Health Inequalities Inquiry

Chest, Heart & Stroke Scotland Supplementary Evidence

Introduction

Chest, Heart & Stroke welcomes the inquiry by the Health and Sport Committee, and the Report of the Ministerial Task Force, *Equally Well*. We recognise that this reflects the commitment of both the Scottish Parliament and Government to tackling health inequality, which remains central to further improvement of the overall health of our population. We are grateful for the opportunity to contribute to this important debate.

We would also wish to commend the real progress which has been made in recent years in improving the life expectancy and quality of life of the most disadvantaged in society. Two particular initiatives have, in our view, both demonstrated cross-party and cross-departmental commitment to addressing inequality, and contributed significantly to progress in this area, i.e.:

- The ban on smoking in public places, the benefits of which are likely to be felt most amongst the most disadvantaged in society, who are most likely to be smokers; and

- The *Keep Well* programme, the first substantive national programme of anticipatory care targeted specifically at cardiovascular disease in the most economically deprived areas of Scotland.

Nevertheless we have to recognise that sustained success in actually reducing inequalities in health remains elusive, particularly in relation to socio-economic status. This was highlighted internationally in the recent World Health Organisation Commission report *Closing the gap in a generation: Health equity through action on the social determinants of health*. This highlighted a 28-year gap in male life expectancy at birth between areas of Greater Glasgow less than 10 miles apart – a graphic illustration of the scale of the problem still to be tackled.
Recommendations in *Equally Well*

The wide range of recommendations in *Equally Well* reflects the multi-factorial basis of inequalities in health, and specifically in cardiovascular disease. The National Health Service cannot be solely, or even primarily, responsible for tackling these. Health inequality is inextricably linked to variation in socio-economic status, as demonstrated not just in Scotland but internationally by the WHO Commission. At a societal level, progress in reducing inequality in cardiovascular health depends on further improvement in Scotland’s most deprived communities in widening access to educational and employment opportunities, good quality housing, an enhanced physical environment and other determinants of quality of life.

The recommendations in *Equally Well* recognise the need for action across Government and between Central and Local Government, the voluntary sector and community organisations. If implemented in a comprehensive, integrated and sustainable manner, they offer a real opportunity to make progress. On the basis of our experience in working on the ground in communities throughout Scotland, including our most disadvantaged areas, Chest, Heart & Stroke Scotland would comment on specific recommendations as follows:

- **Recommendation 11** – CHSS operates an exercise programme in schools, and our experience indicates that, if approached in an innovative and imaginative manner (e.g. using dance rather than ‘traditional’ exercises) young people can be encouraged to adopt a more active lifestyle.

- **Recommendation 18** – in partnership with Citizens’ Advice Bureaux, CHSS provides benefits advice services in the two NHS Board areas with the greatest concentration of deprivation (Greater Glasgow & Clyde and Lanarkshire). Our experience over more than a decade indicates that there is substantial under-claiming of means-tested benefits by people with CVD, particularly those with disabilities following stroke.

- **Recommendation 22** – our experience of working with younger people affected by stroke indicates a significant potential for increased support to enable people with stroke-related disability to access educational, training and employment opportunities.

- **Recommendation 46** – CHSS endorses the approach of targeted anticipatory care taken by the *Keep Well* and *Well North* programmes. To genuinely impact on inequality, these have to focus on individuals and families, not just on areas.
Recommendation 55 – oral health is a significant issue for people affected by stroke and CHD, and if neglected can lead to significant complications and reduced outcomes.

Implementation of recommendations, and impact of anticipatory care

CHSS supports the commitment of the Scottish Government Health Directorates (SGHD) to the Keep Well programme. However, we feel there are three major issues in the implementation of Keep Well which need further consideration. These are:

- How to ensure that the focus is not just on deprived areas, but on those individuals in the poorest circumstances at greatest risk of developing CHD and stroke

- The age range (45-60) may be inappropriate for the most deprived communities, where risk factors for CHD and stroke may be established much earlier in life

- The sustainability of the programme beyond the current funding commitment - experience from elsewhere (e.g. Finland) shows that tackling these issues requires a commitment over decades rather than years

Whilst there is no evidence of inequality in outcome once people receive NHS treatment, a significant factor in variation in outcome is difference in time of first accessing the NHS. A contributory factor to this variation is difference in levels of awareness of symptoms and risk factors. This applies in particular to stroke. A survey undertaken by CHSS in 2007 revealed that one in three Scottish adults were unable to recognize any of the most common symptoms of stroke. Furthermore, the proportion was even higher amongst the over 65’s (most likely to be affected), and those from the more socially deprived areas.

CHSS have therefore undertaken a national awareness campaign to help the public identify the symptoms of stroke and seek appropriate treatment (Face Arm Speech Test – FAST). This achieved considerable coverage, and we are now working with three NHS Boards to undertake follow-up campaigns. We would like to work with SGHD on targeted local campaigns, particularly in the Keep Well areas.

