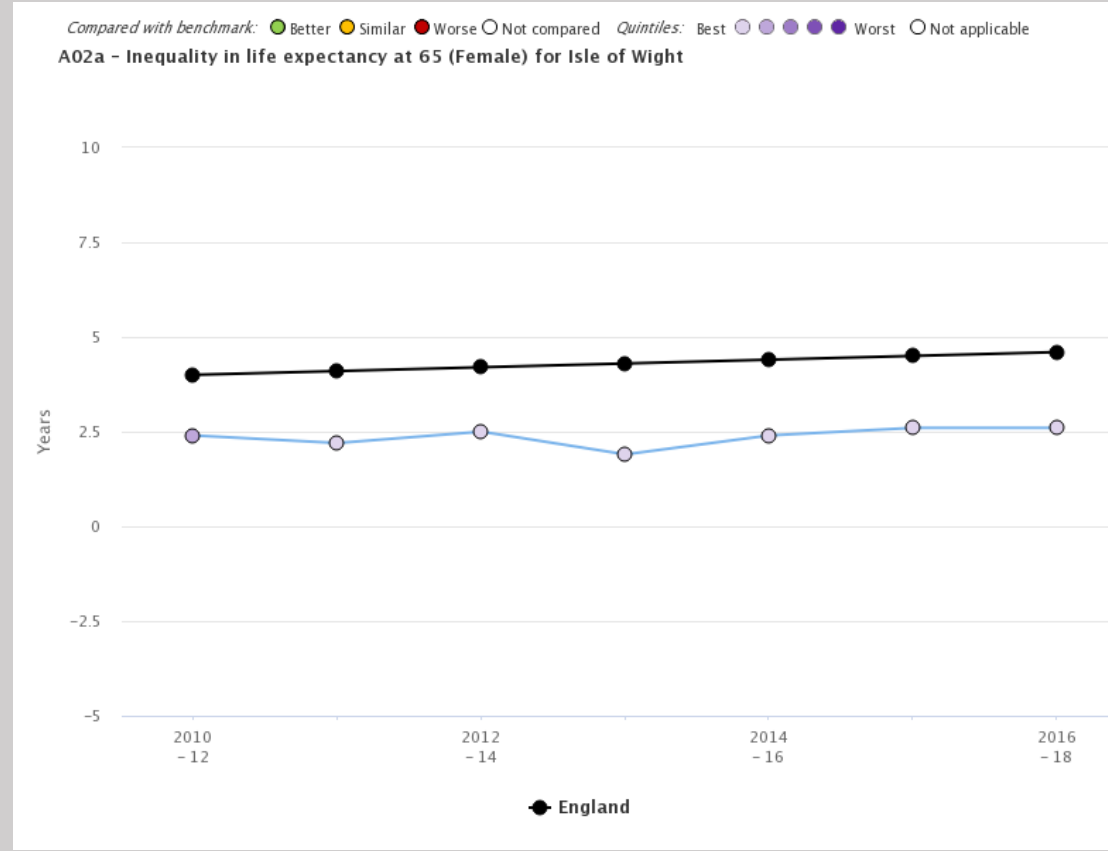


Inequality in life expectancy at 65

Males

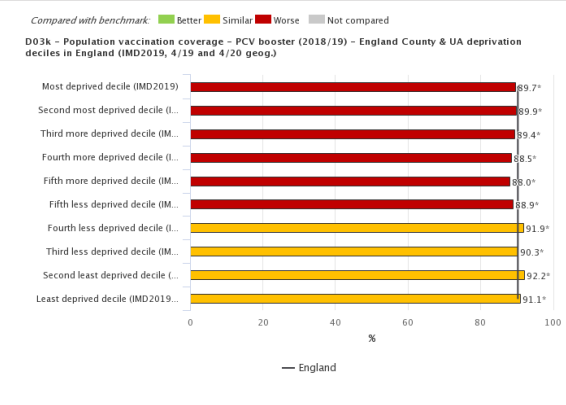


Females

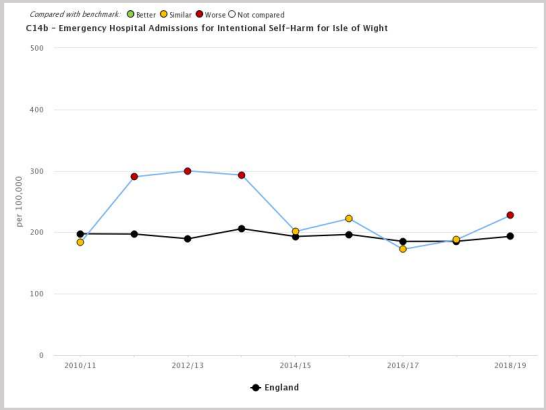


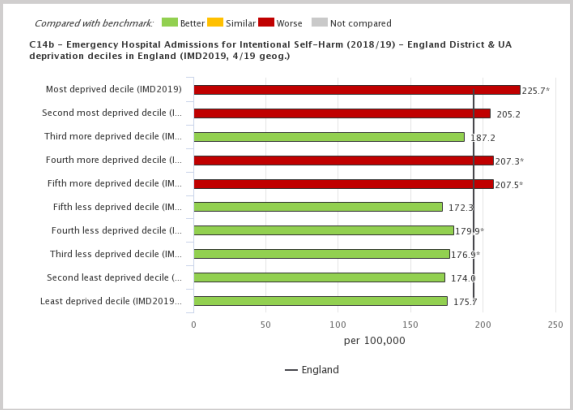
arting Well

lation vaccination coverage - PCV booster

