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FORUM

UK, European and Global Public Health approaches to reducing health inequalities and NCD's

ADPH

Paul Lincoln


BAD
SLIDES
AHEAD

Purpose

- Health inequalities from an NCD perspective
- Update UK, EU , WHO , UN and related civil society developments
- Frameworks, narrative, critique and resources
- Ways forward at different levels
- UKHF perspective

Everything you wanted to know about the UK Health Forum and more

UKHF strategic focus

- Upstream- international, national and local
- High impact
- Systemic and sustainable change
- Take account of equity, inequalities, social justice and sustainable development

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NCD's are a cause and manifestation of health inequalities in current and future generations

Avoidable NCD's and conditions

- CHD and Stroke
- Circulatory diseases
- Cancers
- Respiratory diseases
- Liver disease
- Type 2 Diabetes
- Kidney disease
- Obesity
- Vascular Dementia

NCDs – a major global burden

- **Globally** – almost two-thirds of all deaths in 2008 from NCDs (36 million)
- **WHO European Region** - 86% of deaths and 77% of the disease burden
- **United Kingdom** - the leading cause of death in 2008 (518,400)


Life is to blame
for everything.

Non Communicable Diseases - The Big Challenge

- Major causes of avoidable mortality, morbidity and disability and inequalities
- Common risk factors and wider determinants
- Linked chronic conditions- many manifestations
- That's Life!
- Decades lag period throughout the life course
- Genotype and phenotype interactions
- Habitual and addictive behaviours
- Social and environmental patterning of behaviour

Non Communicable Diseases- The Big Challenge

- Industrial epidemics- commercial determinants
- Major risks from consumption of tobacco, alcohol and ultra processed foods
- Dose and duration
- Changing intergenerational risks
- Avoidable or postponable components of morbidity, disability and ageing
- Solutions predisposed to have considerable ideological bias


...IT LOOKS LIKE WE MIGHT HAVE A MUCH BIGGER ROLE IN THE NEW HEALTH CARE PROGRAM..
caglecartoons.com
LARRY WRIGHT
THE DETROIT NEWS

Comorbidities: Our *current* understanding

- Comorbidity is expected to;
  - grow in prevalence (1.9 to 2.9million 2008-2018)
  - grow in cost *(currently £8-13billion/year in England)*
- Because of;
  - an ageing population
  - historically deteriorating health behaviours
  - increasing health inequalities and reduced access to health resources
  - Poor management of the physical health of people with mental illness
  - Poor management of the mental health of people with LTCs

People with mental illness die of the same causes as the general population but sooner

Table 1: Prevalence of modifiable cardiovascular risk factors in people with severe mental illness and relative risk compared to general population.
Adapted from De Hert et al (2011)

	Prevalence	Relative Risks
Smoking	50-80%	2-3
Obesity	45-55%	1.5-2
Diabetes	10-15%	2-3
Hypertension	19-58%	2-3
Dyslipidaemia	25-69%	≤5
Metabolic syndrome	37-63%	2-3

Population level determinants

- Social
- Environmental
- Economic
- Cultural
- Commercial and market
- Global/EU
- Civic
- POLITICAL

The hazards associated with upstream measures

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Working with Government

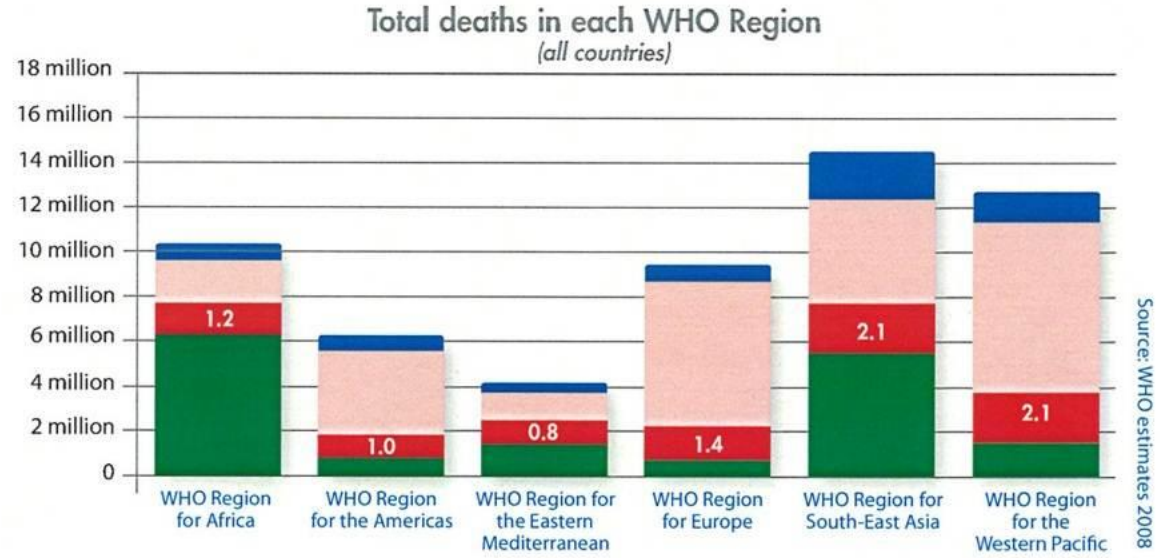
Tackle the “Inverse (Public) Health Law”

- Poor utilisation of evidence of impact
- Avoidance of high impact upstream public health measures
- Poor absolute and relative investments in health improvement especially primary prevention
- Underutilisation of the third sector- civic and civil society
- Commercial freedoms of health damaging industries trump human rights, especially of the young and vulnerable

Global Health- NCD's and inequalities

fact
3

Premature deaths from NCDs occur in all regions of the world



World Health Organization

UN High Level meeting on NCD's 2011

- Second ever UN high level meeting on health
- Political Declaration- 191 countries
- WHO Global action plan 2013
- UN Agencies
- MDG review links

Global magnitude and impact

- More deaths than all other causes combined
- By 2030 projection five times communicable disease death rate (including LMIC's)
- Alter demographics
- Stunts country level development
- Impact on economic growth
- Poverty and MDG's

