TRAFFORD COUNCIL

# The Costs and Harms caused by Inequality

## Trafford Public Health Annual Report 2021

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**ACKNOWLEDGEMENTS**

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# Contents



# Foreword

**Everyone will be only too well aware that we have had another difficult year, with the pandemic still having a major impact on us all. This impact continues to be unevenly felt, demonstrating vividly how poverty and inequality cause harm. People living in low quality or over crowded housing or who are in low waged or insecure employment continue to be disproportionately affected, and we need to work harder to reduce inequalities in the borough.**

On top of this, we are starting to see the impact of climate change: we have had a number of significant weather events such as storms and flooding, and there is no sign of this abating. While the most dramatic climate change is showing itself in the Global South, we need to be under no illusion that we will be exempt. This year we came very close to a major flooding of homes, as well as seeing Trafford General Hospital hit by lightning. We need to ensure that our Carbon Neutral Action Plan will deliver the required carbon reductions and at pace.

On a positive note: we are looking forward to the introduction of the Clean Air Zone across Greater Manchester in 2022, which will make a fantastic contribution to the health of our population. Furthermore, Trafford's recently launched Poverty Truth Commission will bring together people in poverty and local leaders to explore creative ways to tackle poverty across the borough. We need to celebrate the changes that we are making, and work together to describe and deliver a more equal and sustainable Trafford, meeting the needs of all.

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# Introduction

**Last year, Trafford's Public Health Annual Report was on Covid: our experiences in Trafford and the learning that we gained. Much of this focussed on how Covid highlighted and exacerbated existing inequalities, and the consequent need for a whole system response to reduce inequality in order to improve health.**

This year, as a Public Health team, we have continued to spend much of our time responding to the pandemic, but we are also, like all other Public Health teams in England, involved in the system redesign occasioned by the changes to Public Health England and to Clinical Commissioning Groups (CCGs). Major structural change gives opportunities but also can be distracting, and it feels timely to use this year's Public Health Annual Report (PHAR) to focus back on inequality, and the costs and damage that it causes. Too much time was spent last year describing '*health*' and '*the economy*' as if they are in opposition to each other. This misses the critical point that without good health in our population we cannot achieve a healthy economy.

The other learning from the pandemic is that we have shown we can achieve major behavioural change at pace and across the whole population. Some of these changes have been positive, some negative and many mixed, but the recent Intergovernmental Panel on Climate Change (IPCC) report[1] demonstrates that we in the Global North cannot return to our old habits of over-consumption if we are to avert the disaster that climate change will bring. Carbon reduction was a topic explored in the 2019 PHAR and achieving this is more necessary than ever.

Both climate change and health inequalities are complex issues requiring concerted action and bravery if we are to make the changes that will reduce the risks each poses. We rarely find anyone who disagrees that prevention is better than cure, but translating that into doing things differently requires a shift of mind-set, habits and resources and we need to take those harder steps both in our lives and our work.

The aim of this year's report, therefore, is to bring together the evidence for the benefits to our health and our economy of working together to create a more sustainable and equal society in Trafford, in the hope that this will encourage us all to support and implement the necessary changes for a healthy and resilient life.

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# Chapter 1

## What are the costs of inequality, and whom does it harm?

### Defining Health Inequalities:

**Our health is influenced by a combination of 'fixed' and 'modifiable' factors[2]. Fixed factors are hard for us to alter and include biological factors such as age, sex, and genetic factors. In contrast, modifiable factors can be changed. They include individual behaviour (e.g. diet, physical exercise, smoking, drinking), living environment (e.g. housing quality, air pollution, access to clean water and sanitation) and the healthcare available (e.g. access to vaccinations, specialist hospitals, the doctor to patient ratio)[3]. Of course, both fixed and modifiable factors also interact with each other, and this can increase or decrease an individual's risk of a poor outcome[4].**

Health care provision is often mistakenly considered to have the greatest influence on our health[5]. However, it is factors such as where we are born, grow, live, and age, our education and income levels, our living environment, genetics, and our networks of relationships in the society that overall have the most impact on our health[6]. These wider determinants of health affect our behaviour, and can have an impact on our ability and our attitude to accessing services, as well as to likelihood that we will take up habits such as smoking[7]. These lead to avoidable differences in health between different groups in a society: such differences are defined as health inequalities[8].

### Impact of Health Inequalities:

Inequality has been shown to lead to many negative outcomes: higher rates of ill-health, shorter life expectancy, higher infant mortality, lack of community cohesion, violence, drug problems, obesity, mental health problems, long working hours, and large prison populations.[9]

Reducing health inequality is not only about reducing the number of people who live in poverty. Poverty is linked to poor health, but raised levels of inequality negatively affect the health of even the affluent, mainly because inequality reduces social cohesion, a dynamic that leads to more stress, fear, and insecurity for everyone[10, 11]. People live longer[12, 13] in nations with lower levels of inequality, and countries with higher levels of inequality also have worse mental health: for example, a higher risk of schizophrenia[14] and a lower sense of personal well-being[15]. Addressing health inequalities bring benefits to us all, and we need to guard against considering that all interventions and behaviour change should focus on our more deprived populations. For example, when we look at the immediate and long-term health and other threats from climate change, it is our more affluent populations that have the highest carbon footprints and therefore need to change the most.

### What is causing our health inequalities in Trafford?

As we emerge from the pandemic, we need to refocus on those risk factors that contribute to inequalities in either healthy life expectancy or life expectancy. Healthy life expectancy is defined as the number of years a person may expect to live in good health, while life expectancy is the total number of years a person is predicted to live. There are large social, financial and emotional costs to individuals, families and society when there is a large gap between the two. Within Trafford, we know that some of the biggest impacts will be made by reducing smoking, alcohol use, physical inactivity, and obesity and by improving mental health amongst the population[16]. In Trafford, diseases associated with these risk factors contribute to most of the difference (76.9% in men and 73.6% women aged 40-79 years old) in life expectancy between the top and bottom quintile, that is, between the twenty percent most deprived and twenty percent least deprived of the population[17].

Reducing these inequalities across Trafford will improve quality of life, reduce service demand, improve health outcomes, and create a fairer, healthy, economically flourishing environment. Our Health and Wellbeing Strategy has been designed to deliver this, and our emerging One System Board shares these same goals. Achieving these goals is urgent. It has got a lot harder for many people to stay physically and mentally healthy during the pandemic. As an example, deaths that can be directly attributable to alcohol misuse went up by 18.6% in the UK in 2020[18]. We need to understand whether these changes will remain as life returns to normal, and to consider how to tackle them if so.

