

BRIDGING THE GAPS:

Tackling inequalities in cardiovascular disease





About our charity

HEART UK is the nation's cholesterol charity and aims to prevent premature deaths caused by high cholesterol and cardiovascular disease. The charity works to raise awareness of the risks of high cholesterol, campaigns for better detection of those at risk, develops and provides materials and a telephone advice line for the public, and supports health professional training.

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Foreword

Sir Michael Marmot, Professor of Epidemiology and Public Health, University College London Institute of Health Equity

Tackling health inequalities is an integral part of creating a fairer and healthier society. Inequalities in health outcomes arise because of the conditions in which people are born, grow, live, work, and age – the social determinants of health. This means a holistic approach is required to reduce inequalities in life expectancy between different sections of the population, defined socio-economically, by gender, or by ethnic group.

As my review in 2010 showed, inequality in illness has a significant economic impact. It accounts for productivity losses of £31-33bn every year, and lost taxes and higher welfare payments of £20-32bn each year with additional health care costs of more than £5.5bn a year.

Although life expectancy has increased for both men and women over the last three decades, inequalities remain. The variation in life expectancy between the wealthiest and most deprived neighbourhoods has risen in England. And there is a similar pattern with cardiovascular disease (CVD) mortality.

Deaths from CVD have fallen, but the decline has been smaller in the poorest communities. There is a sharp divide between the north and south on prevalence of the condition – much higher in the North of England and Scotland. In addition to social determinants, there are CHD risk factors, such as genetic inheritance, of conditions such as familial hypercholesterolaemia (FH), which contribute to differences in outcomes.

Therefore, this report by HEART UK, the cholesterol charity, is very timely, especially with new NHS structures in public health becoming operational in April. The report examines the socio-economic determinants of health inequalities, current trends in CVD inequalities, examples of local best practice in tackling CVD, interviews with directors of public health which reveal their priorities and solutions, and a set of policy recommendations.

Progress has been made in reducing CVD health inequalities, but the evidence shows that a much more focused and intensive effort needs to occur to address its causes. I wholeheartedly welcome this report as an important contribution to the debate and urge policy makers to support its recommendations and the vital work of HEART UK in raising awareness of the risks of high cholesterol.



Executive summary and recommendations

Cardiovascular disease (CVD) is the greatest contributor to mortality in the United Kingdom. CVD is one of the conditions most strongly associated with health inequalities – the burden of morbidity and mortality from CVD is disproportionately shouldered by groups with the lowest socio-economic status.



Jules Payne
chief executive
HEART UK

While CVD deaths have declined overall in the UK, there appears to have been no narrowing of the relative difference between the most deprived and the least deprived socio-economic groups. These differences or inequalities in cardiovascular health also persist between ethnic groups and geographic areas. Reducing those persistent inequalities in the rates of CVD benefits us all if we are to achieve a fairer society and improve the health of the population as a whole.

This report examines the latest research on health inequalities in CVD – exploring recent trends and initiatives to reduce the gaps in health outcomes. The document also adds the views on inequalities from specialists in public health.

On examining the evidence, HEART UK makes the following recommendations as a call to action for policy and practical solutions to reducing CVD inequalities:

Our recommendations

- 1 The Government should consider the possible impact on health inequalities when developing its domestic policies.
- 2 Public Health England should foster the development of programmes to improve health literacy in CVD management, prepared in conjunction with expert health care professionals and patient representatives.
- 3 Local authorities and clinical commissioning groups must work cooperatively and seamlessly with the NHS Commissioning Board in the delivery of high-quality public health services and ensure that hard-to-reach and lower income socio-economic groups have the best opportunities to access them.
- 4 Public health funding should remain ring-fenced and sufficient to enable local authorities, in partnership with CCGs and others, to deliver a reduction in health inequalities.
- 5 HEART UK believes that the NHS Commissioning Board should take national leadership for inherited (cardiovascular) conditions that are rare and need special diagnosis and management.



- 6 HEART UK welcomes the establishment of health and wellbeing boards and urges them to carefully consider CVD risk, prevention and management as part of their Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies.
- 7 The Government should consider whether implementing legislation that incentivises good practice within the food industry may help reduce the root causes of CVD risk factors.
- 8 In addition to life expectancy, Public Health England should measure gaps in risk factors for CVD between different geographic areas and between different social and ethnic groups, to provide a more comprehensive picture of inequalities.
- 9 Government should invest in addressing the full range of socio-economic factors that determine health inequalities, which will help narrow regional disparities in life expectancy in the UK.

CHAPTER 1:

Introduction

Cardiovascular diseases are those that affect the circulatory system, i.e. heart and blood vessels. Cardiovascular disease (CVD) is the greatest contributor to mortality in the United Kingdom. The two most common subsets of CVD are coronary heart disease (CHD) (45% of CVD deaths) and stroke (28% of CVD deaths).¹ Coronary heart disease is a term utilised to describe diseases that specifically affect the coronary arteries, commonly manifesting in heart attacks or angina.

Although it has wide-ranging effects throughout the population, the burden of morbidity and mortality is disproportionately shouldered by groups with the lowest socio-economic status. While deaths from CHD have declined overall in the UK, there appears to have been no narrowing of the relative difference between the most deprived and the least deprived socio-economic groups.² These differences or inequalities in cardiovascular health also persist between ethnic groups and geographic areas. A reduction in health inequalities in the rates of CVD benefits us all if we are to achieve a fairer society and improve the health of the population as a whole.³

This report brings together the latest research on health inequalities in CVD. In addition to articulating HEART UK's position, this document also adds recent views on inequalities from specialists in public health.

The report aims to:

- Highlight the extent of CVD health inequalities in England
- Examine the socio-economic factors which determine CVD health inequalities
- Focus on how particular groups suffer higher rates of premature death from CVD
- Recommend policy solutions to alleviate health inequalities in CVD

Defining health inequalities

The differences experienced in health outcomes within a population are a result of complex individual and social factors. Health inequalities can be defined as the

¹Townsend, N et al (2012) *Coronary heart disease statistics 2012 edition*. London, British Heart Foundation

²Ibid

³A view articulated in *Fair Society, Healthy Lives* (The Marmot Review) (2010) *Strategic Review of Health Inequalities in England post-2010*, The Marmot Review

