Living in the Gap:

A voluntary health sector perspective on health inequalities in Scotland

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Perth & Kinross Integration Joint Board

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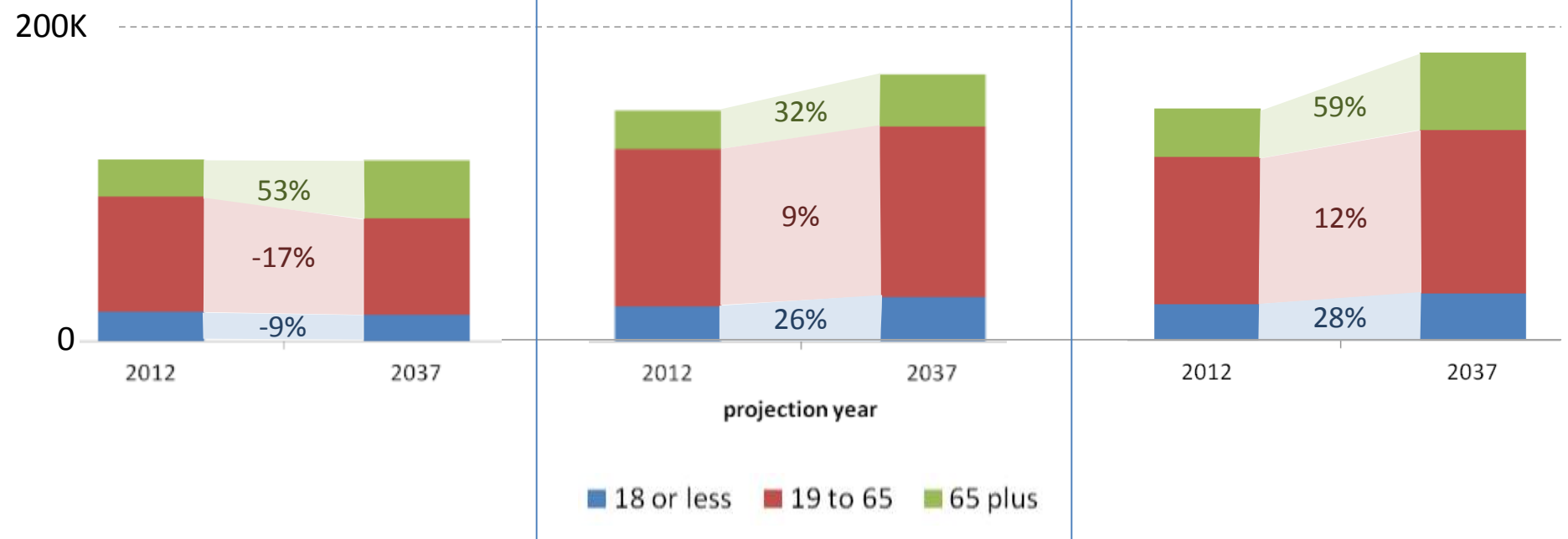
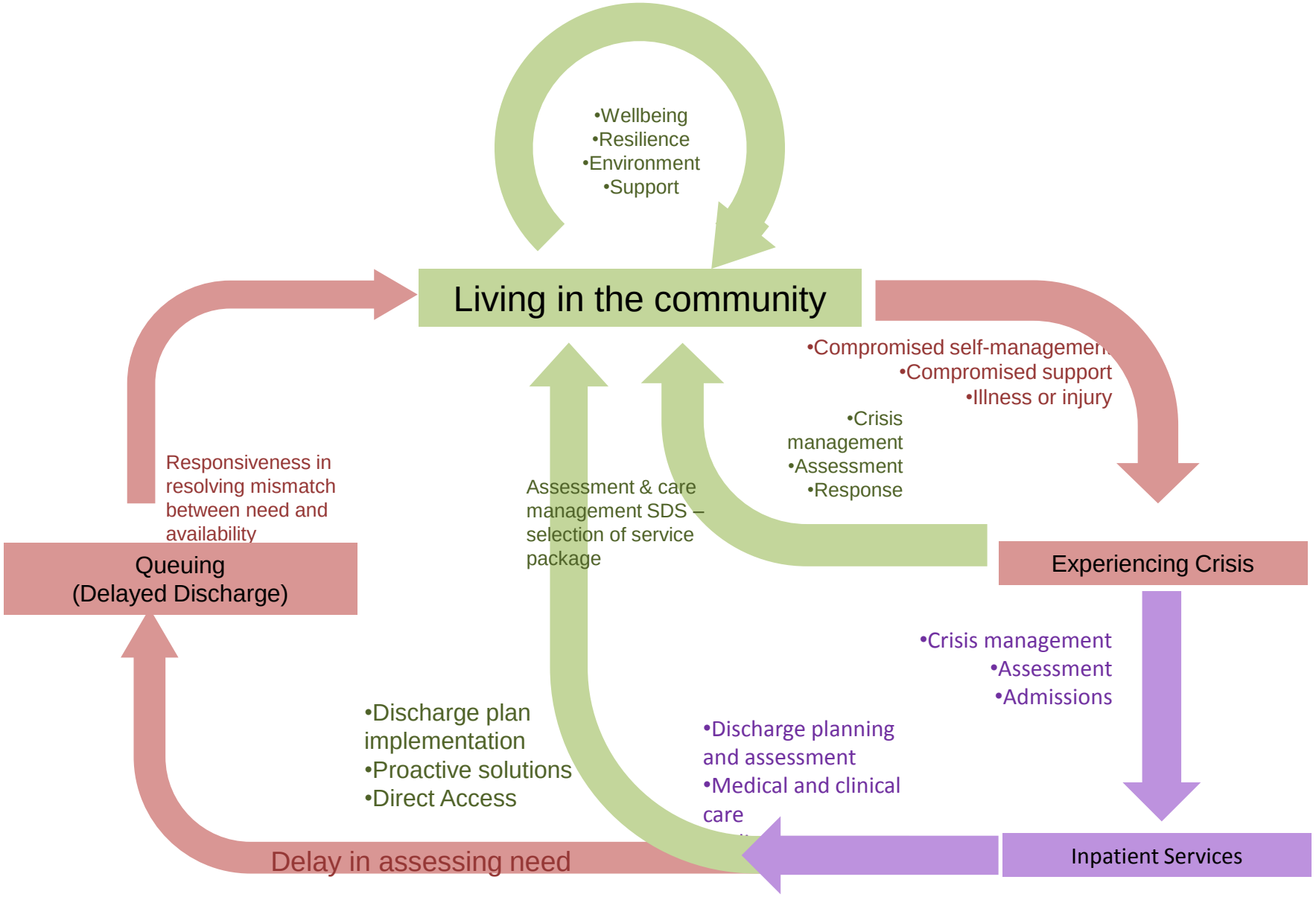
Population projections (Source: NRS)