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# Chapter 2

## Key issues in Trafford

### Deprivation

**Trafford is arranged into 5 Primary Care Networks (PCNs). Across the five networks the levels of deprivation vary with the North and West more deprived than Sale Central, South or Altrincham Health Alliance. This is illustrated by the map below. People who live in the most deprived areas tend to have a lower healthy life expectancy than those living in the least deprived areas, with those in the most deprived areas more at risk of certain health conditions. These inequalities are largely preventable. More information on to this can be found within our Joint Strategic Needs Assessment: http://www.traffordjsna.org.uk/About-Trafford/Key-demographics/Deprivation.aspx**

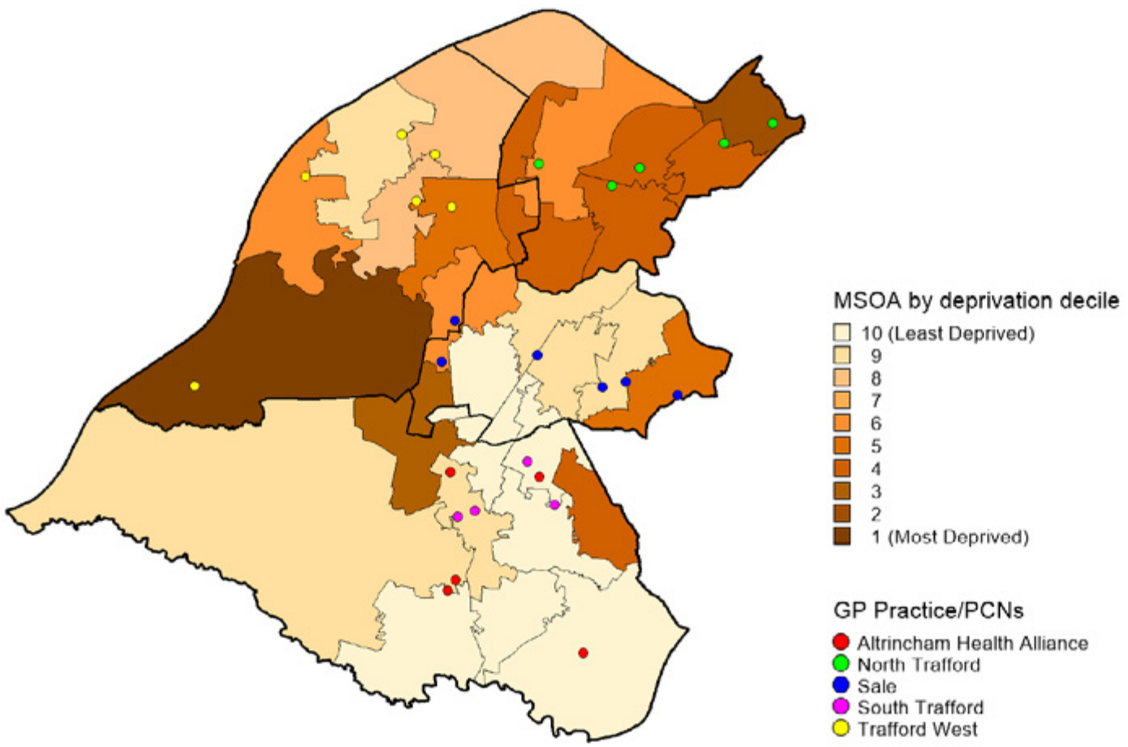


**Figure 1:** Middle Layer Super Output Areas in Trafford illustrating deprivation and Primary Care Network. These super output areas each have a similar size population.



**Cardio-vascular disease (CVD) deaths –** By calculating a standardised mortality ratio (SMR) we can compare the rates we see locally with the numbers we would expect to see compared to the general population. An SMR over 100 shows that our death rate is higher than the expected number, and an SMR below 100 means they are lower. In Trafford, the SMR for CVD deaths for men aged under 75 has increased to 108 in 2020 compared to 99.6 in 2018. Amongst women aged under 75 there has been a small increase from 38.6 in 2018 to 42.5 in 2020. Overall, the risk of dying from CVD has increased in both men and women in Trafford.

**Cancer deaths –** The average SMR of cancer deaths in Trafford was 96.4 between 2015 and 2019, which is slightly below the England average. However, there are differences between the different wards in Trafford. Figure 1 below shows that people in the most deprived wards are more likely to die from cancer than those in the least deprived wards. For example, Timperley, which is the least deprived ward has a Standardised Mortality Ratio (SMR) of 78.8, whereas Gorse Hill has an SMR of 143.0, almost double the risk.

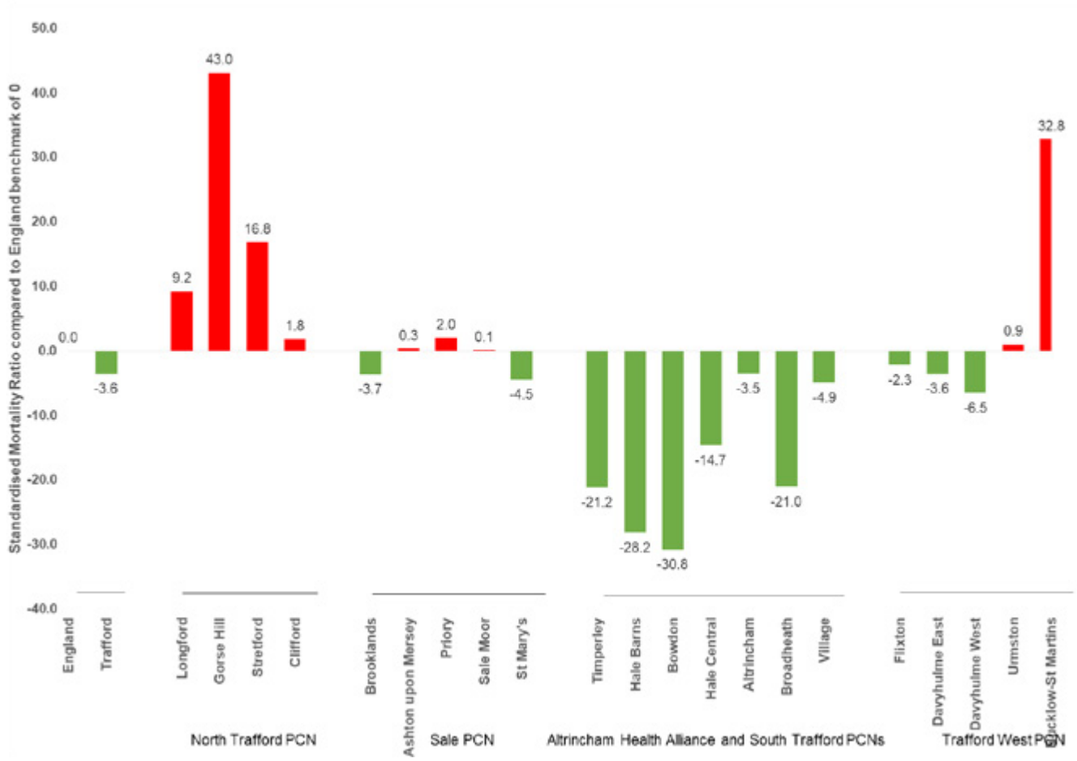


**Figure 2:** Standardised Mortality Ratio of Cancer deaths, all ages. Compared to the England average (100), at ward level, grouped by Primary Care Network

## Diabetes

The data below in Figure 3 show that diabetes is also more prevalent in the most deprived areas of Trafford.