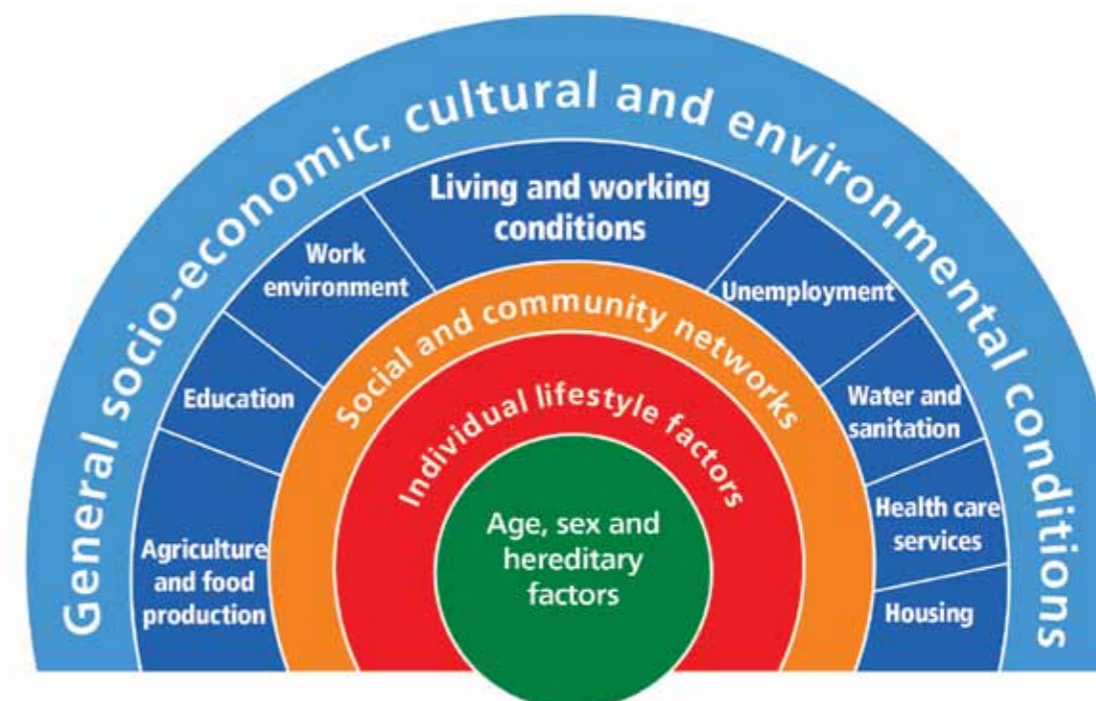
disparity in health outcomes between various sections of the population, the most commonly-used differentiator being those groups with different socio-economic characteristics. Health inequalities can also be present between different ethnic groups or geographic locations.

This chapter will examine the key facts of CVD inequalities in the UK, presenting an overview of the challenges facing politicians, policy-makers, local authorities and the health service in tackling the root causes of inequalities in cardiovascular health. It will also provide an introduction to the social and economic factors that are thought to lead to health inequalities, outlining how individual and area-level characteristics influence the patterns of CVD within the population.

How are health inequalities determined?

Dahlgren and Whitehead (1992) developed a widely-used social model

of health (shown below) that illustrates how the various determinants of health result in unequal distribution of health outcomes within populations. Dahlgren and Whitehead map the relationship between the individual, their environment and disease. Individuals are at the centre, with fixed characteristics, such as age, which cannot be altered by policies. Modifiable health influences surround these characteristics. The first layer is personal behaviour and ways of living that can promote or damage health. The next layer is social and community influences, both positive and negative. The third layer includes structural factors, such as housing and education. The final tier represents general socio-economic, cultural and environmental conditions, such as wages, taxation and prices. These general conditions can affect government spending capacity, which, in turn, can have a direct influence on health and social policy priorities.⁴



The Determinants of Health (1992) Dahlgren and Whitehead

⁴ *Bridging the gap: A health inequalities learning resource, NHS Education for Scotland*: <http://www.bridgingthegap.scot.nhs.uk/understanding-health-inequalities/introducing-the-wider-determinants-of-health.aspx> (accessed December 2012)

The importance of understanding and reducing inequalities in CVD

Sir Michael Marmot's 2010 review of health inequalities, *Fair Society, Healthy Lives*, found that CVD is one of the conditions most strongly related to health inequalities. The review also reported that inequality in illness accounts for productivity losses of £31-33bn each year, and lost taxes and higher welfare payments of £20-32bn per year, and additional health care costs of more than £5.5bn a year.⁵ CVD is responsive to treatments and can be prevented through often simple interventions, so understanding where CVD is having the greatest impact can allow preventative and treatment-focused services to be structured effectively where most required.

Which groups does CVD impact the most?

CVD inequalities are perpetuated by a number of factors, including:

- 1 Differences in the rates of CVD (and their risk factors), as they relate to socio-economic status
- 2 Genetic predisposition to risk factors for CVD
- 3 Poorer health literacy in some groups
- 4 Access to services (and willingness to use them)
- 5 Geographic differences (the 'postcode lottery')

There are significant health inequalities along the socio-economic gradient (which include income, wealth, educational attainment and profession). In 2008, mortality from CVD was 50% higher in the

most deprived quintile compared to the least deprived.⁶ Using the most recent data for individual-level measures; death rates in 2001/03 from CVD, CHD and stroke were all highest in the lowest socio-economic group and lowest in the highest socio-economic group. This inequality was more conspicuous in women than men, with the CHD death rate in female workers with routine jobs five times higher than those with managerial or professional jobs.⁷ This finding highlights the complexity of health inequalities. Even though men have higher rates of premature CHD than women, the inequalities between women from different socio-economic groups are more marked than among their male counterparts.

People with mental health problems also have significantly higher rates of long-term health problems, including CVD. People with severe mental health problems often have shorter life expectancy and have poor access to health promotion and intervention.⁸

Unhealthy lifestyle is an important factor in the marked relationship between rates of CVD and socio-economic status. For example, regular smoking is more prevalent among lower socio-economic groups, while those on higher income are more likely to smoke less, to eat fruit and vegetables and take physical activity.⁹

There is a marked relationship between people's level of health literacy and their health outcomes. Health literacy has been defined as "the degree to which individuals have the capacity to obtain, process and understand basic health

information and services needed to make basic health decisions."¹⁰

Lower levels of health literacy result in poorer health outcomes: compared to those with high levels of health literacy, they have less knowledge of diseases and self-care; worse self-management skills; lower uptake of screening; lower medication compliance; and higher rates of hospitalisation. People with low health literacy also have lower levels of engagement in health promoting behaviours.¹¹ The issue of health literacy is important, and has been shown to impact large sections of the population. For example, one UK study looked at health literacy in a large sample of people aged 52 and over. While there are many aspects to health literacy, this study specifically examined people's ability to understand written instructions for taking an aspirin tablet. The authors concluded that a third of older adults in England have difficulties reading and understanding basic health-related written information. Poorer understanding is associated with higher mortality, which has implications for the conveyance of information and design and delivery of services.¹²

In some cases, people may be more likely to have greater risk factors for CVD due to their genetic inheritance. Familial hypercholesterolaemia (FH) is one such example. FH is a genetic condition that affects one in 500 people. People with FH have highly-elevated levels of cholesterol from birth. If untreated, FH greatly increases the risk of premature death from CVD. Therefore, it is encouraged, where possible, to document details of

individuals' family histories.

Ethnicity and its relationship to illness and risk factors is complex, with some risk factors being higher in certain ethnic groups. Mortality rates from CHD are 46 per cent higher for men and 51 per cent higher for women of South Asian origin than in the non-Asian population. Other related risk factors higher in the South Asian population include diabetes and high blood pressure;¹³ whereas, for example, the Afro-Caribbean population in the UK has the highest rates of stroke of any ethnic group, and, like South Asians, have much higher rates of diabetes than the white population.¹⁴ However, in the UK, aspects of dietary intake are worst in the white population – for example, saturated fat and salt consumption, and the prevalence of elevated cholesterol levels is higher in the general population than among Black and Minority Ethnic groups.¹⁵

Understanding this complex relationship and where incidence and risk factors are highest can help plan and better target services. In Dahlgren and Whitehead's social model of health, the inherited characteristics of ethnicity and genetics are fixed and cannot be altered. There is therefore a need to address



The Afro-Caribbean population in the UK has the highest rate of stroke of any ethnic group

⁵ *Fair Society, Healthy Lives* (The Marmot Review) (2010) *Strategic Review of Health Inequalities in England post-2010*, The Marmot Review