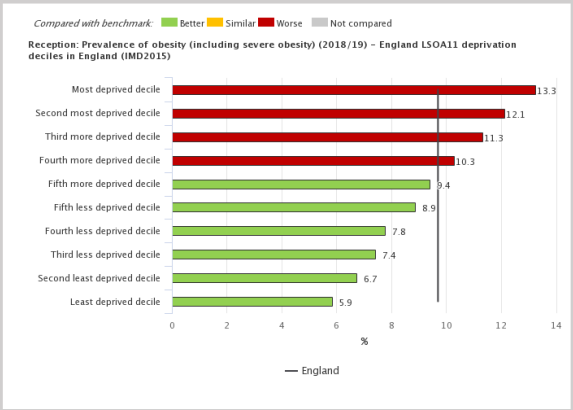


Emergency Hospital Admissions for Intentional Self-Harm

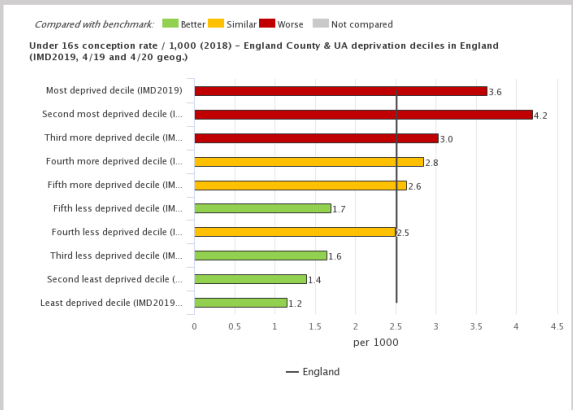




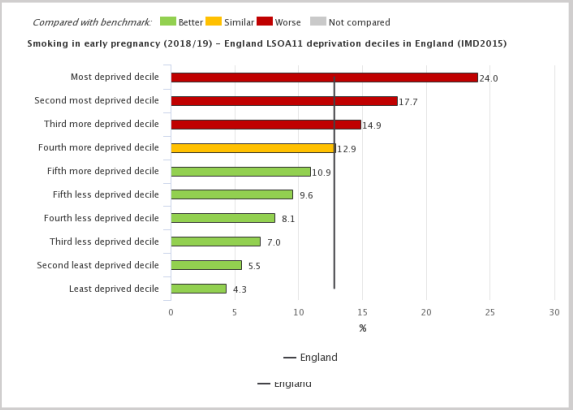
ption: Prevalence of obesity
uding severe obesity)