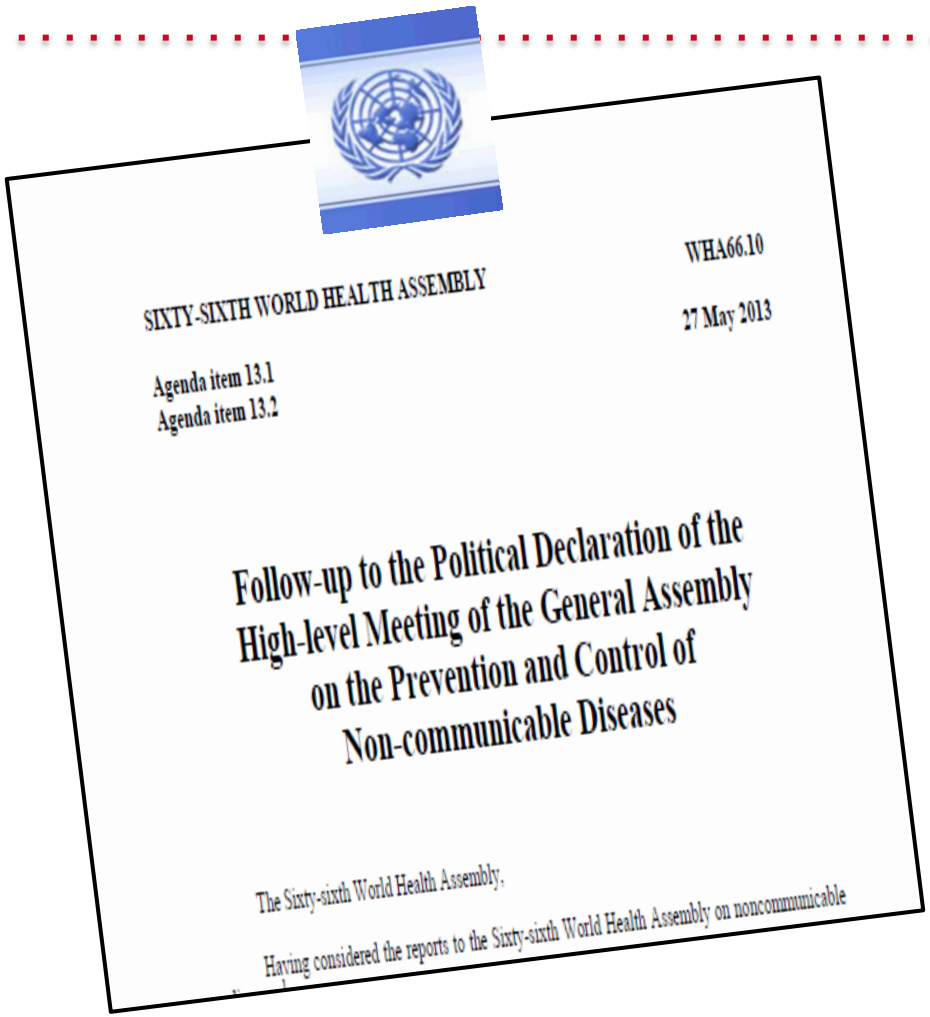
Macroeconomics

- Estimated at $47 trillion over the next two decades.
- Approximately 75% of the 2010 global gross domestic product (GDP). *Source: World Economic Forum / Harvard School of Public Health. 2011*
- Diseases that “break the bank “
- Lancet – 2% reduction per annum, 36 million lives saved,$9 billion
- Austerity
- No new global fund

Magnitude and impact

- “Public health emergency in slow motion”
- “Spreading round the world with stunning speed and sweep”
- Not a mark of failure of individual will power, but politics at the highest level
- Two –punch blow to development- national economies and individuals in poverty
- What are the real determinants of this spread?

WHO NCDs developments



SIXTY-SIXTH WORLD HEALTH ASSEMBLY

WHA66.10

27 May 2013

Agenda item 13.1
Agenda item 13.2

Follow-up to the Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases

The Sixty-sixth World Health Assembly,

Having considered the reports to the Sixty-sixth World Health Assembly on noncommunicable

May 2013 WHA adopted

- WHO Global NCD Action Plan
- WHO Global Monitoring Framework & Targets

WHO Global NCD Action Plan Objectives

1. Strengthen international cooperation and advocacy
2. Strengthen national capacity, leadership and multisectoral action
3. Reduce modifiable risk factors and social determinants
4. Strengthen health systems
5. Support research and development
6. Monitor trends and determinants

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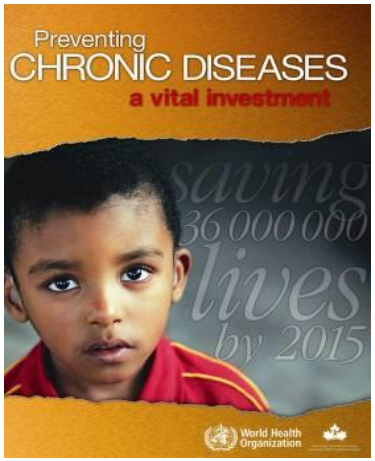
Lancet Four series chronic diseases/NCDs

1. The neglected epidemic, 2005
2. The case for urgent action, 2007
3. Chronic disease and development, 2010
4. NCDs: towards sustainable development, 2013

   (3 Comments, 5 Papers, 1 Viewpoint)



Acknowledgements:
National Heart Forum, United Kingdom
International Development Research Centre, Canada

Profits and pandemics:

- Transnational corporations are major drivers of NCD epidemics and profit from unhealthy commodities
- Public regulation and market intervention can prevent harm caused by unhealthy commodity industries

Marketing and consumption behaviours

- Consumption conundrum
- Industrial epidemics
- The business of business is business
- We produce what we can sell not sell what we produce
- Culture of immediate gratification and solutionism
- Children and young people – new markets
- Responsibility of the developed world to the rest of the world

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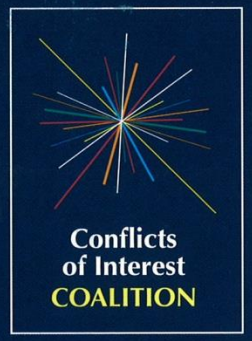
Ensure not conflicted, compromised or captured



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Conflicts of Interest Coalition
Statement of Concern

This Statement of Concern has been developed by the Conflicts of Interest Coalition*. It focuses on the lack of clarity regarding the role of the private sector in public policy-making in relation to the prevention and control of non-communicable diseases (NCDs).

It calls for the development of a Code of Conduct and Ethical Framework to help protect the integrity of, and to ensure transparency in, public policy decision-making, by safeguarding against, and identifying and managing conflicts of interest.

The Statement of Concern has been sent to the President of the United Nations General Assembly and the co-facilitators of the United Nations High Level Meeting on the Prevention and Control of Non-Communicable Diseases.

As of September 2011, the statement has been endorsed by 138 national, regional and global networks and organisations working in public health, including medicine, nutrition, cancer, diabetes, heart disease, lung disease, mental health, infant feeding, food safety and development.

To add your organisation's support for this crucial issue, please email prundall@babymilkaction.org or policy@wcrf.org.