⁶ *Ibid*

⁷ Townsend, N *et al.* *Op cit*

⁸ NHS Confederation, Mental Health Network (2012) Long-term health gains. Investing in emotional and psychological wellbeing for patients with long-term conditions and medically unexplained symptoms. Briefing 237

⁹ Townsend, N *et al.* *Op cit*

¹⁰ Ratzan, SC, Parker, R (2000) National Library of Medicine current bibliographies in medicine: health literacy (introduction). National Institutes of Health

¹¹ Taggart, J *et al* (2012) *A systematic review of interventions in primary care to improve health literacy for chronic disease behavioral risk factors*. BMC Family Practice, 13 (49) <http://www.biomedcentral.com/content/pdf/1471-2296-13-49.pdf>

¹² BMJ 2012;344:e1602 <http://www.bmj.com/content/344/bmj.e1602#ref-1>

¹³ Department of Health (2004) *Heart disease and South Asians. Delivering the National Service Framework for Coronary Heart Disease*. London, Department of Health

¹⁴ Scarborough, P *et al* (2011) *Ethnic differences in cardiovascular disease* (2010 Edition). British Heart Foundation

¹⁵ *Ibid*

inequalities associated with fixed characteristics through greater access to services and information for target populations.

Geography is another notable marker of CVD inequalities in the UK. There is a sharp North-South divide in rates of CHD, with CHD prevalence 50% higher in the North of England compared to the South East. Furthermore, Scotland persistently has the highest rates of mortality from CVD in the UK.¹⁶

Although rates of CVD have been falling since the late 1970s, certain CVD risk factors are increasing in prevalence, with diabetes and obesity on the rise.¹⁷ These risk factors are likely to affect some sections of the population more than others.

For example, one recent study analysed data between 1994 and 2008 which illustrated that risk factors showed clear social gradients, with profiles being better in affluent areas. Risk factors analysed in that study included consumption of fruit and vegetables, and levels of obesity and physical activity.¹⁸

Big picture recommendations for reducing health inequalities

The World Health Organization (WHO) Commission on the Social Determinants of Health was established in 2005 to gather evidence on what can be done to promote health equity, and to cultivate a global movement to help achieve it.

The commission's report features three broad recommendations to realize this:

- 1 Improve daily living conditions
- 2 Tackle the inequitable distribution of power, money and resources
- 3 Measure and understand the problem and assess the impact of action.¹⁹

The WHO notes that heart disease is not caused by the lack of coronary care units, but by the lives people lead, which are shaped by the environments in which they live. The principal action on social determinants of health must therefore come from outside the health sector: to achieve greater health equality, people must be placed at the centre of social policies, economics and politics.²⁰

The Marmot Review follows a similar ethos, noting that reducing inequalities requires action on six policy objectives:

- 1 Give every child the best start in life
- 2 Enable all children, young people and adults to maximise their capabilities and have control over their lives
- 3 Create fair employment and good work for all
- 4 Ensure healthy standard of living for all
- 5 Create and develop healthy and sustainable places and communities
- 6 Strengthen the role and impact of ill-health prevention.²¹

These objectives fit well with practical measures to tackle inequalities in CVD, at the policy, healthcare and public health levels. Measures to address the challenges posed by CVD inequalities are explored more fully in **Chapter 4** of this report.

¹⁶ Scarborough, P et al (2010) *Coronary heart disease statistics 2010*. London, British Heart Foundation

¹⁷ Scholes, S et al (2012) *Persistent socio-economic inequalities in cardiovascular risk factors in England over 1994-2008: A time-trend analysis of repeated cross-sectional data*. BMC Public Health, 12 (129)

¹⁸ *Ibid*

¹⁹ Commission on Social Determinants of Health (CSDH) (2008) *Closing the gap in a generation: health equity through action on the social determinants of health. Final Report of the Commission on Social Determinants of Health*. Geneva, World Health Organization

²⁰ *Ibid*

²¹ The Marmot Review, *op cit*

CHAPTER 2:

Trends in CVD inequalities and review of government initiatives

This chapter examines trends in CVD inequalities in the context of recent targets and initiatives. The data shows that, while progress has been made in reducing CVD mortality and poor lifestyle behaviours in some groups, inequalities may in fact be widening. The chapter concludes with key principles that HEART UK believes should be integral in measures to reduce inequalities in the future.

Trends on health and CVD inequalities

Life expectancy is regarded as one of the key indicators of health inequalities. Although it has improved for both men and women over the last 30 years, disparities remain. Figures published by the University College London Institute of Health Equity in February 2012²² on the second anniversary of the Marmot Review showed that life expectancy had increased in most of the 150 local authority areas in England. However, the variation in life expectancy between the wealthiest and most deprived neighbourhoods had risen in the majority of the local authorities for both men (104/150) and women (92/150).

Although overall life expectancy at birth in England increased by 0.3 years for both men and women between 2007-9 and 2008-10, inequalities in life expectancy between local authority communities increased by 0.1 years for men and was unchanged for women.

Research on CVD mortality shows a similar picture. A study, which examined data between 1982 and 2006 across nearly 8,000 wards in England,²³ found that:

- Across England, deaths from CVD have more than halved
- The decline in rates for men and women aged 65 or over was smaller in the poorest communities – so that the gap between the richest and most deprived areas is wider
- For men aged 65 or over, CVD deaths fell nearly five times more in the best performing one per cent of wards than in the worst performing one per cent
- For women, the variation was ten-fold.

Dr Perviz Asaria, from Imperial College, London, who worked on the study, said: "If people's jobs are less stable, they may be forced to change their diet, or drink

²² *Health Inequalities Widen within Most Areas of England*, UCL Institute of Health Equity press release, 15th February 2012: <http://www.instituteofhealthequity.org/Content/FileManager/pdf/2-year-on-press-release-final.pdf>

²³ Asaria, P et al (2012) Trends and Inequalities in Cardiovascular Disease Mortality Across 7932 English Electoral Wards, 1982-2006: Bayesian Spatial Analysis, *International Journal of Epidemiology*, D41(6): 1737-1749

and smoke more. So we need to be concerned about these issues if we are going to carry on bringing death rates down. As public health gets taken up by local authorities, there's a danger that health budgets will have to compete with other services such as schools. It's essential that cardiovascular screening and prevention programmes don't get cut as a result."²⁴

The latest data on CHD mortality considers the number of CHD deaths per 100,000 people in given areas. The figures show that regional disparities continue to exist along a North-South divide in England.²⁵ Many regions had a CHD mortality rate above the English national average of 74.21: the North East (80.61), Yorkshire and Humberside (86.63), North West (89.48), East Midlands (76.66), and West Midlands (75.33). (See map on right)

Government targets on health inequalities

Governments have set a number of targets for reducing inequalities in recent years. The national health inequalities Public Service Agreement target was introduced in 2001, and focused on reducing inequalities in infant mortality and life expectancy by 2010. The infant mortality target was to reduce by at least 10 per cent by 2010, the gap in the death rate between the routine and manual occupation group and the population as a whole. The life expectancy target is to reduce by at least 10 per cent the gap between the fifth of areas with the worst health and the population as a whole. According to the Marmot Review, the data for the two targets,

"show substantial improvements in life expectancy and infant mortality for all groups, including those in disadvantaged groups and areas".²⁶

The National Service Framework for Coronary Heart Disease set a target to: "Substantially reduce mortality rates by 2010 from heart disease and stroke and related diseases by at least 40 per cent in people under 75, with a 40 per cent reduction in the inequalities gap between the fifth of areas with the worst health and deprivation indicators, and the population as a whole."²⁷