### Diabetes prevelance for those aged 17+ by England, Primary Care Network and Trafford CCG

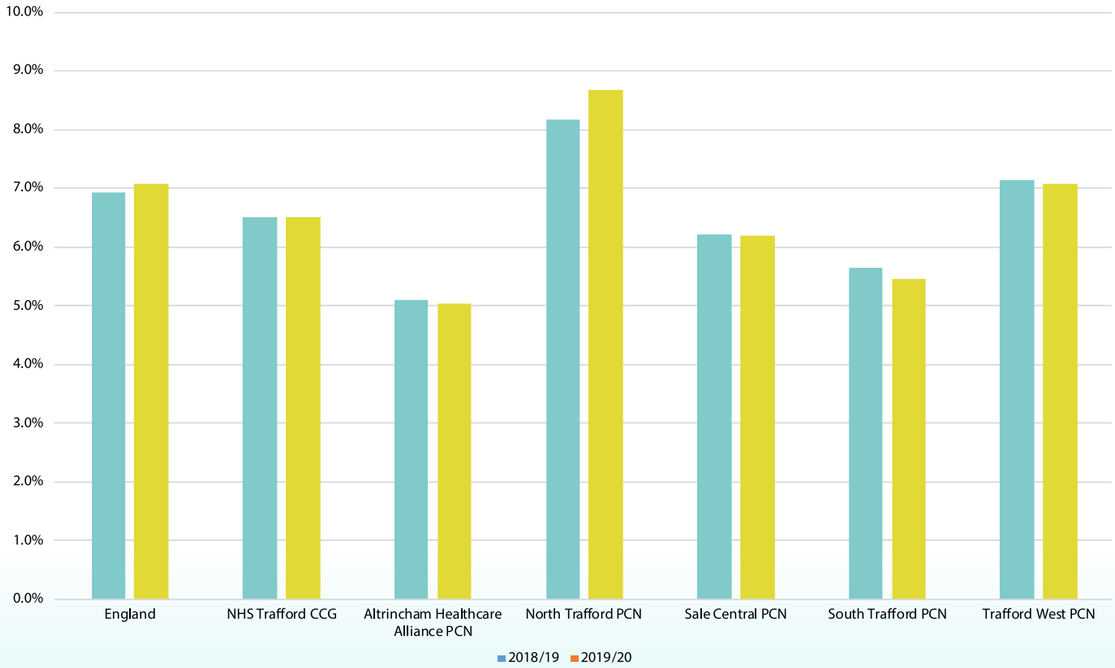


**Figure 3:** Diabetes prevalence for those aged 17+ according to PCN, Trafford CCG or England average.



# Chapter 3

# Designing and delivering health and social care in Trafford

## Neighbourhood working

**As the health and social care system transitions into an Integrated Care System it is important that we take this opportunity to improve our relationship with residents, partners and stakeholders across Trafford, because it is only through working together that we can create healthier, more equal communities and tackle issues such as obesity, physical inactivity and other risk factors contributing towards cancer, diabetes and cardiovascular disease.**

## Role of the One System Board

Our emerging One System Board includes leaders from key health and social care organisations, charged with ensuring our services can prevent and respond to our many challenging issues. It will make collective decisions on services to be provided using population benefits rather than the benefits to a particular provider. Its aim is to work towards a model of care which is closer to home and co-produced with citizens, staff and partners. It will prioritise its resources on tackling inequalities by focusing on the wider determinants of health, taking action to prevent ill health, and working on improving access to effective treatment, care and support. This way of working will be critical if we are to reduce risks such as physical inactivity, smoking, or obesity and as a consequence, deaths from cancer, cardiovascular disease and diabetes. We need to ensure that the One System Board is held to account for the delivery of prevention targets as well as delivery of treatment services, as traditionally resources for prevention have often been sacrificed in order to deliver immediate care needs. This adds system costs and reinforces inequality, and makes our health and social care system unsustainable even in the short term, as Covid is demonstrating. What is more, we will need to ensure that sufficient resources are directed to the voluntary, community, faith and social enterprise (VCFSE) sector to make co-production and engagement reality rather than rhetoric.

## Preventing and tackling long term conditions

When we look at increasing healthy life expectancy, we often start by considering how we prevent people from developing long term health conditions (LTCs). LTCs are conditions for which there is currently no cure, and which are managed with drugs or other treatment. As people get older, the chances of having a long-term condition such as high blood pressure or diabetes increases. Being from a lower income group increases the chances of LTC[19] and therefore, preventing and tackling LTCs helps reduce inequality.

In this report, we will look at how we are tackling obesity and diabetes, which are both strongly linked to an increased risk of cardiovascular disease and cancer [20] [21] but in many cases can be prevented. Other risk factors that affect the quality and length of life are also discussed in the Joint Strategic Needs Assessment (referenced above).

We also need to reflect on the impact of the pandemic. Covid has had a big impact on people with long term conditions (LTCs) in two different ways: they are more likely to be severely ill if they catch Covid, and there has been a reduction in the availability of prevention and treatment services during the pandemic. While the NHS was focused entirely on treating people with Covid, there were many people whose regular treatment was disrupted, and in some cases stopped altogether.

This was not just confined to hospital treatment, as many local staff were re-deployed onto the 'Covid frontline' leading to the suspension of community services, including key preventative programmes such as NHS health checks. In addition, the 'Protect the NHS' messaging meant that many people did not seek medical advice where they might normally have done, including avoiding participating in regular long term condition reviews within primary care[22].

As part of the local recovery plan Trafford CCG has identified five priority long term conditions (asthma, diabetes, depression, hypertension and obesity) as ones where our outcomes for patients could be improved. Work is now underway to improve prevention and treatment of these to reduce health inequalities across Trafford and improve quality of life as well as life expectancy. These areas map well to the Health and Well Being Board strategy, as maintaining a healthy weight and being physically active reduces asthma, diabetes, hypertension and (obviously) obesity risk. These conditions are also ones where a combination of pharmaceutical and non-pharmaceutical interventions give the best outcomes, and improving people's mental health is key to delivering long term behaviour change.