Angus	Dundee	Perth and Kinross
Population decline is expected below-pension age, balanced by a rise in the elderly. Population size is projected to be relatively stable but rapidly ageing population.	The population is expected to increase. The increase is more uniform across the age groups compared to the other areas.	The population is expected to rise and age considerably. The working age group is the slowest-rising group. Half of the overall increase is anticipated to be through net migration.
Dependency ratio 0.58 →0.88	Dependency ratio 0.47 → 0.56	Dependency ratio 0.58 → 0.75



Deprivation Index (Source: SIMD)

Angus	Dundee	Perth and Kinross
6%	56%	8%
Scottish Average 20%	Scottish Average 20%	Scottish Average 20%


•Wellbeing
•Resilience
•Environment
•Support
Living in the community
•Compromised self-management
•Compromised support
•Illness or injury
•Crisis management
•Assessment
•Response
Responsiveness in resolving mismatch between need and availability
Assessment & care management SDS – selection of service package
Queuing (Delayed Discharge)
Experiencing Crisis
•Crisis management
•Assessment
•Admissions
•Discharge plan implementation
•Proactive solutions
•Direct Access
•Discharge planning and assessment
•Medical and clinical care
Delay in assessing need
Inpatient Services

Claire Stevens

Voluntary Health Scotland

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voluntary health scotland

- **Big divide between rich and poor in life expectancy**
- **People ‘living in the gap’ get sick more and for longer**
- **National policy initiatives have had little impact**
- **Health inequalities are unfair, not inevitable, and must be tackled**

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- **Context review**
- **Qualitative study**
- **Electronic survey**
- **Interviews and case studies**
- **Workshop observations**
- **Analysis and reporting**

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Our questions to voluntary [health] organisations

- What role do you play in reducing the impact of health inequalities on individuals, families and communities?
- What can you tell us about the lived experience of people affected by health inequalities?