There has been a decline in death rates from CVD. According to the Care Quality Commission (CQC), most of this decline can be attributed to reductions in significant risk factors, such as cholesterol levels and smoking – through the prescribing of statins and smoking cessation programmes. Nevertheless, the CQC found that CVD inequalities persist because the improvements in reducing risk factors are slower in more deprived groups and areas than in their wealthier counterparts.²⁸ The CQC also found that GPs are less likely to record CVD in the more deprived areas, which means inadequate access to treatment. Unrecorded CVD prevalence is low, but the CQC said that the increase of up to seven per cent in some of the most deprived areas is "worrying."²⁹

Research by the King's Fund into multiple unhealthy behaviours has also shown disparities between socio-economic groups, with implications for the



²⁴ Parkinson, C (2012), *Over-65s Heart Death Gap 'Wider' Between Rich and Poor*, BBC News website. <http://www.bbc.co.uk/news/health-20179498> (Accessed December 2012)

²⁵ MSD (2013), *Heart Hotspots: CHD Mortality – National Data by SHA (2010)*, data supplied by the Health and Social Care Information Centre

²⁶ The Marmot Review, *op cit*

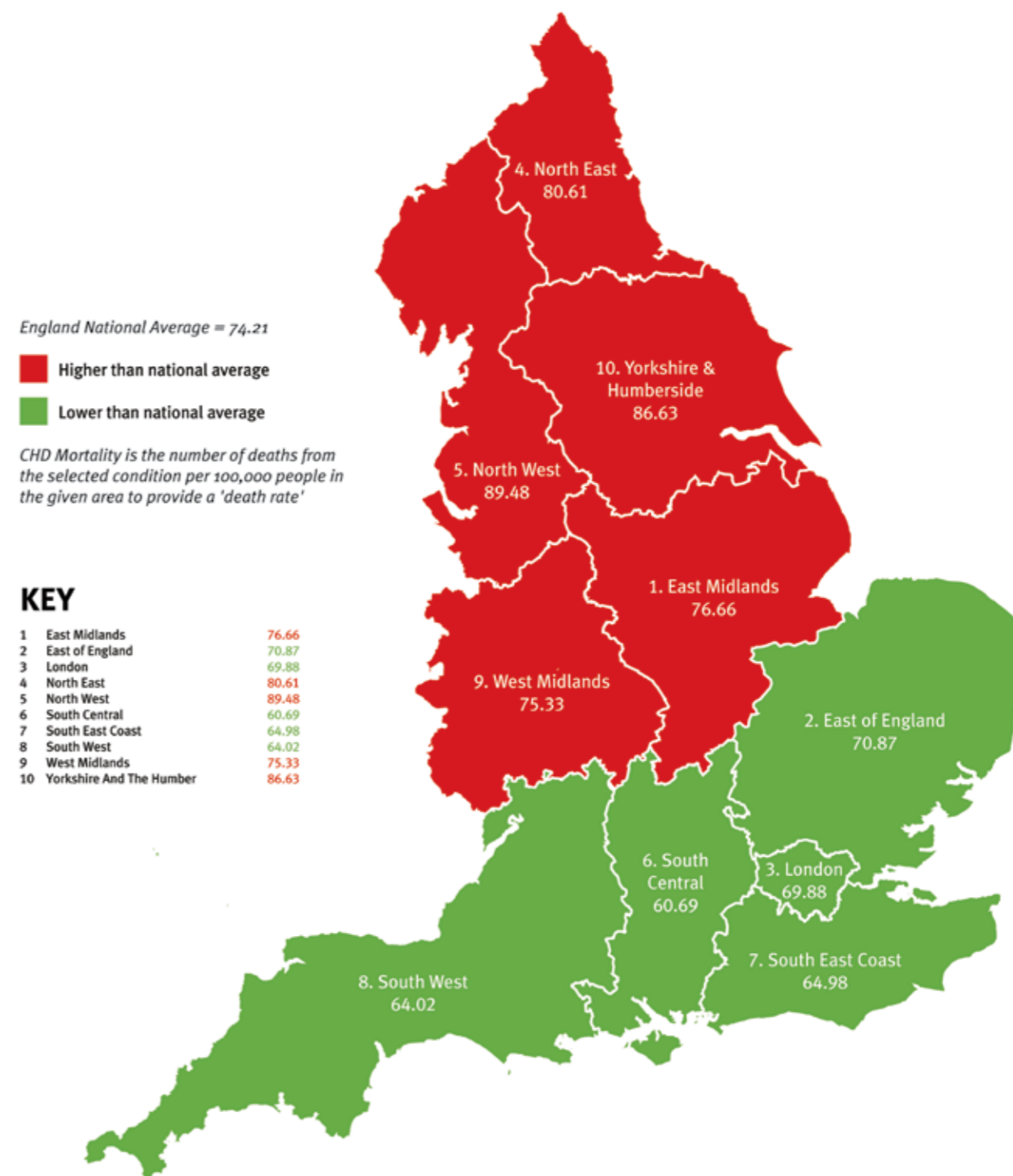
²⁷ Department of Health (2000) *National Service Framework for Coronary Disease*

²⁸ Care Quality Commission (2009) *Tackling Cardiovascular Disease and Health Inequalities by Prescribing Statins and Stop Smoking Service*

²⁹ *Ibid*



Heart Hotspots: CHD Mortality – National data by SHA (2010)



Map created by MSD using data supplied by The Health and Social Care Information Centre.

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tackling of health inequalities.³⁰ The King's Fund used data on four lifestyle risk factors – smoking, excessive alcohol use, poor diet and low levels of physical activity – obtained from the Health Survey of England. The data showed that although the overall numbers of people who engage in three or four unhealthy behaviours has declined between 2003 and 2008, these reductions occurred largely among those in higher socio-economic and educational groups. In 2008, people without any qualifications were more than five times as likely to engage in all four poor behaviours as those with higher education. In 2003, those without qualifications were only three times as likely to do this, suggesting a widening gap in unhealthy behaviour between different socio-economic groups.

Health inequalities initiatives

During the last 15 years, as well as setting national targets on health inequalities, government has implemented a range of initiatives, including:

- Health Action Zones – multi-agency partnerships in 26 areas of England which were allocated approximately £4-5m per year per zone
- Sure Start – to support the early years of children in disadvantaged families
- Spearhead Areas – these were local authority areas that were in the bottom fifth nationally for three or more of the following five factors:
 - Male life expectancy at birth
 - Female life expectancy at birth
 - Cancer mortality rate in under 75s
 - Cardiovascular disease mortality rate in under 75s
 - Index of Multiple Deprivation 2004 score.

In 2009, the House of Commons Health Committee carried out an analysis of government policies and found that Health Action Zones were “under-funded,” and Sure Start “has yet to demonstrate significant improvements in health outcomes for either children or parents policy.”³¹

The committee also said that the awarding of Spearhead status had not been enough to ensure that deprived areas tackled health inequalities. It commended the then government on its adoption of the health inequalities targets, but added:

“Health inequalities have many facets – health is unequal according not only to social class, but to gender, ethnicity, age, disability and mental health status, to name only a few.

“It is crucial that the Government’s focus on socio-economic inequalities alone does not lead to other aspects of health inequalities going unnoticed and ignored.... A wider range of inequalities should be measured”.³¹

Food policy, taxation and the Responsibility Deal

Food policy initiatives can have a very positive impact on consumption, affecting CVD risk factors and their inequalities in lower socio-economic groups, including obesity, cholesterol and blood pressure. However, food policy can have very complex outcomes, affecting the population in different ways.