** The Conflicts of Interest Coalition comprises civil society organisations united by the common objective of safeguarding public health policy-making against commercial conflicts of interest through the development of a Code of Conduct and Ethical Framework for interactions with the private sector.*

The vested interest prevail

Costs of interventions

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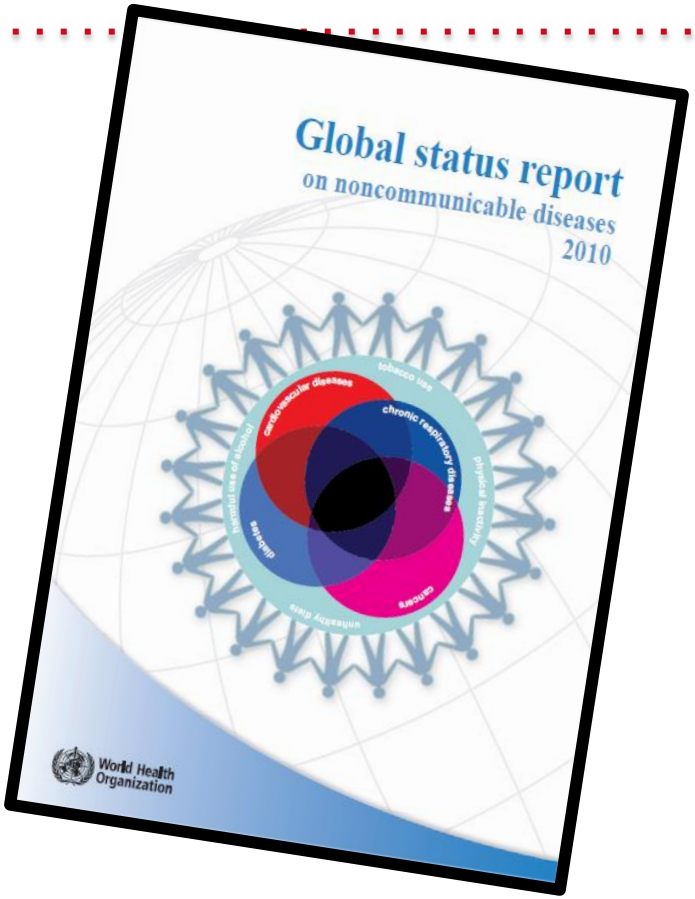
Risk factor	Interventions	Source	Yearly implementation cost per capita					
			Brazil	China	India	Mexico	Russian Federation	South Africa
Tobacco use	**Excise tax increase, information & labeling, smoking restrictions & advertising bans**	**(Asaria et al, 2007)**	**$0.25**	**$0.14**	**$0.16**	**$0.54**	**$0.49**	**$0.60**
Alcohol use	Excise tax increase, advertising bans and restricted access	(Anderson et al, 2009)	$0.15	$0.07	$0.05	$0.24	$0.52	$0.29
Unhealthy diet and physical inactivity	Mass media campaigns, food taxes and subsidies, nutritional information / labeling, marketing restrictions	(Cecchini et al, 2010)	$0.48	$0.43	$0.35	$0.79	$1.18	$ 0.99
High blood pressure and cholesterol	**Reduced dietary salt (mass media campaigns, regulation of food industry)**	(Asaria et al, 2007)	**$0.12**	**$0.05**	**$0.06**	**$0.22**	**$0.16**	**$0.15**
	Combination drug therapy for individuals at high-risk of NCD	(Lim et al, 2007)	$1.89	$1.02	$0.90	$2.74	$0.73	$1.85
Total cost* per capita of core interventions			**$0.37**	**$0.19**	**$0.22**	**$0.76**	**$0.65**	**$0.75**
Total cost* per capita of core and expanded intervetnions			$2.89	$1.72	$1.52	$4.53	$4.08	$3.88

WHO ‘best buys’ for NCD interventions

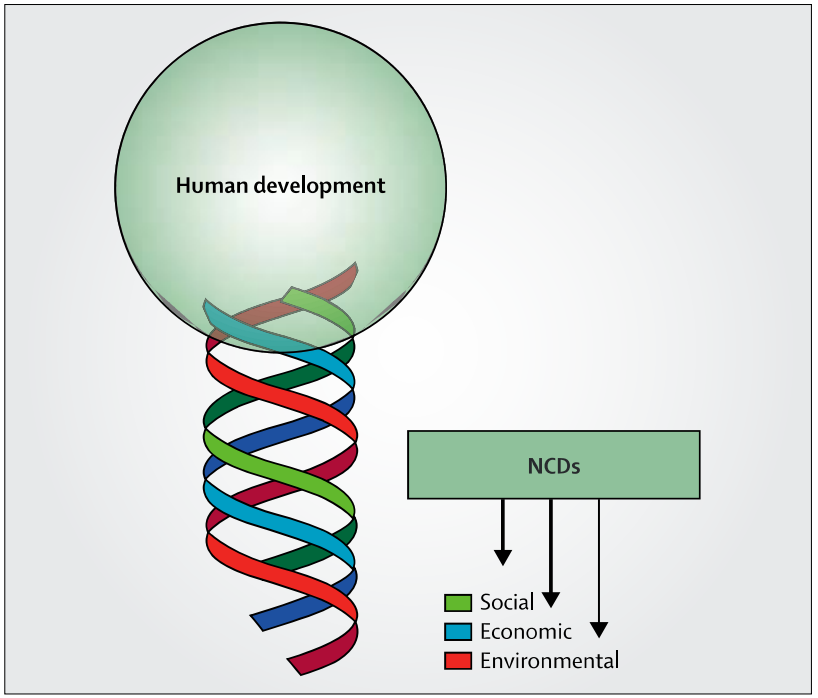
1. Protecting people from tobacco smoke and banning smoking in public places;
2. Warning about the dangers of tobacco use;
3. Enforcing bans on tobacco advertising, promotion and sponsorship;
4. Raising taxes on tobacco;
5. Restricting access to retailed alcohol;
6. Enforcing bans on alcohol advertising;
7. Raising taxes on alcohol;
8. Reduce salt intake and salt content of food;
9. Replacing trans-fat in food with polyunsaturated fat;
10. Promoting public awareness about diet and physical activity, including through mass media.



Embedding NCDs

The post-2015 human development agenda will:

- Include Health as a goal
- Incorporate the agreed "25 by 25" NCD goal (25% reduction in avoidable NCD mortality).



The effects of NCDs on the sustainability of human development

UN High Level Panel Report: "A New Global Partnership"

Overview:

- A single, coherent, universal agenda based on the MDG priorities and progress
- Eradicating extreme poverty by 2030 at the centre
- Merges all 3 dimensions of sustainable development – social, economic, environmental

UN High Level Panel (June 2013) A New Global Partnership: http://www.post2015hlp.org/wp-content/uploads/2013/05/UN-Report.pdf

UN High Level Panel Report: proposed 12 goals, 54 targets

1. End poverty
2. Empower girls and women and achieve gender equality
3. Provide quality education and lifelong learning
4. Ensure healthy lives
5. Achieve universal access to water and sanitation
6. Ensure food security and good nutrition
7. Secure sustainable energy
8. Create jobs, sustainable livelihoods, and equitable growth
9. Manage natural resource assets sustainably
10. Ensure good governance and effective institutions
11. Ensure stable and peaceful societies
12. Create a global enabling environment and catalyse long-term finance

Link with sustainable development and climate stabilisation

Social and Global Factors

- Trade agreements
- Agricultural policies
- Transportation policies
- Urbanization
- Industrialization
- Globalization
- Government policies to protect population health and promote social justice

Rio +20: examples of indicators with co-benefits to other sectors

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Health indicator	Other sectors
Stunting in < 5s	Chronic food insecurity
Obesity	Nutrition security (quality)
Saturated fat	Meat & dairy production / GHG
Trips by public transport, walking & cycling	Sustainable transport
Disease burden attributable to air pollution	Household access to clean energy Outdoor air pollution

Viewpoint: Improving responsiveness of health systems to NCDs. *Atun R, et al*

- The lessons learnt from the HIV response can guide the introduction and stepwise expansion of the actions to address NCDs and multi-morbidity.