# Chapter 4

## Getting it right from the start

**This year has provided many challenges for parents and children under five, with the restrictions in place to limit the spread of Covid meaning both parents and children have missed out. Most parents of babies and young children have not been able to access professional, peer, friends and family support in person and the opportunities for babies and toddlers to interact and develop socially and emotionally have been curtailed. Moreover, parents who are younger, have a lower income or are from a Black, Asian or Minority Ethnic (BAME) background are likely to have had an even more difficult time and have found it more difficult to access services that they need[23]. While life is now returning to normal, we do not know what the consequences of this disrupted early start will be, and what we may need to put in place to compensate.**

### Breastfeeding

One key indicator for children is the percentage of children being breastfed at 6-8 weeks of age. There are proven benefits from breastfeeding, for the baby and the mother[24]. It can help reduce the risk of obesity and cardiovascular disease,[25] improve the emotional bond between the mother and child [26], and can also help with brain development [27]. Despite this, the UK has some of the lowest rates of breastfeeding in the Global North.

Breastfeeding rates are influenced by a number of factors including deprivation and ethnicity, with white women, and women from more deprived areas, less likely to breastfeed. In Trafford in 2018/19, breastfeeding prevalence at 6-8 weeks ranged from 49% in West to 61% in the North and 69% in South[28]. The West and North are more deprived than the South, but the West, while less deprived than the North, has a larger white population, which may help explain its lower rates[29].

Breastfeeding rates have been increasing in every area except the South since 2018/19 Despite this there is still a gap between the South at 69% and the West at 56%[30] although it is promising that the gap has narrowed.

We therefore need to:

- Work with our health visitors and others to ensure that all our parents/carers, babies and toddlers have access to the right level of support, no matter their background, with a strong universal offer as well as focussed resources on those who need it most.
- Support mothers to breastfeed their children to ensure children have the best chance of benefitting from the huge range of advantages of breastmilk brings.

## Children

Covid 19 has had a huge impact on our daily lives, and this has been felt by everyone, whatever their age. Children's education has been hugely disrupted.  For a large part of the last 18 months most children could only receive their education online, which required access to technology and a good internet connection: a big inequality issue straight away.  For a significant period, activities outside the home were restricted and even access to some  play areas in parks was not permitted at times.

Our children's mental health has suffered during this time, and we are seeing an increase in demand to our children and young people's mental health services, including our children's eating disorder services. Locally, we have seen an increase in demand for our children and young people's mental health services, commissioned for our 0-25-year-olds since April 2020. Services are continuing to see a rise in demand each quarter. The most notable increase is in our specialist children's mental health service (CAMHS) which saw 490 referrals between April – June 2021, up from 233 in the same quarter in 2020, which is an increase of 110%.

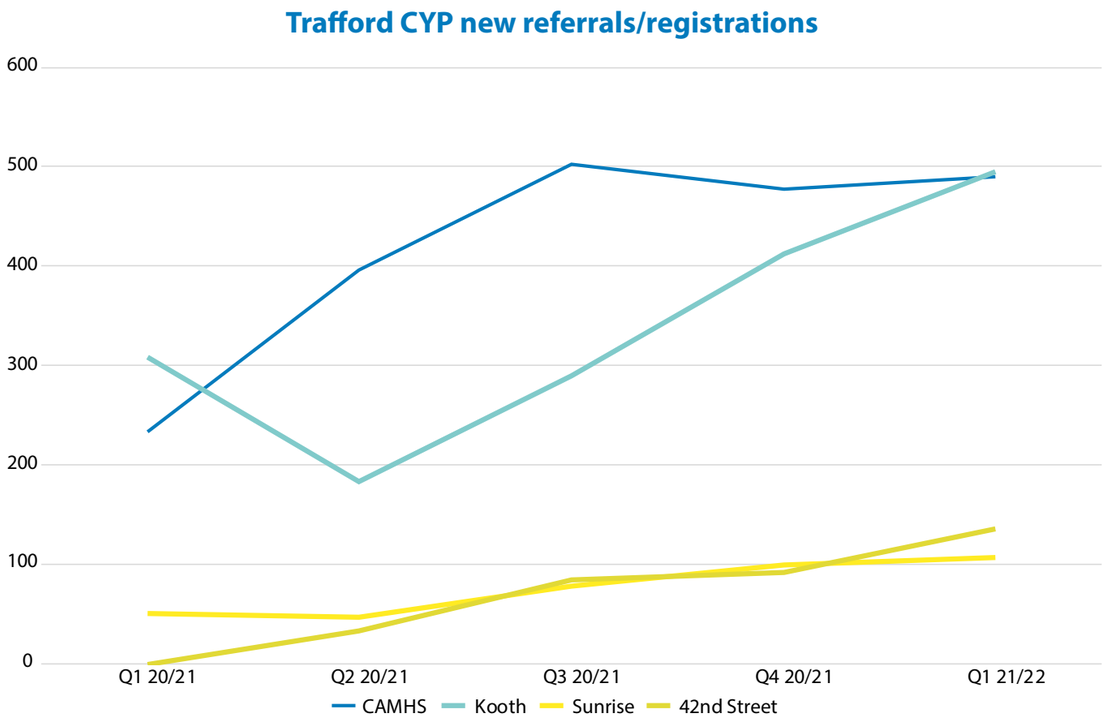


**Figure 4:** Trafford 0-25 new referrals/registrations into services since COVID (Source: Trafford internal contract monitoring data)

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# Chapter 5

## The impact of obesity

**Obesity is a complex issue, caused by several factors[31], and is a highly stigmatised condition.[32, 33] We know that eating habits have changed in the pandemic.  Reduced access to physical activity, and stretched incomes may have led to increased snacking, and thereby led people to eat more calories than they can expend and to buy less healthy food because it may be cheaper and more convenient[34]. Eating habits have also changed within families. Children living in families where they could previously have received free meals at school are likely to have been particularly disadvantaged. The number of people using food banks increased whilst incomes were stretched and at times the availability of food was disrupted. Very worryingly, in the North West of England we have seen an increase in the number of children who are classified as obese by the National Childhood Measurement Programme. The prevalence of obesity in reception age children increased from 10.8% to 15.1 % between 2019-20 and 2020-21[35] and for year 6 children it increased from 22.8% to 25.8%[36]. The inequalities in rates of overweight/obese children are widening across England, with an increase in children in more deprived areas who are overweight or obese, and a widening gap between these children and those living in the most affluent areas.  This is most noticeable in reception age children where both the obesity rate and the gap has increased between the most and least deprived children.**

It is hard for people to lose weight and so seeing more children are overweight or obese at a young age is concerning. Children who are overweight or obese are more likely to be overweight or obese as an adult, which increases the risk of some cancers, diabetes, stroke, heart disease and being overweight or obese can have a negative impact on a person's mental health. We also know that ultra-processed foods are associated with higher rates of obesity [37].  Therefore, we need to work with communities to design environments that support them to live active, healthy lives and provide access to high quality food at affordable prices.

As well as this, we need to understand family dynamics.  Not only do families influence the eating habits of children but there is evidence that the parent of the same sex as the child is more influential[38]. This means that if a mother is overweight or obese, the daughter is more likely to be so as well. This highlights that any efforts to address healthy eating and weight management within a family cannot treat the family as a homogenous group. It is necessary to consider the relationships between family members and how that affects individuals within the family unit.