A recent study explored the complexities of healthy diet policies by comparing case studies from the UK and Brazil. The authors concluded that the benefits of a



healthy diet policy will vary substantially between populations, not only due to differences in dietary intake, but because of agricultural production, trade and other economic factors.³³ The authors conclude that greater understanding and research is needed into the trade-offs and complexities involved in achieving improved diets.

The Public Health Responsibility Deal commenced in 2011, and is a partnership between government, industry and other organisations that aims to help improve population health through the voluntary adoption of a series of pledges.

The Trans Fat pledge (F3), for example, aims to keep artificial trans fats low, and asks partners to agree to the following: “(a) We do not use ingredients that contain artificial trans fats.

“(b) We are working to remove artificial trans fats from our products within the next 12 months.”³⁴

While the Responsibility Deal presents opportunities for change, questions have been raised about its progress.

A *Which?* survey found that people believe that, despite the fact that 91% of

³⁰ Buck, D and Frosini, F (2012) *Clustering of Unhealthy Behaviours over Time: Implications for Policy and Practice*, The King's Fund.

³¹ House of Commons Health Committee (2009), *Health Inequalities: Third Report of Session 2008-2009*.

³² *Ibid*

³³ Lock, K et al (2010) Health, agricultural, and economic effects of adoption of healthy diet recommendations. *The Lancet*, 376: 1699-709.

³⁴ See Responsibility Deal website: <http://responsibilitydeal.dh.gov.uk/2012/02/03/f3-factsheet/> (accessed February 2013)



Healthy food: 28% of adults believe the Government is not doing enough to help them eat a healthier diet

adults are trying to eat a healthier diet, 28% believe that the Government is not doing enough to help them.³⁵

no mandatory sign-up or legislation that requires universal implementation by the food industry.

The voluntary nature of the Responsibility Deal means that there is

The Government should consider legislation that incentivises good practice.

Conclusions

Although overall life expectancy has improved in recent years, inequalities in life expectancy have increased, which show that much more needs to be done to tackle the causes of health inequalities.

The prescribing of statins and smoking cessation programmes have had some success in reducing deaths from CVD, but variations in outcomes persist. Governments have established a number of other initiatives to tackle health inequalities with differing degrees of success.

In order to ensure that progress is made on reducing health inequalities,

HEART UK believes that the following factors are imperative:

- A more holistic approach, which focuses on key issues such as multiple lifestyle risk behaviours
- Adequate funding for programmes aimed at reducing inequalities
- The measurement of a wider range of inequalities
- Initiatives that target the most hard-to-reach groups and those experiencing the poorest health outcomes
- Appropriate incentives for health care professionals.

³⁵ Government must do more to tackle obesity crisis, says *Which?* <http://www.which.co.uk/news/2012/03/government-must-do-more-to-tackle-the-obesity-crisis-says-which-281403/> (accessed February 2013)

CHAPTER 3:

CVD inequalities and the new NHS

This chapter describes how changes in the NHS will impact on levers to address inequalities in cardiovascular disease. In particular, developments in public health present an opportunity to tackle health inequalities through wider population health measures and more targeted localized programmes.

HEART UK worked with the Association of Directors of Public Health to interview a selection of public health directors from different areas of the country. This chapter includes an analysis of the findings, with recommendations on how to better address CVD inequalities from leaders in the public health field.

The chapter also highlights case studies of local health assessments and prevention programmes.

Public health responsibilities in the new NHS

As explained in the previous chapter, action to overcome social determinants of health inequalities cannot be covered by the Department of Health and NHS alone. Alongside public health teams in primary care trusts (PCTs), local authorities have also had an important role in this field with responsibilities across social care, education and housing.

The Health and Social Care Act, passed in March 2012, significantly changes the structure of the NHS and the way services are commissioned. In the new structure, directors of public health will move from PCTs to local authorities, meaning local authorities will have an even greater role to play in improving the health and wellbeing of the population. This is part of their statutory duty.

Further local oversight of healthcare priorities will come from Health and Wellbeing Boards (HWBs).³⁶ These are designed to increase cooperation between public bodies and will be hosted through regional government systems. HWBs will formulate local plans for health priorities in the form of Joint Strategic Needs Assessments (JSNAs).

At a national level, the new executive agency, Public Health England (PHE), is being established to bring in central support and infrastructure for the delivery of public

“Local authorities will have an even greater role to play in improving the health and wellbeing of the population”

³⁶ Great Britain, Health and Social Care Act 2012 c.7 s.195(1), available at http://www.legislation.gov.uk/ukpga/2012/7/pdfs/ukpga_20120007_en.pdf

health services. As part of its remit, PHE will look to share best practice and encourage consistency wherever a common approach is deemed to be beneficial.

The Public Health Outcomes Framework, which sets out the desired outcomes for public health and how these will be measured, will be used to assess the progress of PHE.

First published in January 2012, the framework sets out the Government's objectives of increasing healthy life expectancy and reducing differences in healthy life expectancy between communities.

HEART UK is pleased to see this national prioritisation of the overarching need to tackle health inequalities.

Role of Health and Wellbeing Boards (HWBs)

The newly-established HWBs are taking over responsibility for continuing the JSNA process. The primary objective of

JSNAs is to accurately assess the health needs of a local population in order to guide commissioning in a way that will improve the physical and mental health and wellbeing of individuals and

communities. The Joint Health and Wellbeing Strategies (JHWS) produced by each HWB will be set according to JSNA findings.

These strategies, which help determine actions and local commissioning priorities, are key strategic vehicles to

address local needs and inequalities.

Producing an annual JSNA has been a statutory requirement for the NHS and local authorities since 2007.

However, the creation of HWBs, one of the more popular initiatives to come from the Health and Social Care Act, has the potential to drive better integration of local services, building partnerships across local government, public health, and the third sector.

While the wider membership of each board will be at the discretion of the local authority, they are expected to include core members from local government, social services, children's services, public health, commissioning and HealthWatch.³⁷

The Department of Health's draft guidance to HWBs states: "Health and wellbeing boards will be able to understand, and take action to help tackle inequalities in health and wellbeing; and supported by local partners to influence factors that affect health and wellbeing to improve outcomes through every stage in people's lives."³⁸

HEART UK welcomes the establishment of HWBs and urges them to carefully consider CVD risk, prevention and management as part of their JSNA and JHWS.

This is already being done in some areas, for example Nottingham, where their 2012 JSNA includes a specific chapter on CVD, highlighting the scale of the problem and the specific action required to address CVD inequalities.

“Health and wellbeing boards will be able to take action to help tackle inequalities in health and wellbeing”

³⁷ Ibid s.194(1-9)
³⁸ Department of Health (2012), Draft guidance on Joint Strategic Needs Assessments and joint health and wellbeing strategies; January 2012, page 5. Available at: <http://healthandcare.dh.gov.uk/files/2012/01/JSNAs-and-joint-health-and-wellbeing-strategies-draft-strats.pdf>, last accessed 22 January 2013



The historic Council House and Market Square, Nottingham: There is a large inequality gap in premature mortality from CVD between the most deprived and least deprived areas in the city

Case study:
Nottingham

Primary prevention via health checks is key

CVD mortality is a key point of concern highlighted by the Nottingham City JSNA.³⁹

The assessment notes that the narrowing of the gap in CVD mortality between Nottingham and the England average has decreased in recent years. It also points out that there is a large inequality gap in premature mortality from CVD between the most deprived and least deprived fifth areas in Nottingham.