Electronic survey respondents main areas of work

- **Health (60%)**
- **Children & young people (46%)**
- **Social care (44%)**
- **Disabilities (43%)**
- **Volunteering (43%)**
- **Mental health (37%)**
- **Older people (36%)**
- **Housing (22%)**

The lived reality of health inequalities

- **Social isolation**
- **Service access barriers**
- **Poverty**
- **Stigma**
- **Behaviours**

3rd sector role & impact

- **Shared commitment to address inequalities**
- **Mitigating the negative effects of health inequalities**
- **Wraparound & person centred approach**

Challenges

- **Sustainability**
- **Evidencing value and impact**
- **Level of demand**
- **A culture of too much change**
- **Lack of recognition**
- **Lack of influence**

Opportunities

- **Articulate the lived reality**
- **Work together better**
- **Get upstream**
- **Leadership by the sector**
- **Prioritise inequalities for funding**

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Closing the Gap

- **Make health inequalities everyone's business**
- **Get policy and decision makers to ensure effective partnership working between public and voluntary sectors is the norm**
- **Invest in 'what works well' and develop tools and resources to extend and embed effective interventions**

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Thank you

We welcome new members from all sectors – join us now.
www.vhscotland.org.uk/get-involved

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Round table discussion

How do we make health inequalities everyone's business?

- **Health and Social Care Integration**
- **National conversations**
- **Scottish Parliament Election 2016**

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Case study discussion

- ***Jan Bell - Dundee Home from Hospital Project***
- ***Linda Bates - ASH Scotland***
- ***David Ross - Fife Society for the Blind***

Dr Pauline Craig

NHS Health Scotland

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Health Inequalities and the Voluntary Sector

VHS Living in the Gap 2015

Pauline Craig

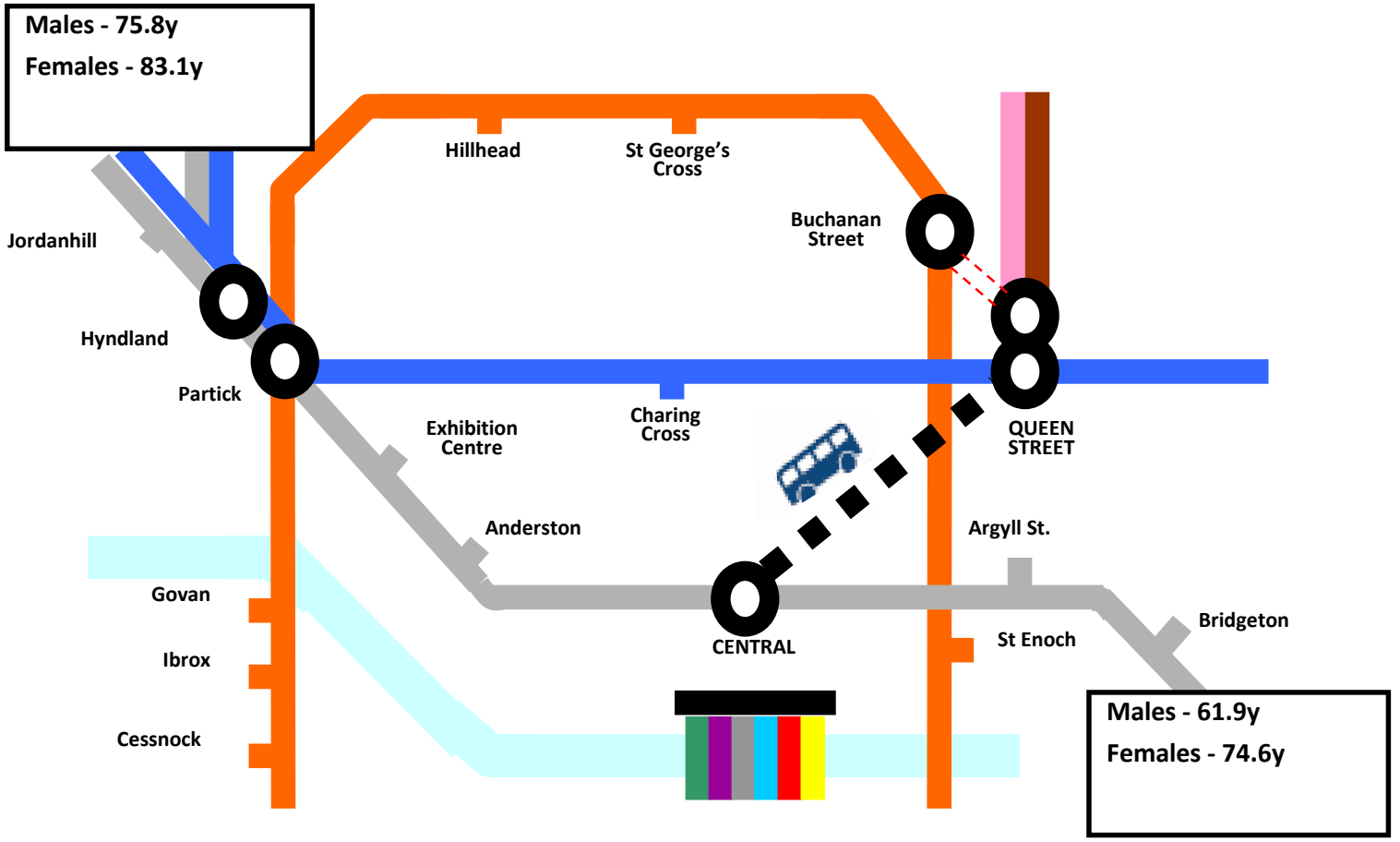
What do we mean by health inequalities?