- The challenge to embracing integration opportunities for NCD prevention and care, will be less clinical, but more managerial and political.

Other possible next steps

- Bretton Wood organisations- beyond the UN system
- Global responsibilities of countries with exporting interests in tobacco, alcohol and HFSS processed foods
- Industry watch - FCAC
- Global support networks- NCD links

What is happening in the UK?

Fair Society, Healthy Lives

UK wide perspective

- Public Health Act – Wales
- MUP alcohol Scotland and Northern Ireland
- Marketing controls in Scotland – retailers
- Salt reduction – Scotland
- Council of the Isles
- Local Government – experiments – MUP, restrictions on sales of alcohol and fast foods

NICE population level reviews

- NICE CVD population level interventions guidance Nos. 25, 2010
- NICE Alcohol population level interventions 2010
- Health inequalities can be reduced through actions that bring aggregate benefits and reduce the overall NCD burden and the greatest improvement for those most affected
- Who's role is it to independently and scientifically assess the evidence?
- Upstream population measures at national and local levels

Public health organisations

ASDA – removed alcohol from store foyers…

… then put it back

"It is up to the government to re-engage with us all and get us to the same position. I'm very happy to take it [alcohol] back out of foyers to support the responsible drinking agenda but only if we are all in the same place and level."

Andy Clarke, CEO Asda, quoted in The Grocer 14 September 2013

Social marketing and framing the debate

- More social change type social marketing
- Addressing the social determinants of health
- Empowering communities
- Seeking and securing permission
- Framing the debate
- Addressing asymmetry and misrepresentation
- Factoring civil society into the social marketing mix

The Law and Public Health

- Limited international and national NCD regulations – FCTC
- Bias for self and co-regulation
- Some national level developments
- Laws on equality and health inequalities

Provisions in public health acts relating to equity

Bulgarian Health Act (2004)	"The protection of the citizens' health as a condition of full physical, mental and social wellbeing is a national priority and it shall be guaranteed by the government through the application of the following principles: …equality in the use of health services…"
Finland's Health Care Act (2010)	"The objective of this Act is to…(2) reduce health inequalities between different population groups;" (Section 2)
Greece's Law on Public Health (2005)	"Action to support vulnerable groups and to reduce socioeconomic inequalities in health is an essential part of public health" (Article 2)
Norway's Public Health Act (2012)	the purpose to "contribute to societal development that promotes public health and reduces social inequalities in health".
South Australia Public Health Act (2011)	"Decisions and actions should not, as far as is reasonably practicable, unduly or unfairly disadvantage individuals or communities and, as relevant, consideration should be given to health disparities between population groups and to strategies that can minimise or alleviate such disparities." (Pt 2, 13)
Swedish Health and Medical Services Act (1982)	lists as the overall objective of health and medical care: "Good health and care for the whole population on equal terms".

Four legislative approaches

1. Health Impact Assessment (HIA)
2. Statutory duties to reduce health inequalities
3. Legislating for a focus on prevention
4. Strengthening community action on health protection and promotion

Statutory duties to reduce health inequalities

- Social justice and economic reasons provide a strong incentive to reduce inequalities in health.
- UK estimates suggest that inequalities in illness account for productivity losses of £31-£33 billion per year and lost taxes and higher welfare payments in the range of £20-£32 billion per year (Marmot Review 2010).

Legislating to focus on prevention

- To reduce risk factors through flexible legislation
- To create or mandate bodies with responsibility for disease prevention
- To legislate specific activities for financing of prevention.

Flexible legislation

- The **British Columbia Public Health Act (2008)** allows the minister to require development of public health plans for health promotion and protection and enables the development of health impediment regulations.

- **South Australia's 2011 Public Health Act** gives the Minister power to develop a code of practice in relation to preventing or reducing the incidence of the non-communicable condition.

Legal duties - summary of key points

- The Health and Social Care Act 2012 contains the first ever specific legal duties on health inequalities.
- NHSCB and CCGs have duties to have regard to the need to reduce inequalities in access to health services and the outcomes achieved for patients
- Secretary of State has a duty to have regard to the need to reduce inequalities covering his NHS and public health functions for the whole population.
- NHSCB, CCGs and Monitor have further duties around integration of health services, health-related services or social care services where they consider this would reduce inequalities.
- Monitor can set licence conditions and may appoint a special administrator
- The Act also contains duties around health inequalities on, variously, SofS, NHSCB and CCGs concerning planning, reporting and assessment.

Duty for Secretary of State for Health

"In exercising functions in relation to the health service, the Secretary of State must have regard to the need to reduce inequalities between the people of England with respect to the benefits that they can obtain from the health service".

(Section 1C of the NHS Act 2006, as amended by the 2012 Act)

The phrase "health service" incorporates both the NHS and public health. This duty will also impact on Department of Health in terms of its role to establish NHS and public health systems.

Local Government

No specific health inequalities duty on local authorities.

Duty to improve the health of the community on upper tier and unitary authorities.

However –

A local authority must, in using the grant, have regard to the need

to reduce inequalities between the people in its area with respect

to the benefits that they can obtain from that part of the health service provided by the local authority.

Fuel Poverty & Health

- There is a growing body of evidence linking cold, damp homes to long term ill health (cardiovascular and respiratory diseases, mental health) and excess winter death.

- The poor health that comes from being fuel poor has become part of the public, mainstream discussion.

- In 2003, the National Heart Forum produced *Fuel Poverty & Health: A toolkit for primary care organisations, and public health and primary care professionals.*

- In summer 2013, UKHF undertook an information needs assessment of Healthy Places – fuel poverty and cold homes were identified as an area of interest and potential expansion.

Fuel Poverty & Health Toolkit

Coming the end of November/beginning of December 2013

The toolkit "bundle" will live on the *Fuel Poverty* key issue page under the *Healthy Housing* theme:

- Fuel poverty & health toolkit **document** (pdf available for download)
- Supplementary documents (pdfs available for download) – flexible
- "Living" list of **resources & signposts** – with active links, easy to update
- **Case Studies** – fuel poverty specific within the Healthy Places directory
- Appropriate **regulatory options**
- Fuel poverty specific **news** feed - members resources

Fuel Poverty & Health Toolkit

The **document** will highlight the latest evidence and the current policy framework...