In tackling these problems, the assessment states that addressing premature

CVD death is "important in addressing health inequalities and increasing life expectancy". As such, their main recommendations focus on primary prevention, in the form of NHS Health Checks and early diagnosis.

The introduction of performance targets and measures to tackle variation in how the health checks programme is carried out are also highlighted as important vehicles for pushing the prevention agenda.

These recommendations are set to be reflected in

Nottingham's JHWS in line with their vision to "improve the health and wellbeing of the Nottingham citizens and improve the health of the poorest fastest by working in partnership with our communities".⁴⁰

Initial drafts reveal that the JHWS will highlight the importance of the Nottingham Plan entitled 'Health Nottingham' which aims to address lifestyle factors such as smoking, diet, exercise, alcohol and substance misuse in helping to prevent diseases such as CVD.

³⁹ NHS Nottingham City (2012), Nottingham City Joint Strategic Needs Assessment – Cardiovascular and cardiac disease (not including stroke); April 2012. Available at: <http://www.nottinghaminsight.org.uk/insight/jsna/adults/jsna-cardiovascular-disease.aspx>, last accessed 22 January 2013
⁴⁰ Nottingham City NHS (2012), Development of Nottingham Joint Health and Wellbeing Strategy 2013-2016; August 2012, available at: <http://open.nottinghamcity.gov.uk/comm/download3.asp?dltype=inline&filename=53296/Item4.pdf>, last accessed 22 Jan 2013

Case study: Tower Hamlets

The Tower Hamlets JSNA found that, compared to the rest of London, the borough has the second highest CVD premature mortality rate.⁴¹ The assessment also highlights that CVD prevalence is “strongly linked to socio-economic deprivation as well as gender and ethnicity”.

The assessment claims that this link provides a powerful rationale for stronger and broader joint working across health, social care and wider council services, such as employment and housing.

However, it is also noted that the uneven distribution of deprivation across the borough highlights the importance of the localisation agenda and increasingly



New and old: The borough has second highest CVD premature mortality rate in London

targeted joint partnership working.

Proactive strategies have been developed by the borough to address these issues and are set out in the Tower Hamlets Health and Wellbeing Strategy.⁴² The Primary Care Investment Programme (PCIP) was set up to enhance primary care for major chronic diseases such as CVD, through

the creation of GP networks, and delivery of care packages through these networks which places the patient at the centre of care. There is also an emphasis on the continued implementation of the NHS Health Checks Programme. The strategy claims that this programme has demonstrated significant improvements in CVD health outcomes for Tower Hamlets residents.

Case study: Newcastle

The JSNA for Newcastle identified that the city will be unlikely to meet CVD inequalities targets set by the Government if past trends are to continue.⁴³

While mortality rates from CVD have fallen in the past decade, the assessment found that this decline has not been as steep in Newcastle as the rest of England. The assessment attributes this, in part, to the fact that Newcastle belongs to the Spearhead group with areas of high deprivation, high mortality rates and entrenched inequalities.

Combined with significant variations in CVD secondary



Social housing in Newcastle: There are many areas of high deprivation, high mortality rates and entrenched inequalities

prevention between practices, this is understood to contribute to Newcastle’s poor CVD equality record. As such, the assessment identifies five key priorities to address CVD inequalities in the area:

- Implementing NHS Health Checks with a particular focus on hard-to-reach and easy-to-overlook groups
- Implementing a systematic approach for recording cases of CVD so as to close the gap between reported and expected numbers on disease registers
- A greater focus on primary care performance monitoring for CVD
- Allocating more adequate funding to the primary/secondary prevention of CVD
- Ensuring that services are delivered in a cohesive and streamlined manner to increase efficacy and efficiency

The NHS Health Checks Programme

The NHS Health Checks Programme, announced in 2008, with implementation beginning in April 2009, represents a major step forward in adopting a preventative approach to CVD.

HEART UK firmly believes that the NHS Health Checks, if fully implemented throughout England, can engage the public in health prevention by: identifying

potential risk factors for vascular disease; providing individuals with information to reduce their risk of CVD through lifestyle changes; and reducing their risk of CVD through treatment where necessary. NHS Health Checks have the potential to positively impact on long term health. They can influence behavioural change amongst patients, who can be encouraged by their GP or healthcare professional to adopt healthier practices following identification of raised

⁴¹ Tower Hamlets Council (2012), Life and Health in Tower Hamlets: Joint Strategic Needs Assessment Summary 2011; April 2012

⁴² Tower Hamlets Health and Wellbeing Board (2012), Tower Hamlets Health and Wellbeing Strategy: An outline; September 2012

cholesterol, high blood pressure, high body mass index, or multiple risk factors.

HEART UK’s 2011 report, *Cholesterol and a Healthier Nation: shared responsibility for better public health* included FOI data showing that the early implementation of the health checks programme had been patchy and inconsistent.⁴⁴ While some regions had been proactive and innovative in their approach, others were yet to start delivering health checks,

blaming lack of funding and waning support from GPs.

More recent research from Diabetes UK showed that in 2011–12, some PCTs offered an NHS Health Check to more than 25% of the eligible population, whereas others had offered them to less than 2%.⁴⁵ A separate study by GP Magazine showed that a fifth of PCT respondents to an FOI request said they would fail to meet the compulsory target in 2012-13.⁴⁶

⁴³ Newcastle City Council and Newcastle Primary Care Trust (2012), Newcastle JSNA: Cardiovascular disease; available at: <http://www.newcastlejsna.org.uk/node/917>

⁴⁴ HEART UK (2011), *Cholesterol and a Healthier Nation: shared responsibility for public health*; December 2011, available at: http://heartuk.org.uk/files/uploads/documents/2011_12_HeartUK_CholesterolHealthReport2011_FINAL.pdf

⁴⁵ Diabetes UK (2012), *The NHS Health Check Programme: Let’s Get It Right*; September 2012, available at <http://www.diabetes.org.uk/Documents/Reports/nhs-health-check-lets-get-it-right-0912.pdf>, last accessed 22 January 2013

⁴⁶ Michelle Roberts (2012), *Over-40s missing out on heart checks, figures suggest*; BBC, 15 August 2012, available at: <http://www.bbc.co.uk/news/health-19255443>, last accessed 22 January 2013

Critics of the programme claim that it will only reach the so-called “worried well”. However, as highlighted in our *Cholesterol and a Healthier Nation* report, some PCTs have developed innovative schemes to engage with hard-to-reach groups and the individuals who would most benefit from this important, free service.⁴⁷

By offering health checks in places such as parks, sporting grounds, supermarkets, job centres, mosques and even bus shelters, as well as the more traditional GP practices and pharmacies, there is more scope to extend the benefits of the programme beyond the “worried well”.

At a national level, the health checks programme has had good cross-party political support and was listed in the national performance measures in the NHS Operating Framework for England 2011–12. Take up of the programme is one of the indicators in the Public Health Outcomes Framework, against which Public Health England will be held to account.⁴⁸

As local authorities assume their wider public health responsibilities, HEART UK urges them to prioritize the NHS Health Checks Programme as an important driver of their prevention agendas. By working to extend the programme to at-risk and vulnerable groups, they can do more to promote prevention and premature interventions among those who need them the most.