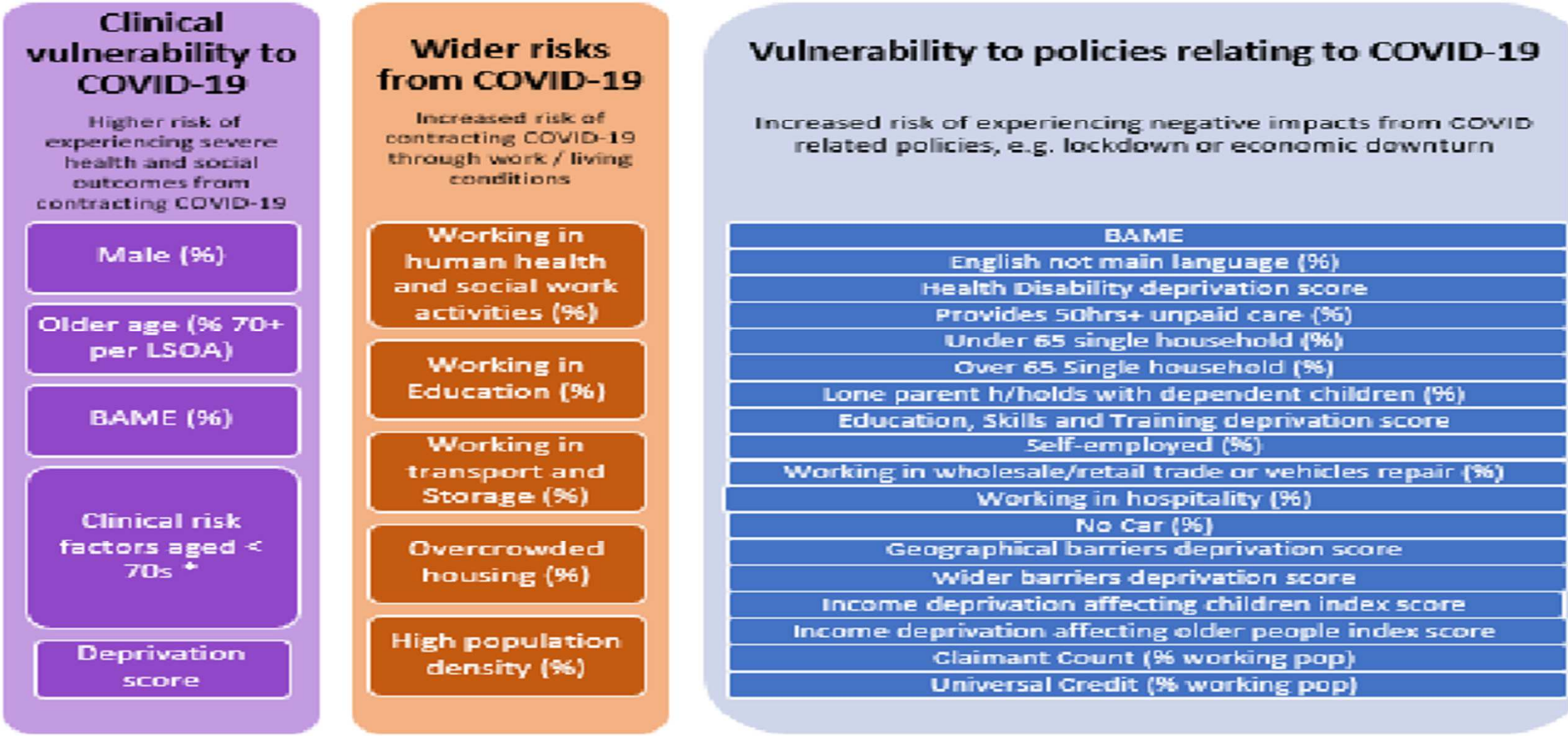
Under 16s conception rate / 1,000



Smoking in pregnancy

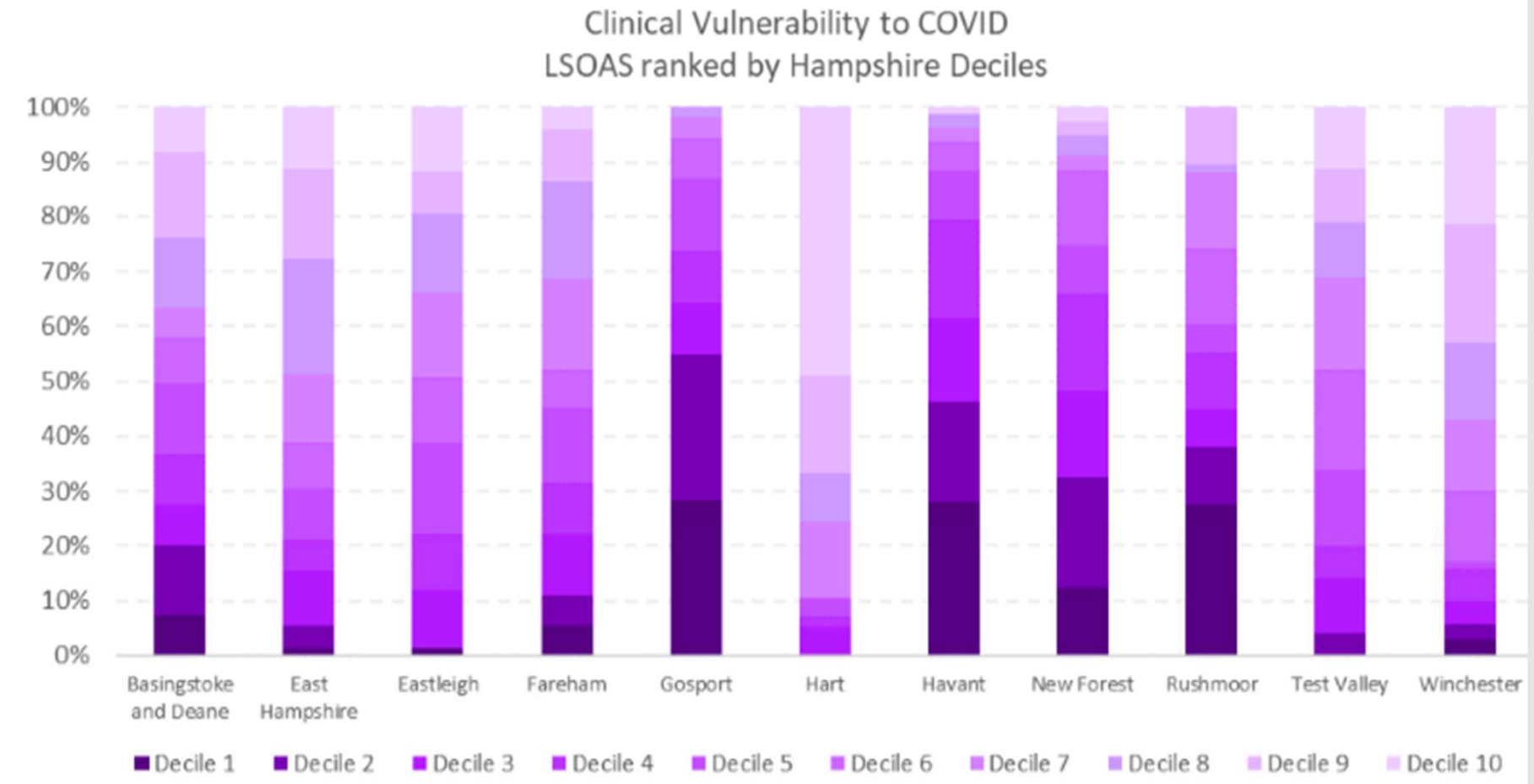


2. COVID-19 Vulnerability Indices



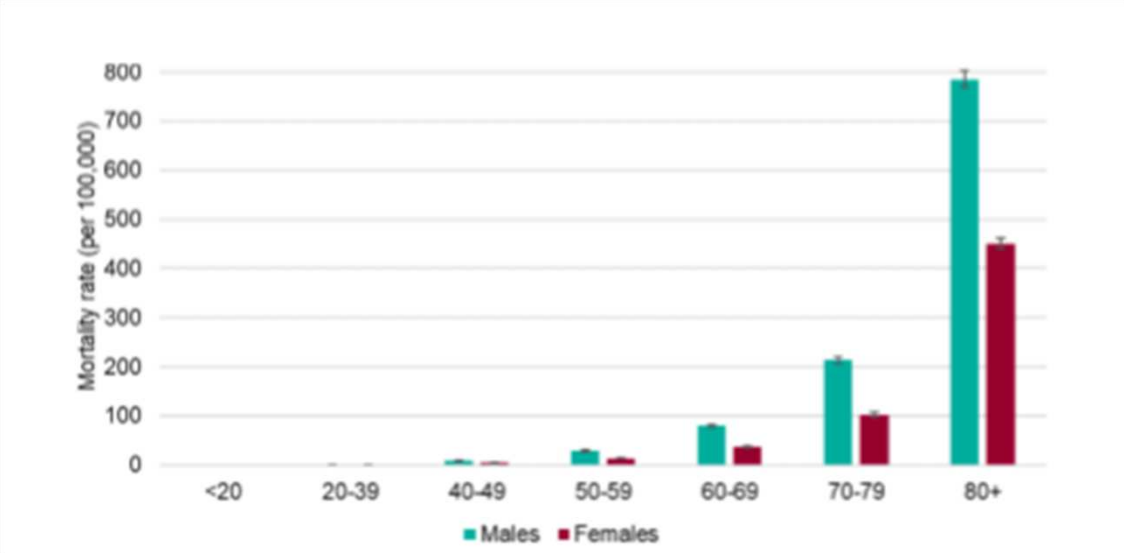
ttps://documents.hants.gov.uk/public-health/jsna-covid19/Vulnerabilities-report.pdf

Chart 1: Clinical risks to COVID-19 by district



Age and sex – COVID differences

- Diagnosis rates are higher among females under 60, and higher among males over 60. Despite making up 46% of diagnosed cases, men make up almost 60% of deaths from COVID-19 and 70% of admissions to intensive care units.
- The rate of diagnosed cases increases with age, but the age profile is markedly different among those in critical care. The largest number of patients in critical care come from age groups between 50 and 70 for both males and females and only small numbers aged over 80.
- Working age males diagnosed with COVID-19 were twice as likely to die as females.



is not yet fully clear what drives the ifferences in outcomes between males and emales. Some could be driven by different risks f acquiring the infection – for example due to ehavioural and occupational factors – and by ifferences in how women and men develop ymptoms, access care and are diagnosed, or by iological and immune differences that put men t greater risk.