- An introduction to fuel poverty
- The effects of fuel poverty and cold homes on health and well-being
- The national and local policy framework for tackling and preventing fuel poverty and cold homes
- The role of Health & Well-being Boards, public health teams and health professionals in addressing fuel poverty and cold homes

European Union

- Equity Action – Joint action across member states and European Commission

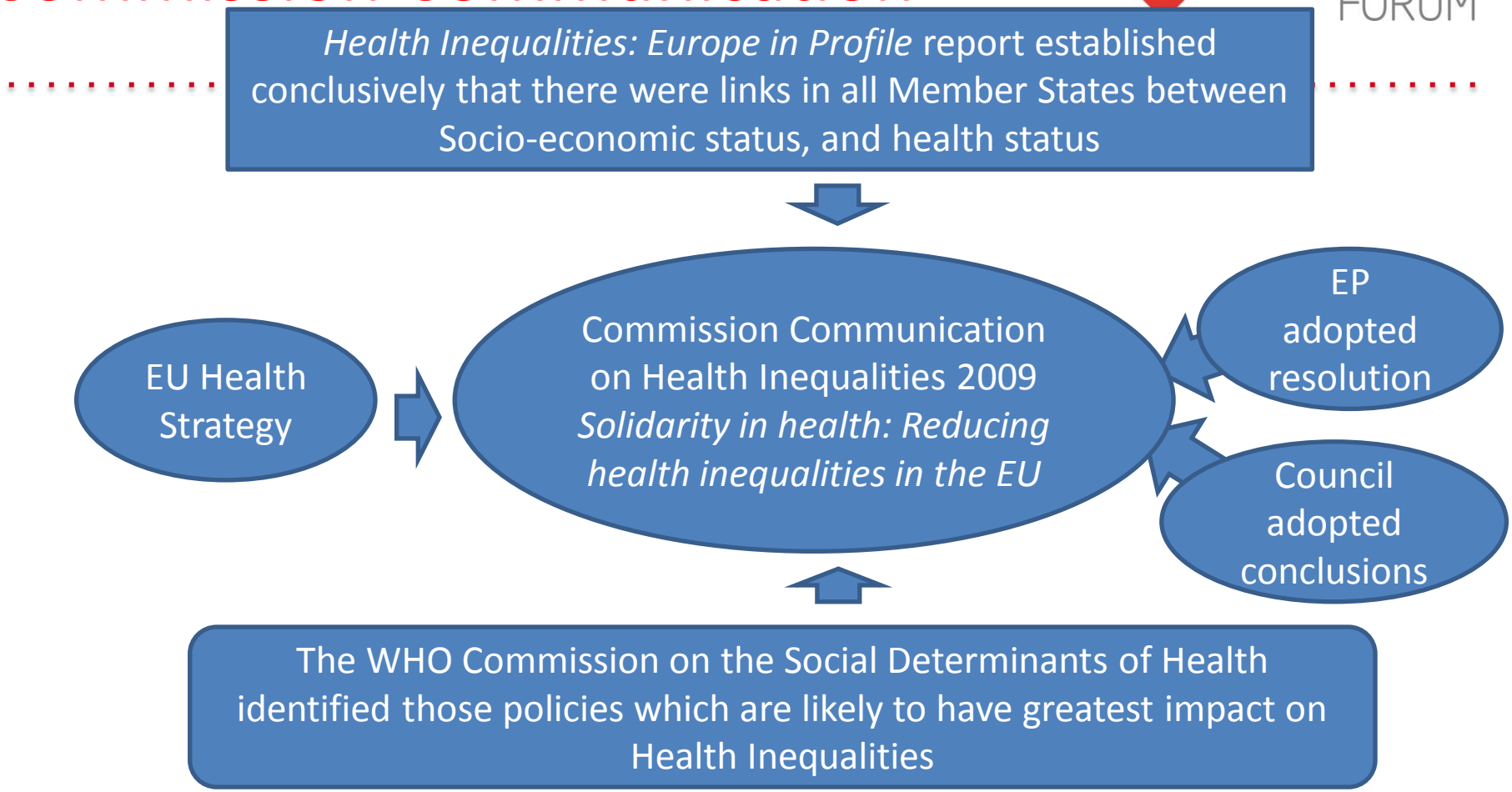
Equity Action Final Conference

- Where: CHARLEMAGNE BUILDING, EUROPEAN COMMISSION, BRUSSELS
- **When: 23rd January 2014**
- Title: **ADDRESSING HEALTH INEQUALITIES** 2014 and beyond
- BUILDING COHESION AND STRENGTHENING HEALTH FOR GROWTH

Equity Action Final Conference

- **Purpose**
- To showcase the results of the Joint Action on health inequalities ‘Equity Action’
- To assess progress on addressing health inequalities in the EU.
- To consider opportunities and priorities for action.

EU level actions -- the Commission Communication



Council of the European Union- reflection process –NCD's in public health and health care systems

- Health care costs 700 bn Euro's
- 3% invested in prevention
- Joint action plan 2014 – 10 million Euro's
- Central priority-all action will seek to help reduce inequalities
- Health in all policies- greater action on risk factors
- Irish presidency – childhood obesity 2014-20

EU action

- Better data and forecasting and planning
- Knowledge exchange
- Tipping points – frailty etc
- Horizon 2020
- Health information
- Targeted prevention
- Chronic disease management-multiple morbidity
- EU summit 2014

EU level actions on Health Inequalities

The EU Communication has helped give a strong focus on Health Inequalities.

There have been several levels of policy response:

- Overarching frameworks, such as 'Europe 2020' focus on poverty and social inclusion.
- Policies that recognise their explicit role in addressing health inequalities both within and outside public health (e.g. Environmental Action Programme)
- Policies focusing on 'at risk' and excluded groups (e.g. Roma and Migrant Health)
- Policies focused on lifestyle, which are strongly socially patterned (e.g. tobacco, nutrition)
- Policies focused on a particular condition (e.g. European Pact for Mental Health)
- Improving data sources such as EU Survey of Income and Living Conditions
- As well as funding to improve baseline data (e.g. ECHI – European Community Health Indicators).
- and funding to improve access to funds (e.g. Joint Action/Euregio III re structural funds)

WHO HEALTH2020

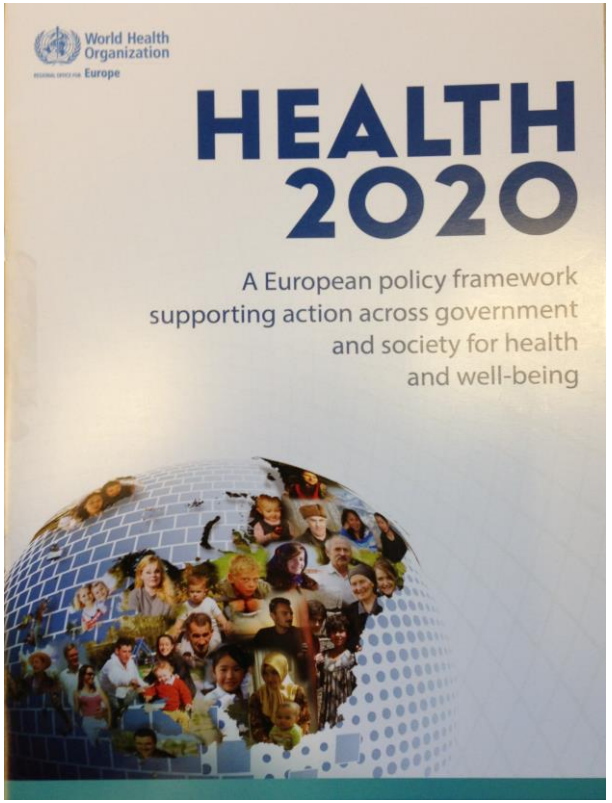
Priority areas:

1.Lifecourse and empowering people

2.NCD's and communicable diseases

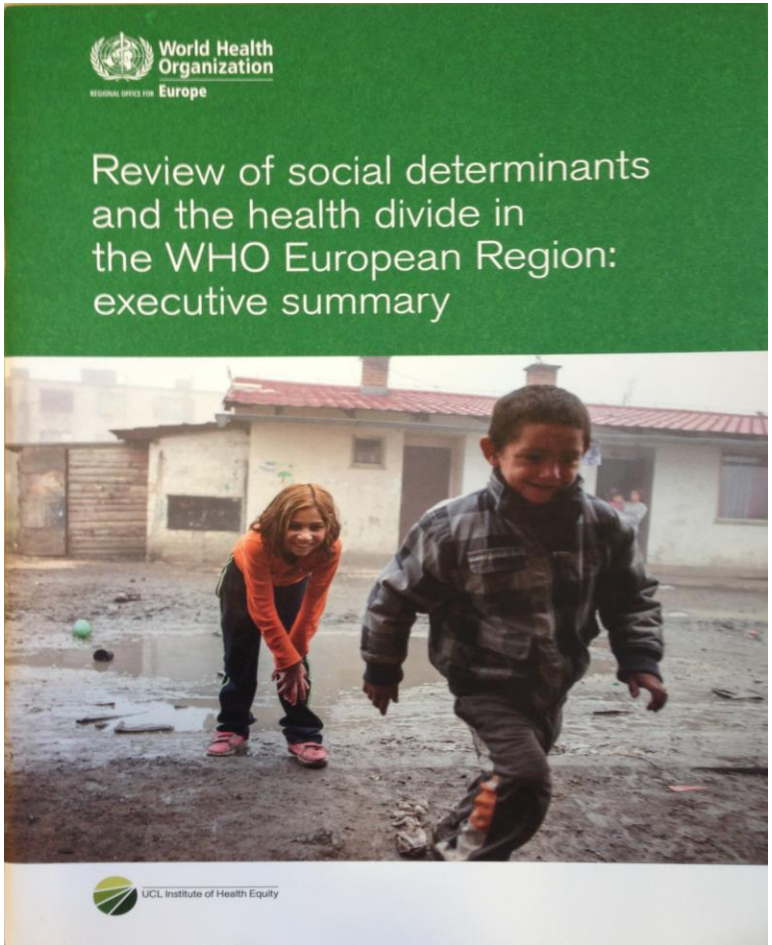
3. Strengthening health systems

4. Resilient communities and supportive environments

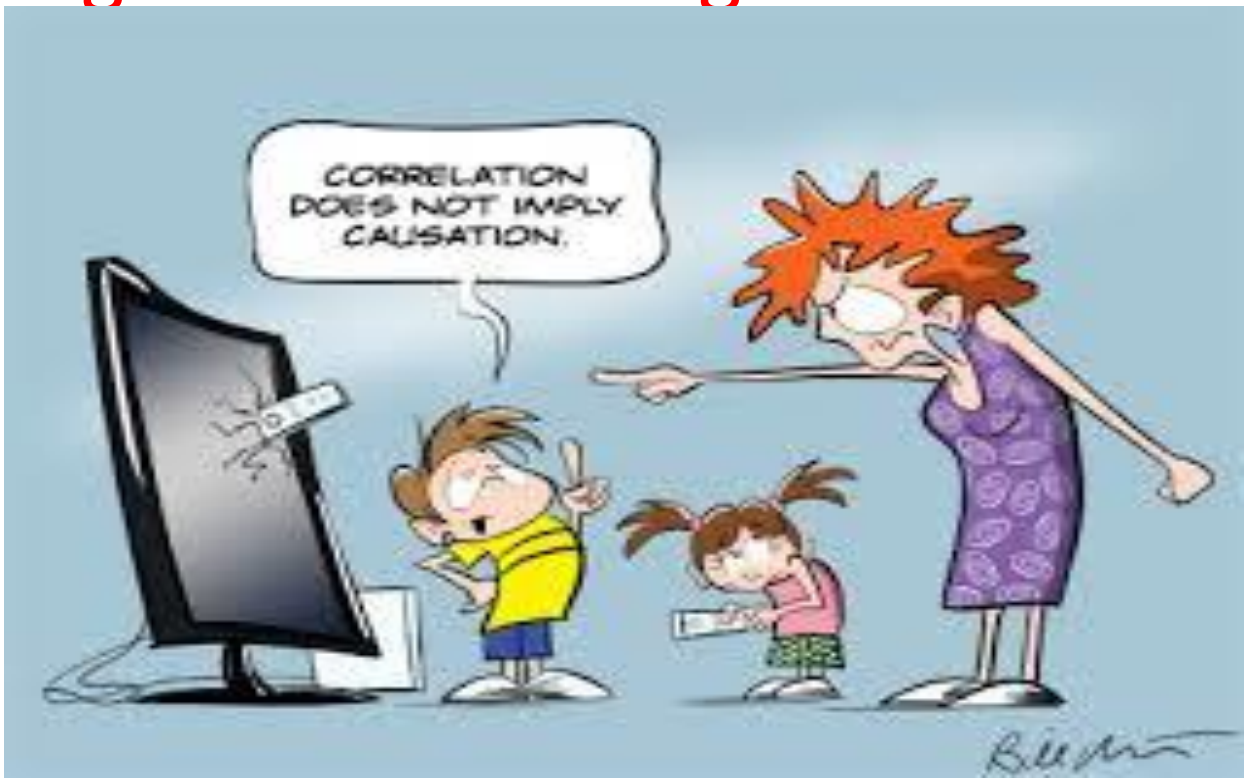


WHO Social Determinants

- Social determinants
- Intergenerational equity
- Life course approach
- Child poverty
- Chronic morbidity –older people
- Socially progressive policies- austerity and social protection
- Human rights and freedoms
- Co- production