▶ 24

⁴⁷ HEART UK (2011) *op cit*

⁴⁸ Department of Health (2012), Public Health Outcomes Framework: Healthy lives, healthy people, Improving outcomes and supporting transparency; January 2012, available at http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/en/documents/digitalasset/dh_132559.pdf, last accessed 22 January 2013

Health checks on the quayside for deep-sea fishermen

Best practice local interventions Case study: Fishwell

NHS Norfolk has teamed up with the Fishermen’s Mission, an emergency and welfare support organization for fishermen and their families, to deliver the FishWell project.

Deep-sea fishing is one of the most hazardous peacetime occupations. Fishermen do a physically demanding job, often working long hours in harsh conditions with unpredictable catches and lack of income security.

These factors combine to make it difficult for fishermen to keep themselves healthy and well, and to access health services.

The FishWell project is a pilot outreach service that brings health services to fishermen in Norfolk. As part of this, fishermen are being offered NHS Health Checks from the quayside.

Tim Jenkins, senior superintendent at the Fishermen’s Mission, explains how the project was carried out:

“We took a mobile office to three different quayside venues in 2012, spending two days at each. In total, 74 people received a Health Check. “As well



The FishWell project has provided a practical solution for an unusual industry: Above, from left, Justine Hottinger from NHS Norfolk, King’s Lynn fishermen and Tim Jenkins, right. Below right: A Cromer fisherman with health care staff from Boots in Cromer

as the health checks, we are also providing a health trainer service, whereby fishermen can benefit from sessions designed to provide motivation, encouragement and support for anyone wanting to make healthy lifestyle changes.

“The trainers work with fishermen to identify specific behaviours they want to change, set achievable goals and find other agencies that can help.”⁴⁹

⁴⁹ Telephone conversation with Tim Jenkins, senior superintendent at the Fishermen’s Mission (December 2012)





No Smoking Day

Stopping smoking is the most positive impact on reducing health inequalities

An analysis of HEART UK's interviews with directors of public health

HEART UK undertook a series of interviews with directors of public health (DPHs) to gauge their views on:

- Local priorities and concerns
- NHS health checks
- The new public health structures
- The best initiatives for changing behaviour and reducing health inequalities
- How government can help reduce health inequalities

When asked about the top public health priorities in their local area, the three most frequently cited were: tackling inequalities, smoking and alcohol.

The majority of these priorities had been agreed with the local HWB. DPHs

considered that the areas of greatest concern to be: the lack of understanding of health inequalities, public health funding, and the transition to the new structures.

This indicates that there needs to be a concerted effort at both national and local level to ensure a comprehensive understanding of the causes of health inequalities, and that government must strive to provide adequate funding to help deliver better outcomes in their reduction.

Interviewees were asked about what improvements could be made within their local areas to reduce health inequalities. The top three responses were: better employment, better health promotion, and better education. This reflects the findings of the Marmot Review that a range of socio-economic

Best practice local interventions Case study: Wigan

Life expectancy within Wigan is lower than the England and North West average. Although the life expectancy gap is closing it's not as fast as elsewhere and there is still a seven-year life expectancy gap within Wigan. The main cause is CVD, accounting for 42% of all preventable deaths in men under 75 years and 43% for women.

A 2009 audit highlighted the need to "improve preventative care targeting people at increased risk of CVD as the single most important area for the Borough in improving life expectancy and reducing health inequalities".⁵⁰

A CVD prevention partnership was therefore established in 2010 to raise the profile of CVD prevention work including Wigan's Find and Treat CVD screening programme which started in 2007.

Following the publication of the 2010 Marmot Review, a multi-agency task group was established to use the six Marmot recommendations to provide a strategic framework and engage with local people and organisations including

Lifestyle changes are the essential health message



©Wigan Council

Wigan town centre: Focus on holistic and integrated programmes

local businesses and local professional and amateur sporting clubs – building on Wigan's proud sporting tradition.

This *Start Well, Live Well, Age Well* approach has helped the Health and Well-being Board to shape Wigan's new joint health and well-being strategy and strategic needs assessment with a focus on holistic, integrated, patient designed programmes on weight management, tobacco control, and alcohol harm reduction. The emphasis is on equipping local people with the skills and knowledge to make good health choices linked to Wigan Council's strategic objective of building self-reliance.

Wigan works closely with academic centres to ensure an

evidence-led approach with all programmes evaluated for their effectiveness.

One of the programmes, *Lose Weight Feel Great* is a comprehensive direct access community weight management service which provides tailored advice and interventions – "personal public health" – to empower individuals to change their lifestyle in order to achieve sustainable weight loss.

Another of the key initiatives – developed with Wigan and Leigh Housing Trust – is to encourage smoke-free homes. Wigan also has currently the largest healthy living pharmacy programme in England harnessing the health improvement potential of community pharmacists.

⁵⁰ NHS Ashton, Leigh and Wigan (2009), Feasibility Study For Developing A Coordination/Delivery Structure For Wigan CVD Prevention Services; April 2009



Increased exercise was also seen as a vital public health education initiative

factors need to be addressed in order to tackle health inequalities.

It was encouraging to see that those interviewed said that NHS Health Checks were either “very much a priority” or “mostly a priority” and that nearly all were confident that they would be delivering them for their local authority from April 2013.

“These responses reflect the success of smoking cessation programmes in the UK over the last decade”

On the management of the call and recall for the programme, most of those we spoke to said that they were commissioned as part of the overall health checks service.

We asked the directors of public health for their views on the transition to Public Health England and HWBs in

April 2013, and most said that the new structures would help in setting policies to reduce health inequalities in their area. In terms of the biggest opportunity that the new bodies could provide, interviewees identified bringing together partner organisations, a whole system approach to tackling health inequalities, and health promotion.

The interviews included questions around which public health education initiative would be best placed to change people’s lifestyle choices.

The two most popular responses were smoking cessation and increased exercise. The former was seen as having the most positive impact on reducing health inequalities and their costs. These responses reflect the success of smoking cessation programmes in the UK over the last decade.

DPHs were asked what government can do to help reduce health inequalities.

There were a wide range of responses, including: ensuring that the public health budget remained ring-fenced, controlling fast food advertising, a minimum unit price for alcohol, reducing licensing hours, and continuing with regulatory interventions (such as plain cigarette packets).

Summary of findings

Tackling health inequalities is one of the key priorities for directors of public health, but many are concerned about the lack of understanding of the issue. They are also worried

about funding levels. Health checks are a priority and there is confidence that they will continue after the transition to the new structures in April 2013.

From the interviews we carried out, there seems to be overall support for Public Health England and HWBs, and a belief that they can bring together partner organisations to help reduce health inequalities. The response by DPHs on what government can do to help reduce health inequalities demonstrated that there was a good understanding that a range of issues had to be tackled in order to narrow the gap in life expectancy between socio-economic groups.

Conclusions

HEART UK is optimistic that the establishment of Public Health England and local HWBs will bring opportunities to identify priorities and to facilitate joint working between partner organisations. The move to a more closely integrated, system-based approach to health inequalities is promising.

It is important that CVD is covered in local JSNAs in order to ensure that Joint Health and Wellbeing Strategies focus on tackling one of the conditions most strongly related to health inequalities.

The NHS Health Checks Programme is an essential part of the CVD prevention agenda. Local authorities must ensure that it continues to be a priority, and that work is done to enable the poorer and more vulnerable members of society to access the programme.

As this chapter has highlighted, there are a number of innovative local schemes designed to tackle inequalities in CVD. We urge local authorities and clinical commissioning groups to work through their HWBs to help develop initiatives that will benefit to those most at risk.

