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JSNA Chapters:

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[Warrington Joint Strategic Needs Assessment Index](#)

[Warrington JSNA Smoking Chapter](#)

[Warrington JSNA Alcohol Chapter](#)

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[Warrington JSNA Socio-Economic Deprivation Chapter](#)

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Warrington Joint Strategic Needs Assessment (JSNA) 2011 - Life Expectancy Chapter



The Joint Strategic Needs Assessment (JSNA) considers a wide range of factors that affect the health and wellbeing of the people of Warrington. The objective of the JSNA is to involve partner organisations, such as the local NHS, local authorities, Police, Fire and third sector organisations in order to provide a top level, holistic view of current and future need within the borough. The JSNA is used to agree key priorities to improve the health and wellbeing of all our communities at the same time as reducing health inequalities.

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Executive Summary

Introduction

Life expectancy is an internationally accepted measure of the overall health of a population. Life Expectancy measures broadly the same thing as All-Age, All-Cause Mortality rates, but is often considered a more intuitive and thus an easier to understand indicator. Improvements in life expectancy featured in the previous Government's over-arching national target for tackling health inequalities, which was; "By 2010 to reduce Health inequalities in health outcomes by 10% as measured by infant mortality and life expectancy at birth".

Life Expectancy (LE) Gap: Comparison of the gap between a local area and the average for England is a useful measure of health inequalities at national level. Currently life expectancy in Warrington is lower than the average for England for both males and females. Analysis of the gap by cause of death can help identify key issues for Warrington.

Disability-free life expectancy (DFLE) is an estimation of the length of time that an individual can expect to live free from a limiting long-standing illness or disability. This indicator therefore adds a qualitative dimension to measures of life expectancy. *(Previously only available from 2001 Census data, the Office of National Statistics (ONS) has made available estimates of DFLE at local authority level for males and females at ages 16 and 65, derived from data collected in the Annual Population Survey.)*

Key Issues and Gaps

At **77.6 years**, life expectancy for **males** in Warrington is lower than the England average of 78.3 years.

Life expectancy for Warrington females is also lower than the average for England. Currently, **female** life expectancy within Warrington is **81.2 years**, compared with 82.3 years for England.

The biggest contributor to reduced life expectancy for males is by far **Coronary Heart Disease**, which accounts for almost **51%** of the gap in life expectancy between Warrington and England. Heart disease is also the major contributor for females, accounting for **24%** of the gap.

There are substantial differences in life expectancy within Warrington, with the pattern following the pattern of deprivation. For males there is a difference of **9.9 years** between the most and least deprived 10% of areas within Warrington. For females the difference is **7.4 years**.

The gradient between the least and most deprived areas is a useful measure which can be used to compare Local Authorities. The gradient within Warrington for males is the **87th** highest (worst) of 324 local authorities. For females, Warrington has the **88th** highest gradient for life expectancy inequalities.

Statistical modelling suggests that identifying and treating people with undiagnosed hypertension (high blood pressure) could have a substantial impact on life expectancy in Warrington.

Warrington currently has relatively low rates of infant mortality; further reducing the number of infant deaths would greatly impact on life expectancy.

Inequalities in disability-free life expectancy between Warrington and England widen with increasing age.

Intra-Warrington inequalities in disability-free life expectancy are substantial, with the internal inequalities gradient in Warrington higher than the average for England for females, and substantially higher for males.

Recommendations for Commissioning

Life expectancy is an over-arching measure of population health, and thus improvements in life expectancy and in the life expectancy gap are ultimate summary measures of improvements to population health and health inequalities, which should be regularly monitored.

Clear and up to date understanding of the current and likely future needs of local populations and sensitive targeting of effective initiatives is needed.

Action should focus on reducing the gradient in health, rather than focussing solely on the most disadvantaged.

The implementation of proven effective interventions such as smoking cessation services and therapies to control blood pressure should be targeted specifically at people with the highest levels of need, and the impact monitored regularly.

Required activity targets should be quantified and stipulated so that there is clarity as to the numbers that need to be treated from each area or population segment in order to reduce health inequalities.

Contract negotiations with providers should stipulate that health improvement interventions need to be appropriately targeted to address health inequalities.