### Weight management and Diabetes Prevention

As mentioned above, obesity is linked to diabetes, and both are strongly linked to an increased risk of cardiovascular disease and cancer. We also know, as shown in data above, that people in more deprived areas of Trafford are more likely to have diabetes.  We are therefore very pleased to be working with the National Diabetes Prevention Programme, a service for people at high risk (as measured by their blood sugar levels, blood pressure, age, ethnicity and family history) of developing type 2 diabetes. This is often known as being 'pre-diabetic'.  The programme supports people to change their diet and physical activity habits in order to reduce their risk of developing diabetes.

In Trafford from 1st April 2019 to 30th November 2021 there have been 641 referrals made into the NHS National Diabetes Prevention Programme; a rate of 270 per 100,000 population. Of these referrals, 302 (47%) started the programme, There is a time lag between referral and attendance at their first session so the uptake is expected to increase.

The referral rate in some, but not all of the least deprived areas is higher than in the most deprived areas, and of the 302 people who have attended at least one session, 38% were from the least deprived quintile compared to 10% from the most deprived quintile.

So in Trafford, disappointingly, more people from affluent communities attend this programme than people from less affluent communities, even though prevalence of both non-diabetic hyperglycaemia (NDH – or pre-diabetes) and type 2 diabetes is greater in our least affluent communities, and so in these areas more people are likely to benefit from the programme. Failing to engage these people in the service will exacerbate health inequalities as diabetes can cause a number of other diseases and reduce healthy life expectancy. We therefore need to:

- undertake targeted outreach with specific communities and groups that are more likely to be living with excess weight, and at higher risk of developing diabetes at a lower BMI.
- work with General Practices that serve communities at higher risk of living with excess weight and developing type 2 diabetes to support identification of high risk patients.

We have commissioned a range of services for people who need support with weight loss, to complement those commissioned nationally, and engaged with local VCFSE sector organisations to work with at a hyper-local neighbourhood level to give support to access these services.



# Chapter 6

## Inequalities in choices

**As highlighted earlier in the report, the social determinants of health have a huge impact on our health and on the choices we can make.**

**People with a higher income are less likely to be stressed, more likely to be able to access and buy good nutritious food, live closer to green and blue spaces, have a better education and live in an area with lower pollution. All these factors mean they are more likely to be in good health. There is a downside: with a higher income people are also more likely to over-consume resources, and consequently use more carbon and to create more air pollution. However, the impact of this carbon use and the pollution emitted by cars falls more heavily on poorer people.**

### Poverty

People who are less well-off have a different life experience to those with a higher income. They may be on means tested state benefits, which can be stigmatising and therefore damaging to people's mental health and sense of self. Statistically, they are more likely to have a long-term health condition, which could affect their ability to work, which will also cause stigma[39, 40]. They are more likely to be living in poor quality or overcrowded accommodation which can be harmful to mental and physical health [41]. They are less likely to have reached a high standard of education, so are more likely to be in low-income employment, or unemployed [42]. Money and other worries can affect people's ability to think clearly about other aspects of their lives, and can reduce feelings of control over their lives[43]. According to Maslow's hierarchy of needs, thinking about the longer term health impacts of behaviour requires basic physiological needs to be met. For many people in poverty in this country, these needs will not be felt to be secure[44]. This in turn may make people less likely to seek medical advice in a timely manner and may make them less able to act on the advice, especially when taking the advice would cost time or money[45]. Overall, this means that many people in poverty lack choices, and/or may not feel that their actions are going to have any impact on their health or other outcomes. All these factors can make people both more likely to experience poor health and less able to take steps to improve their health, which then makes it more likely that their life expectancy and healthy life expectancy will be lowered.

## Women

Women are often the main person providing childcare in families and care for other dependants. This can often lead them to need to work part time, to take ad-hoc time off to deal with emergencies, or to need to work very locally. All these factors can limit their employment opportunities and can often lead to them taking lower paid jobs. Statistically, being an unpaid carer is bad for your health and can increase stress levels[46]. Women are not only more likely to work part time but also to earn less than men even when doing the same role. As we know, a lower income can have a significant impact on someone's choices and health.

During the pandemic many of us worked from home, and for many of us this gave advantages through a reduced commute. However, in households with children, women picked up more of the responsibility for childcare and since the reopening of the economy, women are more likely to continue to work from home so that they can, for example, fetch from school and manage the running of the home. While this is convenient in the short term, in the longer term this may lead to further disadvantage to women in the workplace as we know that people who work from home are less likely to be given a promotion for a variety of reasons[47] so there is a risk that in the longer term they will suffer not only financially but also through higher stress levels by being at a lower level within an organisation[48].

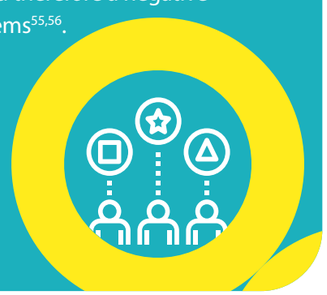
Notwithstanding the discrimination women face in the workplace and in other aspects of their lives, they are more likely to seek healthcare than men. Despite this, they are more likely to experience poorer health outcomes[49] although they have longer life expectancy. The health of family members is often seen as women's responsibility, and women are likely to encourage their partners to access health services [50,51,52]. Perhaps this is because health is seen as a female construct and therefore that they should play that role not only with their dependants but with the significant men in their lives. This 'emotional load' can add to the stress women feel.

## Race/Ethnicity

People from a non-white background are disproportionately likely to experience poorer health outcomes and report poorer experience of health services. Recent research has shown that black women are more likely to die during childbirth than their white British counterparts, and that this difference cannot be fully explained by differences in socio-economic status.[53] We read frequent reports of black women being disbelieved when they report health issues in pregnancy, and it is not surprising that this then leads to a mistrust in the health system more generally.

Structural racism also contributes to health inequalities through, for example, differences in access to employment and housing. Even with the same level of education as a white British person, people from a non-white British background are more likely to be in lower paid and less senior roles[54]. This type of discrimination can understandably have a negative impact on someone's mental and physical health and therefore a negative impact on their healthy life expectancy, as well as with their trust in services and systems[55,56].

To summarise: people from a non-white British background experience many factors which negatively impact on their health and are more likely to have poor experiences when accessing health services and to experience discrimination other parts of their lives such as employment. This makes it less likely that they will trust institutions, feel they are able to make positive choices, or have control over their lives.





## Intersectionality

In this chapter we have looked at how negative experiences can reduce choice and agency. When we add together the impact of race, sex /gender and poverty, we can see how cumulative negative experiences can lead someone not to seek healthcare services[57]. Furthermore, it can mean that those people who would most benefit from healthcare services are the least likely to do so. We see this consistently with preventative services such as screening or more recently uptake of Covid 19 vaccine, where people from more deprived groups, even though they were at relatively higher risk from Covid because of job or housing conditions, were paradoxically the least likely to come forward for vaccination – with a lack of trust in the vaccine being the most common reason given[58]. To address this, we need to focus on the wider determinants of health and on tackling inequality, racism and other forms of discrimination to win back this trust. If we achieve this, those who need the health services the most will find it easier, and be more prepared, to access them and this will help reduce our longstanding inequalities in health outcomes.