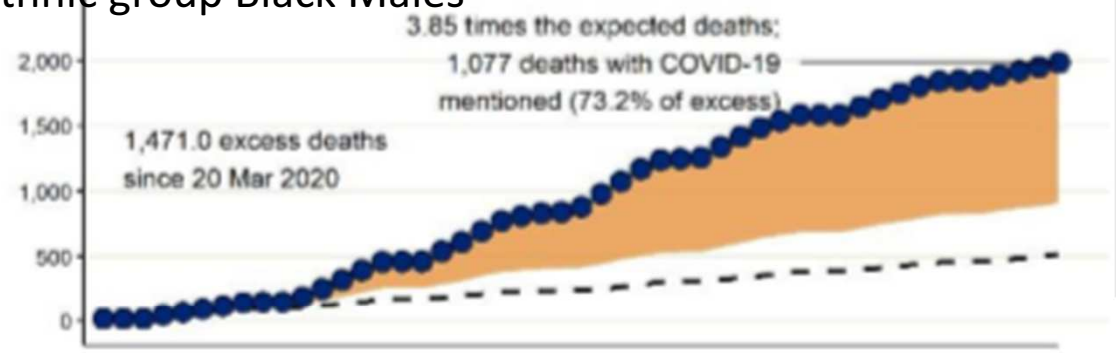
Deprivation

- The trend in the number of diagnosed cases by deprivation quintile shows that cases in the least deprived group peaked earlier and lower than other groups.
- The mortality rates from COVID-19 in the most deprived areas were more than double the least deprived areas, for both males and females.
- Survival among confirmed cases, after adjusting for sex, age group, ethnicity and region was lower in the most deprived areas, particularly among those of working age where the risk of death was almost double the least deprived areas.
- In summary, people in deprived areas are more likely to be diagnosed and to have poor outcomes following diagnosis than those in less deprived areas. High diagnosis rates may be due to geographic proximity to infections or a high proportion of workers in occupations that are more likely to be exposed. Poor outcomes remain after adjusting for ethnicity, but the role of underlying health conditions requires further investigation.

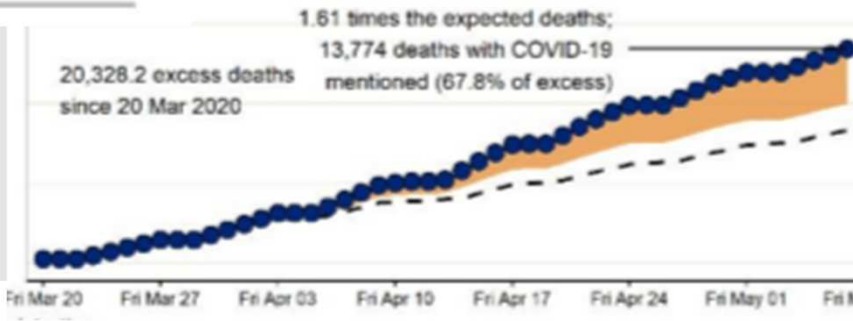
Ethnicity

- The highest age standardised diagnosis rates of COVID-19 per 100,000 population were in people of Black ethnic groups (486 in females and 649 in males) and the lowest were in people of White ethnic groups (220 in females and 224 in males).
- An analysis of survival among confirmed COVID-19 cases shows that, after accounting for the effect of sex, age, deprivation and region, people of Bangladeshi ethnicity had around twice the risk of death when compared to people of White British ethnicity. People of Chinese, Indian, Pakistani, Other Asian, Black Caribbean and Other Black ethnicity had between 10 and 50% higher risk of death when compared to White British.
- Comparing to previous years, all cause mortality was almost 4 times higher than expected among Black males for this period, almost 3 times higher in Asian males and almost 2 times higher in White males. Among females, deaths were almost 3 times higher in this period in Black, Mixed and Other females, and 2.4 times higher in Asian females compared with 1.6 times in White females.

Ethnic group Black Males



Ethnic group White Females



To note These analyses were not able to include the effect of occupation.
These analyses were also not able to include the effect of comorbidities or obesity.

Co-morbidities

- Among deaths with COVID-19 mentioned on the death certificate, a higher percentage mentioned diabetes, hypertensive diseases, chronic kidney disease, chronic obstructive pulmonary disease and dementia than all cause death certificates.

Ageing Well

- There is powerful evidence of gender inequalities in financial insecurity in later life, with women facing specific and enduring challenges related to their ability to save for retirement.
- Several studies focus on older people's access to and use of health care services, pointing to chronological age being a barrier to treatment for a range of physical and mental health conditions.
- Where you live is another influential factor, with older people living in disadvantaged areas having less access to health care than those living in more affluent communities

Actions

- For the NHS each organisation and programme has identified an inequalities and prevention executive or equivalent to lead reduction in inequalities in each organisation including ensuring the voice of under represented groups is heard.
- Work through Health and Wellbeing Boards, local authorities and third sector partners to reduce health inequalities through improving wider determinants of health
- We will continue to use data and population health management to identify health inequalities, to understand how outcomes compare with peers and reduce unwarranted variation in access, quality and outcomes. Health Equity Audits will be embedded in the system.
- We will refocus our healthcare provision to take into account the specific needs of those facing health inequalities. Targets will be agreed across HIOW partners and integrated across all work areas to reduce future demand across the health and care system.