Health inequalities are:

- **Unfair** differences in health within the population across social classes and between different populations

These unfair differences:

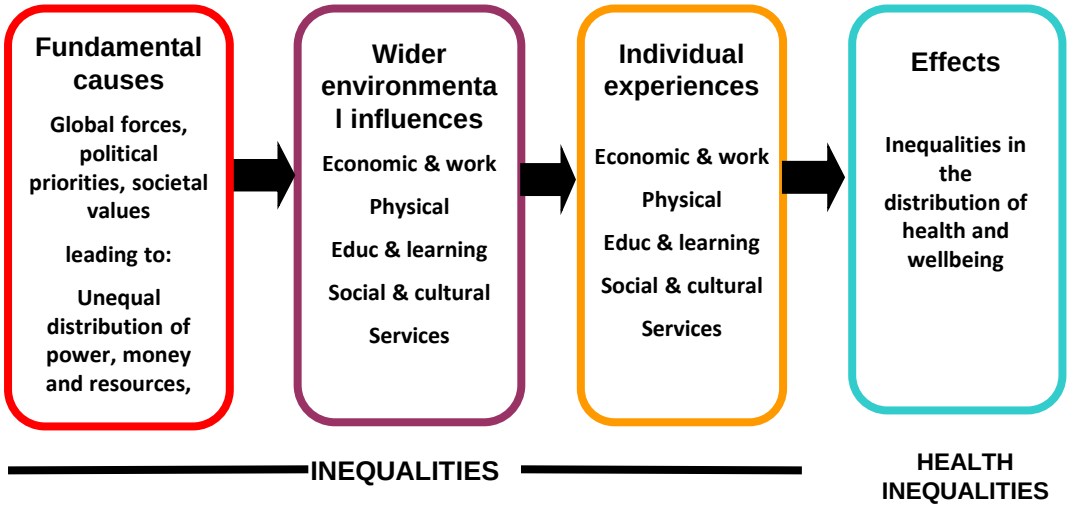
- Are **not random**, or by chance, but largely socially determined
- Are **not inevitable**.



Life expectancy data refers to 2001-05 and was extracted from the Glasgow Centre for Population Health community health and wellbeing profiles. Adapted from the Strathclyde Partnership for Transport travel map.

Source: McCartney G. Illustrating Glasgow's health inequalities. *JECH* 2010; doi 10.1136/jech.2010.120451 .

What causes health inequalities?