At a more general level, there is scope to develop tools to facilitate greater public access to health information. CHSS are working with others on a health information literacy package, to assist health professionals in improving access to patient-usable information.

CHSS are committed to patient involvement on all of our activities, and also believe this approach is fundamental to tackling inequalities. The people most
affected are patients, and it is important that the patient perspective is involved in moves to identify and reduce inequality.

Traditional approaches to patient involvement have tended to generate a disproportionate representation from those with a professional background and above-average educational status. CHSS believes the means of securing a more inclusive representation is to provide a programme of training and support for potential “patient representatives”, and to make this as accessible as possible, particularly to traditionally under-represented groups.

Over the past two years, in partnership with The British Heart Foundation, we have successfully piloted this approach in CHD work with the Hearty Voices Scotland programme. This has now been offered in every NHS Board in Scotland, with the aim of enabling meaningful patient involvement of people with direct experience of CHD in managed clinical networks and other service planning groups.

We now plan to extend this to people affected by respiratory illness and people affected by stroke. Again, we will make the programme as inclusive as possible and ensure that people from traditionally under-represented areas are involved. CHSS are particularly grateful for the financial support from SGHD, which has enabled us to expand this programme.

CHSS participated in the production and dissemination of the 2007 SIGN guidelines on prevention and treatment of heart disease. The ASSIGN risk assessment framework, developed by SIGN, offers the opportunity to specifically target enhanced treatment at those from socially deprived areas. CHSS endorses this unique Scottish approach, which offers a real opportunity to reduce inequalities in incidence of coronary heart disease.

Using a broad definition of anticipatory care, CHSS would argue for increased investment in community-based rehabilitation programmes. Cardiac rehabilitation, for example, is a highly cost-effective means of reducing subsequent cardiac and stroke events, and is highly appreciated by patients. However, more needs to be done to develop innovative approaches to improve access to programmes, including by people in deprived areas and remote and rural communities, women, and people from ethnic minorities.

Provision also needs to be extended to a wider group of patients than those currently offered the service – primarily those who have suffered a heart attack or undergone bypass surgery. Cardiac rehabilitation can also be beneficial for people treated on a non-emergency basis, and, in an adapted form, for people affected by heart failure and stroke.
Practical barriers

Chest, Heart and Stroke Scotland would wholly support the analysis in Volume 2 of *Equally Well*, particularly the Briefing Paper on Health Inequalities (Professor Macintyre), which demonstrates clearly some of the practical barriers which reduce the effectiveness of general approaches to health promotion. Even programmes which are effective at a population level, for example on smoking, diet and exercise, can have the unintended consequence of increasing inequalities through differential takeup of the message amongst different socio-economic groups.

More innovative methods of ‘getting the message across’ are clearly required, learning lessons from other sectors, making greater use of intermediaries, and using a social marketing approach. Within CHSS, for example, we have supported a variety of health information initiatives, ranging from action through street football aimed at homeless young people, to funding of schools theatre productions in disadvantaged areas, to information aimed at traditionally excluded groups, such as those with communication difficulties.

The underlying fact remains, however, that the major practical barrier to reducing inequality in health is socio-economic deprivation. This is a function not simply of low income and material poverty, but also of poverty of hope and aspiration, and of life expectations.

Resource implications

It appears unlikely that the full range of interventions required to make a sustained impact on reducing inequalities can be funded from existing NHS resources, given the enormous range of competing demands, the continuing development of new (often expensive) treatments, and rising expectations of health care.

In any event, CHSS would argue that health inequality arises from, and impacts upon, all areas of society, not just health. Government therefore needs to look at investment in reducing inequalities on a holistic basis and not simply, or even primarily, as a function of health expenditure.

Within the specific area of NHS expenditure, there may be capacity to redirect resources from general, population-level information activities to interventions targeted more specifically at the most disadvantaged groups, making use of the innovative approaches noted above. There is also scope for investment channelled through voluntary organisations working on the ground, who have the capacity to target resources more precisely, and also to attract additional investment from other sectors to supplement pump-priming resources from Government.
Other related issues

As *Equally Well* makes clear, one of the most effective ways of reducing inequality is regulatory action, which can be more effective than, for example, population-based health education campaigns in directly reducing unhealthy behaviour amongst the most disadvantaged in society. A good recent example would be the ban on smoking in public places, which is likely to have a disproportionately positive effect on the cardiovascular health of the groups in society with the highest current rate of smoking, i.e. those with lowest socio-economic status.

One area where there may be scope for further regulatory action is in content of processed foods. Due to difficulties of access to affordable fresh foods and the costs of food preparation, young families, older households and others living in deprived areas are likely to make greater use of processed and takeaway meals. This tendency is likely to be exacerbated by rapidly-rising gas and electricity prices. These foods tend to be high in saturated fat, salt and sugar content – all of which are detrimental to cardiovascular health. The Scottish Government should evaluate initiatives taken overseas to control food content, and identify lessons which could be applied in Scotland.