CHAPTER 4:

Recommendations on how CVD inequalities can be tackled

Considering the evidence in the report, this chapter sets out recommendations for the Government, the NHS Commissioning Board, Clinical Commissioning Groups, Public Health England, and Health and Wellbeing Boards on how to help address CVD inequalities.

Taking action on inequalities

The Marmot Review noted that reducing health inequalities requires action on six policy objectives, to help ensure people have greater control over their lives, better universal opportunity and living standards, healthy living spaces and access to robust prevention programmes. To tackle these issues, the Government will need to implement policies that address childhood poverty, provide fair access to education and training, foster greater employment opportunities and provide fair wages to all. Urban planning must examine and pay attention to the built environment, including the availability of work, amenities, and vibrant, clean living spaces.

RECOMMENDATION 1:

The Government should consider the possible impact on health inequalities when developing its domestic policies.

CVD prevention and inequalities

In order to ensure people can better control their health, people need to properly understand CVD and its risk factors. It is possible to improve health literacy skills over time for patients with long-term conditions, and for those patients to become more active in their own health care consultations, which in turn will help patients make informed lifestyle choices. By recognising the different dimensions and stages of health literacy, health care professionals need to communicate health information in a digestible format. This will result in patients developing a better understanding of their conditions.

The diabetes programme X-PERT is an example of a successful patient education package that helps improve patient literacy and self-management. The aim of the six-week programme is to develop the knowledge, skills and confidence in participants to enable them to make informed decisions regarding lifestyle and diabetes management. X-PERT has been shown to be clinically and cost effective. The Department of Health's recent initiative to develop Patient Decision Aids are a positive step towards improving patient literacy and engagement, and their evaluation and uptake could help to reduce health inequalities and improve preventative measures.

RECOMMENDATION 2:

Public Health England should foster the development of programmes to improve health literacy in CVD management, prepared in conjunction with expert health care professionals and patient representatives.

Public health and local authorities

Local authorities have an important role to play in delivering on public health objectives. From April 2013, local authorities will have the lead for many important public health initiatives that impact on CVD and their potential to reduce health inequalities.

These include local programmes to address physical inactivity, obesity programmes, alcohol misuse services, local tobacco control services such as stop smoking services, nutrition initiatives, assessment and lifestyle interventions for NHS Health Checks, workplace health, social marketing and behaviour change campaigns, health intelligence and information dissemination.

Directors of public health indicated to us that the public health budget should remain ring-fenced to help them deliver real change in inequalities at the local level.

The relationship between local authorities, CCGs and the NHS Commissioning Board will impact on service delivery.

For example, following health check assessments (commissioned by local authorities), CCGs are responsible for commissioning treatment and ongoing risk management, depending on the results from the health check.

In the delivery of health checks and other prevention mechanisms, it is particularly important that the hard-to-reach are given considerable attention – as demonstrated in the case of the Newcastle JSNA.

In practice, this means diversity of access, cultural sensitivity, sympathetic assessments, and quality patient information and resources.

RECOMMENDATION 3:

Local authorities and CCGs must work co-operatively and seamlessly with the NHS Commissioning Board in the delivery of high-quality public health services and ensure that hard-to-reach and lower income socio-economic groups have the best opportunities to access them.

RECOMMENDATION 4:

Public health funding should remain ring-fenced and sufficient to enable local authorities, in partnership with CCGs and others, to deliver a reduction in health inequalities.

Genetic conditions

It can be argued that people with inherited conditions are born with an automatic health inequality – they certainly had no opportunity to alter their lifestyle before birth.

As the Cholesterol Charity, HEART UK is particularly interested in familial hypercholesterolaemia (FH), a genetic condition which causes high concentrations of cholesterol in the blood.

People with FH are at very high risk of developing coronary heart disease from a young age. This is a tragedy for families and a significant

burden on the NHS and the economy. Approximately 120,000 people in the UK have FH, but only 15,000 patients have been identified and treated. This means thousands of people are still unaware that they have the condition and that their family members are at risk.

Localised commissioning works well for most conditions. However, rare and unfamiliar conditions may require special attention or risk being forgotten altogether.

In the case of FH, the NICE Guideline for the condition (CG71) is not being implemented in England, and as a result the condition is remaining largely undiagnosed and insufficiently managed at a PCT level. For rarer conditions, therefore, the NHS Commissioning Board should play an important role in ensuring access to diagnosis and treatment services.

RECOMMENDATION 5:

HEART UK believes that the NHS Commissioning Board should take national leadership for inherited conditions (such as FH) that are rare and need special diagnosis and management.

Joint Strategic Needs Assessments

According to the Department of Health's draft guidance, Health and Wellbeing Boards (HWBs) will "be able to take action to help tackle health inequalities; and supported by local partners to influence factors that affect health and wellbeing to improve outcomes through every stage in people's lives."

Given the high contribution of CVD towards inequalities in health and wellbeing, CVD prevention and

treatment will form an important component of Joint Health and Wellbeing Strategies (JHWS).

RECOMMENDATION 6:

HEART UK welcomes the establishment of HWBs and urges them to carefully consider CVD risk, prevention and management as part of their Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies.

Food policy

Initiatives such as the health checks programme have the opportunity to make changes through proactive prevention of CVD.

Other initiatives could be increased in strength and magnitude to improve population-level health. These include measures to improve food labelling and mandatory changes to the food supply.

Food policy initiatives can have a positive impact on consumption, affecting CVD risk factors and inequalities in lower socio-economic groups.

In many ways, the Responsibility Deal is a positive partnership aimed at improving public health through industry participation. However, the voluntary nature of the Responsibility Deal means that there is an absence of mandatory sign-up or legislation that addresses diet which requires universal implementation by the food industry.

The Government should therefore consider legislation that incentivises good practice. Research suggests that the design of population-level programmes to address diet through food policy will need careful consideration if they are to positively impact on reducing health inequalities.

RECOMMENDATION 7:

The Government should consider whether implementing legislation that incentivises good practice within the food industry may help reduce the root causes of CVD risk factors.

Measurement of inequalities

At present, the measurement of health inequalities focuses on life expectancy, but further measures could be added, examining the gaps in lifestyle behaviours, including levels of obesity, saturated fat and alcohol consumption, levels of exercise, consumption of five portions of fruit and vegetables a day, and levels of smoking.

These measures could be correlated across different geographic areas and between different social and ethnic groups. This would help us assess whether lifestyle improvements have been made, which would contribute to a reduction in risk factors.

It would also help target interventions to impact more on certain groups and thereby reduce the inequalities gap.

RECOMMENDATION 8:

In addition to life expectancy, Public Health England should measure gaps in risk factors for CVD between different geographic areas and between different social and ethnic groups, to provide a more comprehensive picture of inequalities.

Investment in addressing inequalities between North and South

This report has highlighted the inequalities that persist between the North and South of England. The north-south divide may well be exacerbated by the current economic recession. Indeed,

one of the factors that the directors of public health frequently cited to improve health inequalities was better employment opportunities.

It is apparent that a range of socio-economic factors need addressing in order to tackle health inequalities – health promotion and prevention programmes are just part of the bigger equation.

RECOMMENDATION 9:

Government should invest in addressing the full range of socio-economic factors that determine health inequalities, which will help narrow regional disparities in life expectancy in the UK.



We're passionate about preventing early deaths caused by high cholesterol and cardiovascular disease. We provide support, guidance and education about the dangers of cholesterol.

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