Intervention evidence

- Interventions such as information based campaigns, written materials, messages for the whole population, programmes requiring individual agency are *least likely* to reduce health inequalities

- Interventions such as structural changes in the environment, fiscal policy, welfare support, improving accessibility of services, intensive input for disadvantaged groups are *most likely* to be effective in reducing health inequalities

Sally Macintyre for Equally Well, 2008

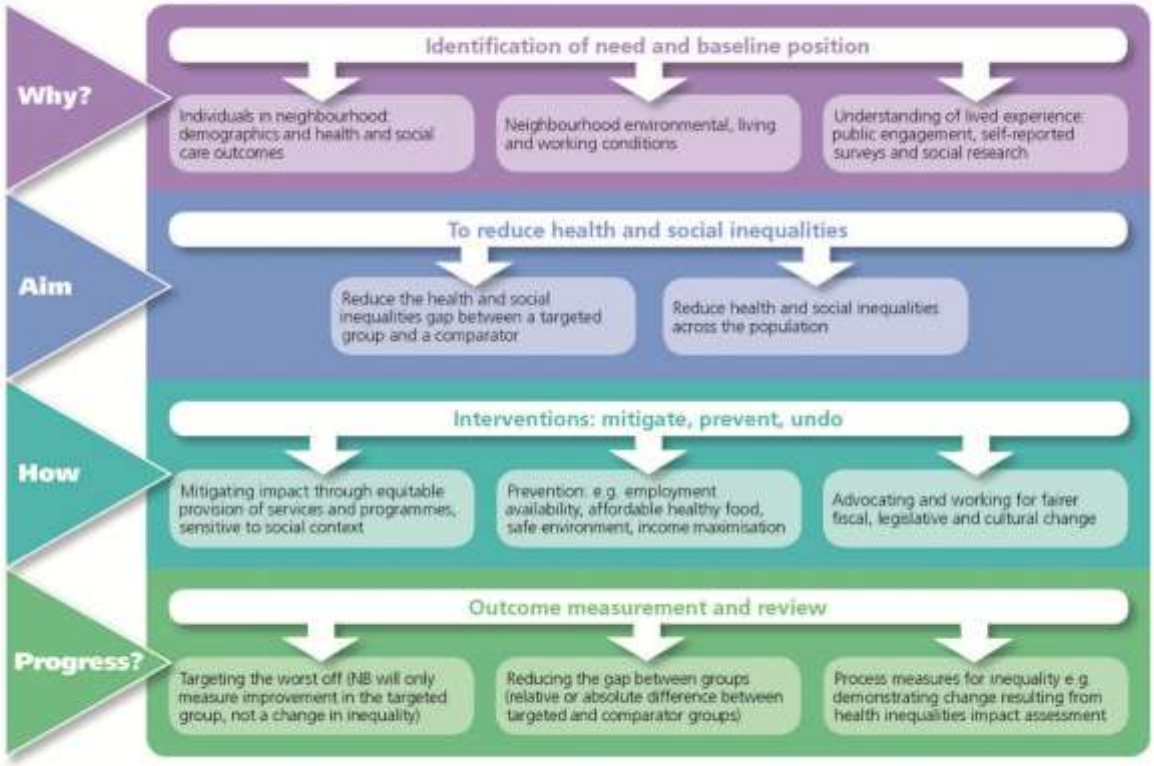
Principles for addressing health inequalities

- Thirty five years of health inequalities research since the Black Report – patterns and trends, policy analyses, theories

- Principles for action
  - Focus on social causes of health inequalities as well as individuals
  - Aim to reduce inequalities: different from the aim to improve population health
  - Know your population: demographics, indicators of deprivation plus complexity eg poverty interaction with gender, disability, ethnicity, discrimination
  - Our role in action: are we mitigating, preventing or undoing?
  - Targeting, reducing gaps and flattening gradients: asking the right questions for understanding progress

- Key theorists: Whitehead and Dahlgren; Hilary Graham; David Hunter; Sally Macintyre; Michael Marmot

Framework to review action on health and social inequalities



What might your contribution be to reducing health inequalities?

- **Mitigating** impact of social inequalities through equitable access to and outcomes from inequalities sensitive quality services and programmes - universal services in proportion to need

- **Prevention** of harm to health from social inequalities by compensating for lack of income, resources and power eg availability of affordable healthy food, safe environment, income maximisation, strengthening social connectedness and participation

- **Undoing** inequalities through advocacy and working for fiscal, legislative and cultural change: using epidemiological and other evidence to understand fundamental causes and influence fairer distribution of resources

What are our roles?

- Strengths in public sector
- Strengths in voluntary sector
- Strengths in partnership

Thank you for attending

We welcome new members from all sectors – join us now.

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