Modelling and Forecasting



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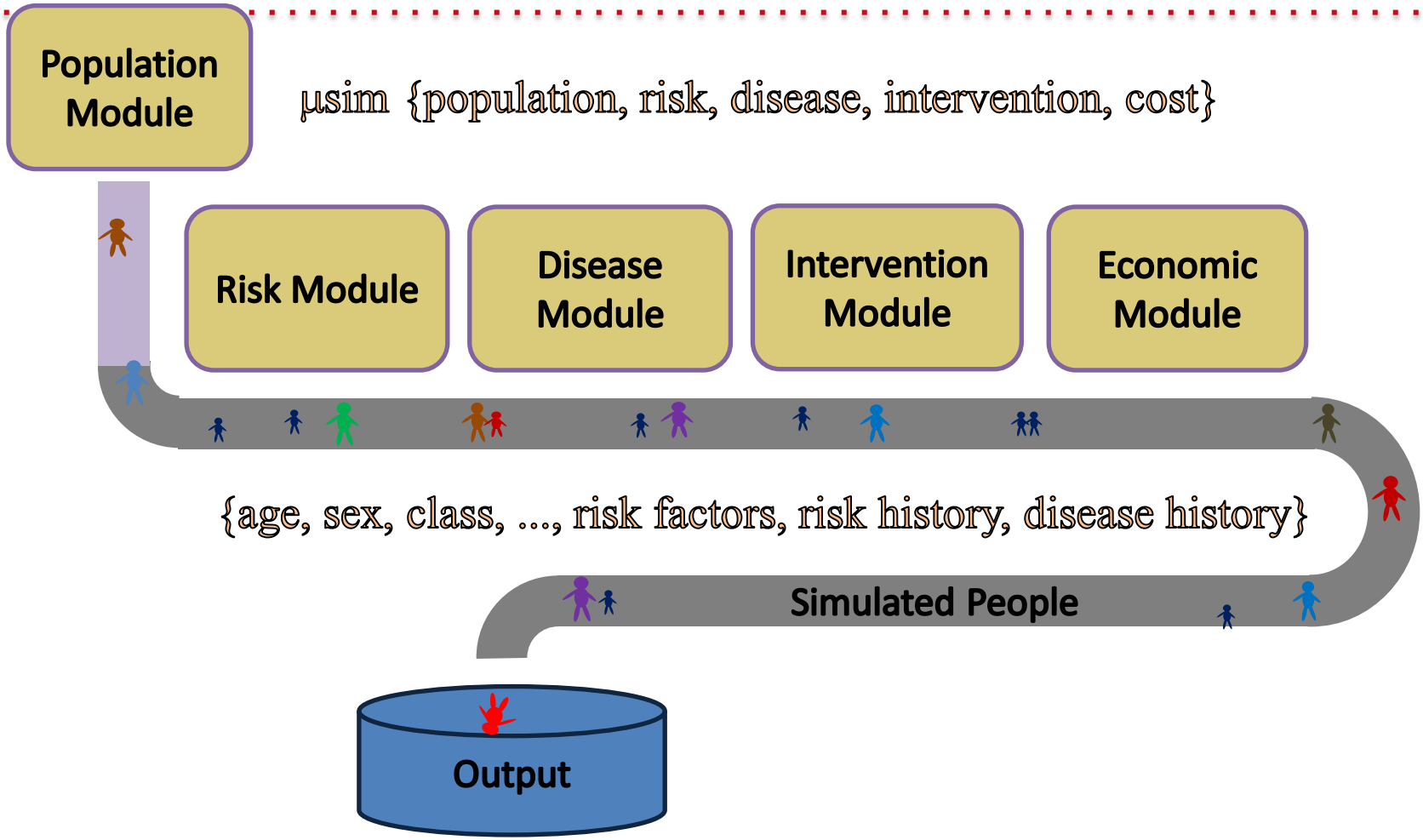
It is far better to foresee even without certainty than not to foresee at all.

Henri Poincare in *The Foundations of Science*

Micro-Simulation



The power of modelling

Rates of BMI ≥25kg/m² + in 2030

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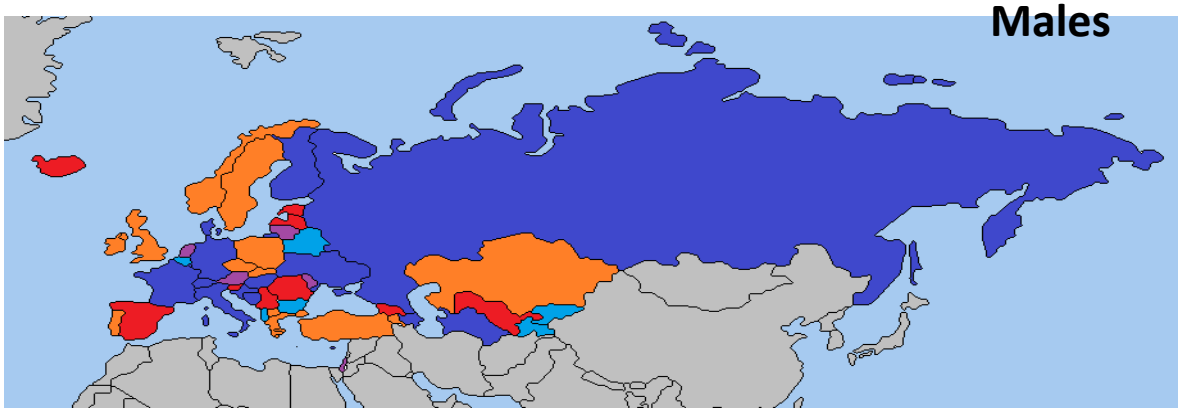