To succeed, we need to listen and respond to people's experiences, and support them to lead service design. We must not approach people as a homogenous group with one attribute. Rather, we need to work with communities not only to build trust but to respond to their needs. We are doing this through our work focussed on community engagement to co-produce the services communities need, but this needs to become embedded throughout our services, systems and processes.

# Chapter 7

## Reducing Inequalities through increasing trust

### Voting and why it matters

Voting is important for many reasons, but not least because political parties of all colours are more likely to focus on issues that are of concern to people who vote. If there are systematic differences between people who are likely to vote, and those who are not, then inequalities can be exacerbated. For example, poor health has been shown to reduce voter turnout in deprived communities, but not more affluent ones.[41,59] Furthermore, young people and people from ethnic minority groups are less likely to register to vote, whilst unskilled workers and long-term unemployed people are more disengaged from the formal political process than people from other occupational backgrounds[60]. This means that issues that predominately affect younger or poorer people, while they may be of major interest to politicians, may be less likely to affect election results than matters that affect older people. This may mean that the older people's perspective is heard more loudly, and this can turn into a vicious cycle, with the lack of relevant policies meaning that people from more disadvantaged groups see less point in voting, as well as having less confidence that their vote will make a difference. Despite this, there is good evidence to show many people who choose not to vote remain strongly interested in political issues.[43] However, disengagement from the formal electoral process is important because it may point to a lack of trust in the systems around them, with potentially serious implications for public services.

To take an example: in Trafford, the Covid vaccination programme has shown how important trust is to increasing uptake of the vaccine. One of the frequent reasons we have heard for not getting vaccinated is that people don't trust it. Similarly, lack of trust that voting leads to change is a reason often given for not voting.

### Relationship between COVID-19 vaccine uptake/voter turn out and IMD for Trafford Wards

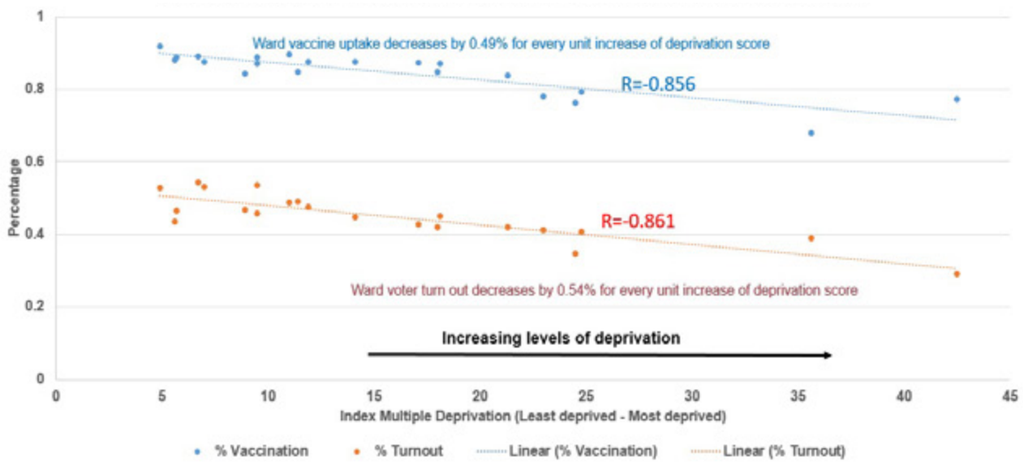



**Figure 5:** Relationship between Covid-19 Vaccine Uptake/ Voter turnout and by IMD for Trafford Wards turnout



Correlation can be used to see if there is a relationship between two factors. It doesn't mean that one causes the other, but it can be used to see if as one factor changes, what happens to the other. Values range between 0 and +/- 1, and the closer they are to 1, the closer the relationship between the factors. There is a strong negative correlation (r = -0.86) between deprivation in Trafford wards and Coronavirus vaccination and deprivation and turnout in the 2021 local election. This means that in Trafford, the less deprived the ward is, the more likely it is that residents of that ward will accept the vaccine or participate in elections and vice versa. With an $R^2$ value of >0.7, it implies deprivation is a strong factor that may be influencing both vaccine hesitancy and reduced participation in elections in Trafford.

As noted in the second Marmot review[61], community engagement can improve the sense of control and self confidence amongst people and increase social cohesion. Creating Indicators of possible disaffection such as voter turnout at elections could be a key 'early warning' sign of trust breaking down. Within this, we are interested in relative differences in turnout between deprived and affluent areas rather than absolute numbers who vote.

We know that trust can be increased by

- Increasing the amount of public engagement when it comes to designing services. The more say the public have in their community the more ownership they will feel about their area[62].
- Increased community engagement with local residents[63,64]. Not everyone wants to be involved in designing services, but they do want their voices heard and needs understood. Community Champions can play a key role in this[65].
- Tackling poverty and the underlying causes of health inequalities.

**To take an example: in Trafford, the Covid vaccination programme has shown how important trust is to increasing uptake of the vaccine.**

# Chapter 8

## Recommendations

To improve the health and resilience of our population, improve sustainability and reduce inequalities we need to:

- Use the measures in our Corporate Plan  to identify and improve the wider determinants of health, thereby reducing heath inequality
- Set targets for reductions in inequalities between our most and least deprived groups (and subgroups) in key indicators such as school readiness and educational attainment[66], smoking, physical activity, air pollution, and obesity.
- Reduce poverty through ensuring all workers receive a living wage and/or appropriate benefits where required
- Reduce the risks to our population from climate change by ensuring that our carbon reduction plan meets the net zero requirement in time, and engage our population in honest discussions on how we do this without creating avoidable harm or increasing inequality.
- Work with communities to lead service design so that services better meet the needs of the people who need them the most.
- Explore the extent that we can use measures such the uptake of screening or vaccination, or turn out at elections, as proxy measures of engagement and trust.
- The Council to lead by example in:
    - → Tackling inequality and discrimination in all its forms, such as through increasing diversity within the workforce.
    - → taking account of all employees' needs including providing equitable access to training, development, and opportunities for advancement, no matter where someone works.
    - → Providing  opportunities to work flexibly, part time and remotely.