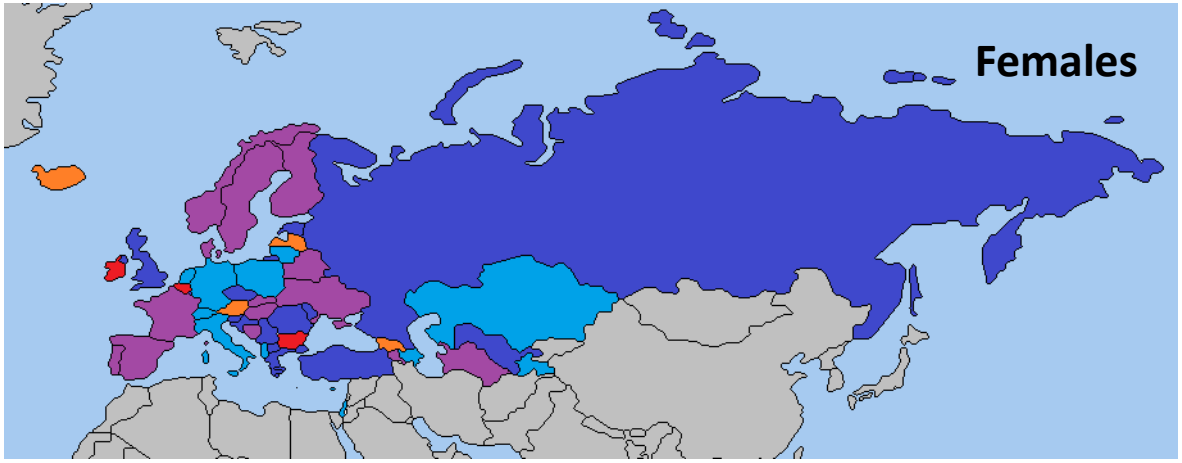

WHO report on Obesity forthcoming

Rates of BMI ≥30kg/m² in 2030

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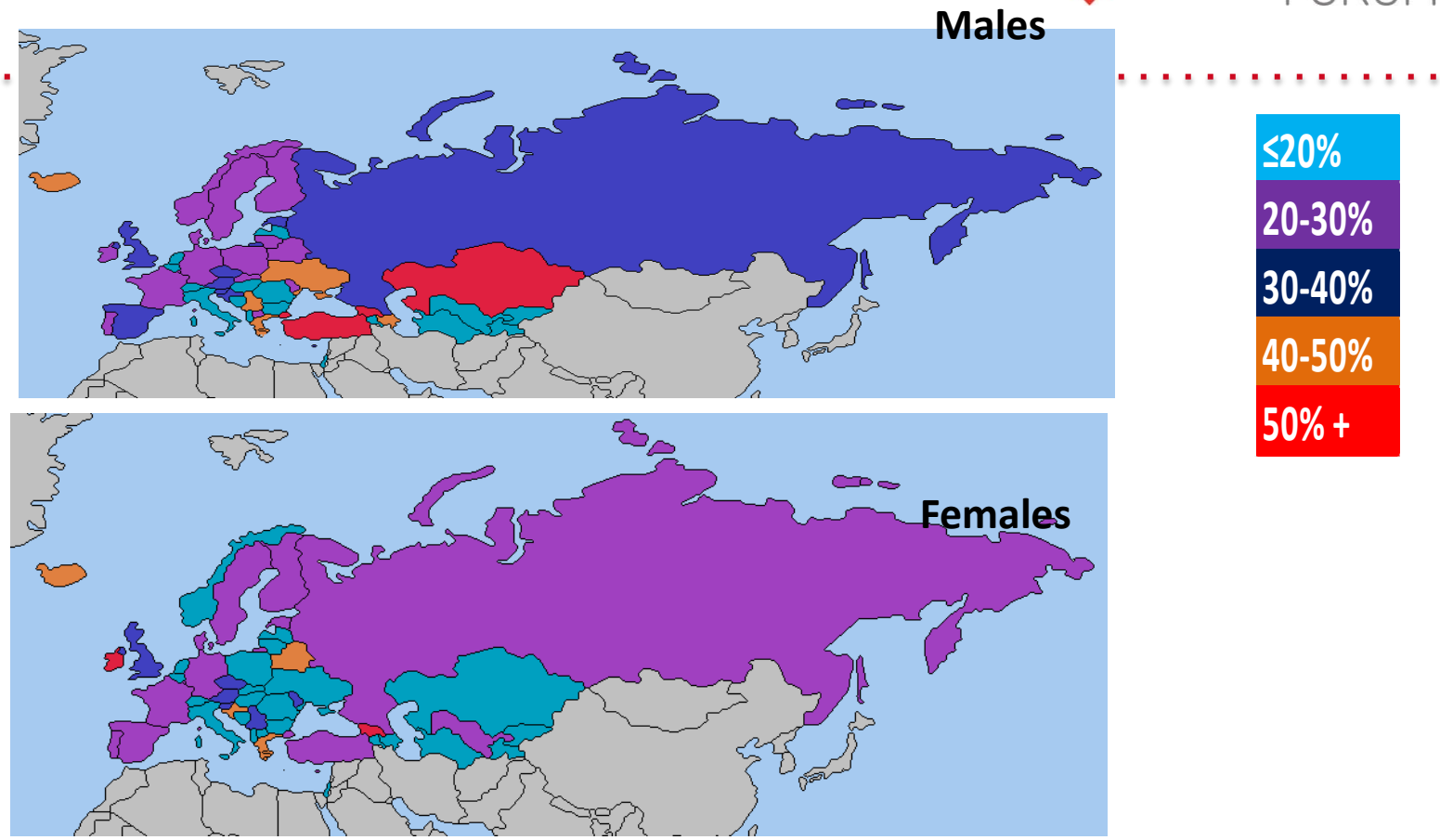

WHO report on Obesity forthcoming

Observatory – on vector marketing risks

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OXFORD MARTIN SCHOOL

UNIVERSITY OF OXFORD

Agenda for the Long Term

- Threats posed by business as usual
- Generated most of the externalities
- Existing structure bestows a higher premium on immediate returns on investment
- What is owed to future generations?
- Revalue the future
- Invest in younger generations
- Establish a common platform of understanding

The UKHF's information niche

Healthy Places web-based resource

Enabling Active Travel

Walking and cycling through active travel provides opportunities for everyday physical activity.

Access to Healthy Food

For people to make healthy food choices, healthy food options need to be available and accessible.

Promoting Active Communities

Healthy, active lives can be fostered through the creation of more activity-friendly places.

Case Studies

Practical examples of how law has been used to promote healthier local places

Information services

Websites, information & knowledge products

	Prevention Information and Evidence eLibrary (P.I.E) UKHF website ukhealthforum.org.uk	Obesity Learning Centre – Knowledge and innovation network obesitylearningcentre.org.uk	Healthy Places – Wellbeing in the local environment healthyplaces.org.uk	Ncdlinks.org Community of Practice ncdlinks.org
Audience	NHS, local authority/gov, VCS, government, international organisations, academia	NHS, local authority/gov, VCS, government, international organisations, academia, schools, industry, weight management orgs.	Public health, local authorities, city/transport planners, VCS	Global policy, government, health and care practitioners
Topics	Prevention of NCDs: risk factors, determinants & inequalities	Obesity, physical activity and nutrition	Access to healthy food, local alcohol control, active communities, active travel, healthy housing	Physical activity & nutrition (Panacealink), Tobacco (Globalink), Alcohol (Caribapan for the Caribbean; new Alcohol and Health Link).
Content	Collection and dissemination of quality assessed news (media), policy reports, case studies etc.	Collection and dissemination of quality assessed news (media), policy reports, case studies and tools.	Regulatory and case law, soft policy (e.g. government scheme for local fuel poverty)	Feeds through topic specific news and content from P.I.E
Functionality	Searchable P.I.E elibrary, subscription briefing service	Discussion boards, membership and resources directory, national networks, content geared to specific roles (e.g. local gov.), legacy, elearning	Case studies, plain language case law, regulatory options, cross-sector links, PDF maker	The closed networks function independently, knowledge and information sharing in discussion boards, membership directories

Concluding threads

- NCD's major continuing cause of health inequalities - between population groups, countries and generations
- Individual, social, economic disasters
- Consider an integrated approach to NCD's, their common risk factors ,determinants and distribution – including co-morbidities
- Address the "Inverse PH Law" – tackle -structural inequalities
- A difference will only be achieved by smart investment in publically supported upstream measures especially on the commercial determinants

Concluding threads

- Social marketing – move to social change and public permission
- Observatories on marketing of disease vector industries
- Development of PH Law
- Integrate NCD prevention with sustainable development and poverty reduction and health in all policies
- Revalue the future - ROI – modelling
- Conflicts of interest
- And finally

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The persistence of NCD inequalities is a political and technical failure

The end!

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Do you have any question ?