### Specific Recommendations on weight management and diabetes prevention: to improve outcomes and reduce inequalities in these measures we need to:

- Work with communities to tackle the stigma of overweight and obesity.
- Ensure planning takes account of health policies to reduce the number of takeaways and increase the number of outlets that provide affordable, healthy food.
- Ensure all schools (including academies) provide school meals that meet or exceed the School Food Standards.
- Support our population to become more physically active, and in particular to build physical activity into people's everyday lives through measures such as active travel (walking, cycling, and using public transport) thereby improving air quality and reducing carbon emissions too.
- Encourage and enable children and their parents/carers to walk or cycle to school through a comprehensive School Streets offer for Trafford.
- Evaluate success of locally and nationally commissioned support services for weight loss and diabetes prevention, in order to determine what works best for different Trafford communities.
- Continue to work with VCFSE organisations and groups to ensure that the people who need support with managing their weight can access it.
- Contribute to the Waiting Well programme to support people waiting for hospital procedures and appointments to maintain and improve their health while they are waiting.

# Conclusion

In this report, we have focused on the damage that inequality causes to our society and have identified some actions that we can take to reduce this. To be effective, we will all need to work together differently. We need to develop more trust between public sector bodies and our residents, and we also need to have more honest conversations about the changes to lifestyles and behaviours that will be required if we are to meet clean air and carbon reduction requirements, as well as to address inequalities and improve outcomes for all. Many of these changes will be positive for people, some may be challenging, but the simple truth is that we cannot afford to go on as we are. By acting now, we can take control of our destiny and enable the people of Trafford to adapt and grow to meet these challenges and flourish in the future.



# References

1. AR6 Climate Change 2021: The Physical Science Basis https://www.ipcc.ch/report/ar6/wg1/
2. WHO. (2015). Chronic diseases and their common risk factors. [Online] Available from: http://www.who.int/chp/chronic_disease_report/media/Factsheet1.pdf [Accessed 9th November 2021]
3. Hanif, B. (2015). Building an evidence base for effective commissioning decisions to reduce inequalities in health: A mixed methods study to profile and benchmark general medical practices on health needs and quality of care. University of Manchester. [Online] Available from: https://www.escholar.manchester.ac.uk/uk-ac-man-scw:275906 [Accessed on 9th November 2021].
4. DAHLGREN, G. & WHITEHEAD, M. (1991). Policies and strategies to promote social equity in health. Stockholm: Institute for Futures Studies. [Online] Available from: http://core.ac.uk/download/pdf/6472456.pdf. [Accessed 9th November 2021]
5. WHO. (2017). Determinants of Health. [Online]. Available from: https://www.who.int/news-room/q-a-detail/determinants-of-health [Accessed 9th November 2021]
6. WHO. (2018). Health inequities and their causes. [Online]. Available from: https://www.who.int/news-room/facts-in-pictures/detail/health-inequities-and-their-causes . [Accessed 9th November 2021]
7. WHO. (2015). Chronic diseases and their common risk factors. [Online] Available from: http://www.who.int/chp/chronic_disease_report/media/Factsheet1.pdf [Accessed 9th November 2021]
8. Hanif, B. (2015). Building an evidence base for effective commissioning decisions to reduce inequalities in health: A mixed methods study to profile and benchmark general medical practices on health needs and quality of care. University of Manchester. [Online] Available from: https://www.escholar.manchester.ac.uk/uk-ac-man-scw:275906 [Accessed on 9th November 2021].
9. Wilkinson, R., & Pickett, K. (2009). The Spirit Level: Why More Equal Societies Almost Always Do Better. London: Allen Lane
10. OECD Social, Employment and Migration Working Papers No. 163: Trends in Income Inequality and its Impact on Economic Growth (2014) https://www.oecd-ilibrary.org/docserver/5jxrjncwxv6j-en.pdf?expires=1638546717&id=id&accname=guest&checksum=4434E77CD056B816E46F77A244BEDBE8
11. Inequality & Health; Inequality.Org (2021) https://inequality.org/facts/inequality-and-health/
12. Life expectancy and Healthy life expectancy: Data by country (2020) http://apps.who.int/gho/data/node.main.688?lang=en
13. https://data.worldbank.org/indicator/SI.POV.GINI https://data.worldbank.org/indicator/SI.POV.GINI
14. Income inequality and schizophrenia: Increased schizophrenia incidence in countries with high levels of income inequality; Burns, J.K., Tomita, A., & Kapadia, A.S. (2013) https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4105302/
15. Top Incomes and Human Well-Being Around the World; Burkhauser, R.V., De Neve, J.E. & Powdthavee, N. (2016) https://cep.lse.ac.uk/pubs/download/dp1400.pdf
16. PHE Strategy 2020-25 Executive Summary https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/830105/PHE_Strategy__2020-25__Executive_Summary.pdf
17. Public Health England. Segment tool. 2015-2017 (https://analytics.phe.gov.uk/apps/segment-tool/)
18. Alcohol-specific deaths in the UK: Registered in 2020 https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/causesofdeath/bulletins/alcoholrelateddeathsintheunitedkingdom/registeredin2020 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1019663/Follow_up_stud_2020_main_report.pdf
19. Department of Health (2012). Report. https://www.gov.uk/government/news/third-edition-of-long-term-conditions-compendium-published
20. Does obesity Cause Cancer?; Cancer Research UK https://www.cancerresearchuk.org/about-cancer/causes-of-cancer/obesity-weight-and-cancer/does-obesity-cause-cancer
21. Diabetes & Cancer; Diabetes UK https://www.diabetes.org.uk/diabetes-the-basics/related-conditions/diabetes-and-cancer
22. Indirect acute effects of the COVID-19 pandemic on physical and mental lealth in the UK: a population-based study; Mansfield, K.E., Mathur, R., Tazare, J., Henderson, A.D., Mulick, A.R., Carreira, H; (2021) https://www.thelancet.com/journals/landig/article/PIIS2589-7500(21)00017-0/fulltext#seccestitle150
23. 600,000 Babies born in lockdown are overlooked; Home Start (2021) https://www.home-start.org.uk/news/600000-babies-born-in-lockdown-are-overlooked
24. Breastfeeding and maternal health outcomes: a systematic review and meta-analysis Chowdhury, R. (2015) https://pubmed.ncbi.nlm.nih.gov/26172878/
25. Benefits of Breastfeeding; NHS.uk (2020) https://www.nhs.uk/conditions/baby/breastfeeding-and-bottle-feeding/breastfeeding/benefits/

**26.** Benefits of Breastfeeding; NHS.uk (2020) https://www.nhs.uk/conditions/baby/breastfeeding-and-bottle-feeding/breastfeeding/benefits/

**27.** The Effect of Breastfeeding on Children's Cognitive and Non-cognitive Development; Borra, C. (2012) https://papers.ssrn.com/sol3/papers.cfm?abstract_id=2101984

**28.** Breastfeeding prevalence at 6-8 week check by locality of health visiting clinic (Trafford, 2019)

**29.** Breastfeeding practices in the United Kingdom: is the neighbourhood context important. Peregrino et al. Maternal and Child Nutrition 14:4 2018 Wiley Online Library

**30.** Locally collected Health Visitor data, Trafford Local Care Organisation, 2021

**31.** Obesity System Map https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/296290/obesity-map-full-hi-res.pdf

**32.** Obesity System Map https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/296290/obesity-map-full-hi-res.pdf

**33.** Obesity Stigma: Important Considerations for Public Health; Puhl, R.M., Heuer, C.A., (2010) https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2866597/

**34.** A hidden side of the COVID-19 pandemic in children: the double burden or undernutrition and over-nutrition; Zemrani, B., Gehri, M., Knob, C., Pellaton, R. (2021) https://equityhealthj.biomedcentral.com/articles/10.1186/s12939-021-01390-w

**35.** National Child Measurement Programme, England 2020/21 School Year - NHS Digital

**36.** National Child Measurement Programme, England 2020/21 School Year - NHS Digital

**37.** Ultra-processed food consumption and indicators of obesity in the United Kingdom population (2008-2016) Rauber, Fernanda ; Steele, Eurídice Martínez ; da Costa Louzada, Maria Laura ; Millett, Christopher ; Monteiro, Carlos Augusto ; Levy, Renata Bertazzi; Meyre, David PloS one, 2020-05-01, Vol.15 (5), p.e0232676-e0232676

**38.** Is the intergenerational transmission of overweight 'gender assortative'?; Costa-Font, J., Jofre-Bonet, M. (2020) https://pubmed.ncbi.nlm.nih.gov/32823228/#:~:text=The%20parent%2Dchild%20associations%20are,assortative%20intergenerational%20association%20of%20overweight

**39.** Long Term Conditions Compendium of Information: Third Edition; www.gov.uk https://www.gov.uk/government/publications/long-term-conditions-compendium-of-information-third-edition

**40.** Employment Outcomes for People with LongTerm Conditions: A rapid evidence assessment; Nathwani, T. et al (2015) http://cfe.org.uk/app/uploads/2016/09/Emp-outcomes-for-people-with-LT-conditions_REA.pdf

**41.** The links between housing and poverty; Tunstall, R. et al (2013) https://www.jrf.org.uk/report/links-between-housing-and-poverty

**42.** Experience of poverty and educational disadvantage; The Joseph Roundtree Foundation (2007) https://www.jrf.org.uk/sites/default/files/jrf/migrated/files/2123.pdf

**43.** Psychological perspectives on poverty; The Joseph Roundtree Foundation (2015) https://www.jrf.org.uk/report/psychological-perspectives-poverty

**44.** H. Maslow (1943) Originally Published in Psychological Review, 50, 370-396. Maslow's Hierarchy of Needs – Research History

**45.** Improving access for all: reducing inequalities in access to general practice services; NHS England (2018) https://www.england.nhs.uk/wp-content/uploads/2017/07/inequalities-resource-sep-2018.pdf

**46.** Health Survey for England 2019 providing care for family and friends; NHS Digital (2020) https://files.digital.nhs.uk/CA/3A5B58/HSE19-Carers-rep.pdf

**47.** Homeworking hours, rewards and opportunities in the UK: 2011 to 2020; ONS (2021) https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/labourproductivity/articles/homeworkinghoursrewardsandopportunitiesintheuk2011to2020/2021-04-19#promotions-and-training

**48.** Health Inequalities among British civil servants: The Whitehall II Study; Marmot, M.G. et al (1991) https://www.thelancet.com/journals/lancet/article/PII0140-6736(91)93068-K/fulltext

**49.** Women's Health Outcomes – Is there a gender gap?; House of Lords Library (2021) https://lordslibrary.parliament.uk/womens-health-outcomes-is-there-a-gender-gap

**50.** No man's land: men, illness and the NHS; Banks, I., (2001) https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1121551/

**51.** The Cognitive Dimension of Household Labor - Allison Daminger (2019) https://journals.sagepub.com/doi/10.1177/0003122419859007

**52.** Factors affecting presentation and delay in patients with testicular cancer: results of a qualitative study; Gascoigne, P., Mason, M.D., Roberts, E. https://pubmed.ncbi.nlm.nih.gov/10335558/

**53.** Saving Lives, Improving Mothers' Care; MBRRACE-UK (2021) https://www.npeu.ox.ac.uk/assets/downloads/mbrrace-uk/reports/maternal-report-2021/MBRRACE-UK_Maternal_Report_2021_-_FINAL_-_WEB_VERSION.pdf

**54.** Opportunities Knocked? Exploring pay penalties among the UK's ethnic minorities; Resolution Foundation (2018) https://www.resolutionfoundation.org/app/uploads/2018/07/Opportunities-Knocked.pdf

**55.** Racism & Mental Health; Royal College of Psychiatrists (2018) https://www.rcpsych.ac.uk/pdf/PS01_18a.pdf

**56.** Workplace Racism and its undeniable impact on mental health; Porteous-Sebouhian, B.; Mental Health Today (2018) https://www.mentalhealthtoday.co.uk/news/inequality/workplace-racism-and-its-undeniable-impact-on-mental-health

**57.** Inequalities and multiple discrimination in access to and quality of healthcare; European Union Agency for Fundamental Rights (2013) https://fra.europa.eu/sites/default/files/inequalities-discrimination-healthcare_en.pdf

**58.** COVID-19 vaccine hesitancy among ethnic minority groups; BMJ editorial (2021) https://www.bmj.com/content/372/bmj.n513

**59.** The Conditional Effects of Health on Voter Turnout Gregory Lyon J Health Polit Policy Law (2021) 46 (3): 409–433. https://doi.org/10.1215/03616878-8893529)

**60.** Political disengagement in the UK: who is disengaged? (parliament.uk) 43 Market Values and Youth Political Engagement in the UK: Towards an Agenda for Exploring the Psychological Impacts of Neo-LiberalismAllsop, Bradley; Briggs, Jacqueline; Kisby, Ben. Societies; Basel Vol. 8, Iss. 4, (Dec 2018). DOI:10.3390/soc8040095

**61.** Health Equity in England:The Marmot Review 10 Years On; Marmot, M. et al (2020) https://www.health.org.uk/publications/reports/the-marmot-review-10-years-on

**62.** Valuing Community-Led Design; Alexiou, K., Zamenopoulos, T., Alevizou, G. (2013) https://oro.open.ac.uk/39646/1/

**63.** Effective Engagement Requires Trust and Being Trustworthy; Wilkins, C.H. (2018) https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6143205/

**64.** Community engagement: improving health and wellbeing and reducing health inequalities; NICE Guidelines (2016) https://www.nice.org.uk/guidance/ng44/resources/community-engagement-improving-health-and-wellbeing-and-reducing-health-inequalities-pdf-1837452829381

**65.** Sheffield Community Health Champions Programme: Addressing obesity through community engagement; NICE (2013) https://www.nice.org.uk/sharedlearning/sheffield-community-health-champions-programme-addressing-obesity-through-community-engagement

**66.** A systems map of the determinants of child health inequalities in England at the local level; Jessiman, P.E., et al (2021) https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0245577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