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1) Who's At Risk and Why

1.1) Life expectancy is affected by many wide ranging and multi-faceted factors. These include Social, Economic and Demographic indicators, including income, social class, occupation and parental occupation, level of education, housing condition, neighbourhood quality, geographic region, gender and ethnicity. Improvement in life expectancy is therefore an over-arching, summary measure of improvements to population health and health inequalities.

Life expectancy for everyone in England has improved in recent years, and now stands at almost 78.3 years for men and 82.3 years for women. However, the improvement rate has been slower in the most deprived areas and, measured on a national scale, the gap has continued to widen ([life expectancy data, charts and maps available here](#)).

It is recognised that improving life expectancy and reducing health inequalities is not just an issue for the health service; inequalities arise from socio-economic factors. It has been estimated that up to 85% of health inequalities arise from socio-economic determinants, such as income, education and housing, with a much smaller proportion resulting from poor access to good-quality health services. As stated by Professor Margaret Whitehead, "inadequate access to health services is only one of many determinants of the observed inequalities in health, and a relatively minor one at that" (Whitehead 2009, in House of Commons Select Committee Report).

It is important, therefore, to recognise that whilst we need to ensure that access to Health Services is equitable, as this will contribute to reducing the gap, we also need to recognise that improvement in equity of access to health services on its own cannot tackle the problems of differential life expectancy that arise from whether someone is rich or poor or where they tend to live. Partnership working is crucial to tackle some of the wider determinants of health inequalities.

In terms of service factors and lifestyle interventions, implementation of the key interventions, identified in the London Health Observatory Health Inequalities Intervention Tool, provides a cost-effective way of reducing some of the gap in life expectancy. However, on a national level, a report by the National Audit Office (2010) states that these have yet to be adopted on the scale required to close the inequalities gap.

1.2) Disability-Free Life Expectancy: National studies, by White and Edgar (2010) have demonstrated a clear social inequality in the length of life and in the functional health status during those years lived. At both age 16 and age 65 there is a clear socio-economic gradient; with disability-free life expectancy increasing with rising social class. In addition to the inequalities observed between social classes, the study also found that there were further inequalities related to area, i.e. routine and manual workers living in more affluent areas had higher disability-free life expectancy than routine and manual workers living in more deprived areas.

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2) The Level of Need in the Population

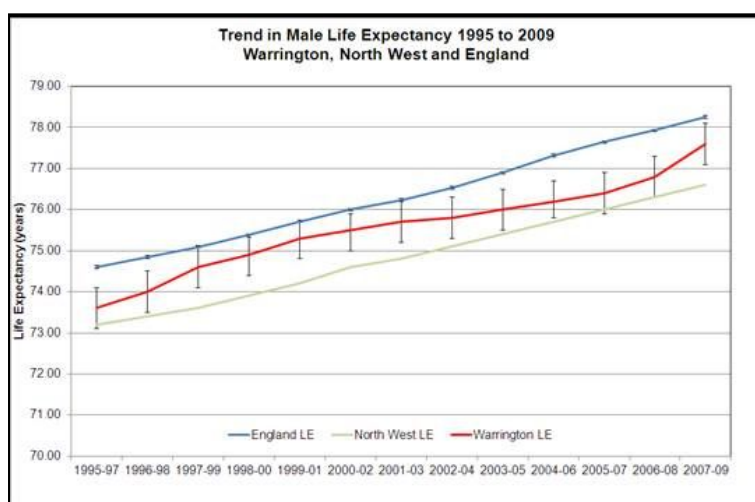
2.1) Life expectancy within Warrington is currently lower than England for both males and females ([life expectancy data, charts and maps available here](#)).

At 77.6 years, life expectancy at birth for males in Warrington is lower than the England average of 78.3 years.

Life expectancy for Warrington females is also lower than the average for England. Currently, female life expectancy within Warrington is 81.2 years, compared with 82.3 years for England.

Charts 1 and 2 show the trend in male and female life expectancy at birth since 1995, for Warrington and comparator areas. The latest comparative data available is for 2009. As the charts illustrate, life expectancy for both males and females is increasing. In Warrington however, the rate of increase for females is not keeping pace with that of England as a whole and thus the inequalities gap between Warrington and England has widened since 1995-1997.

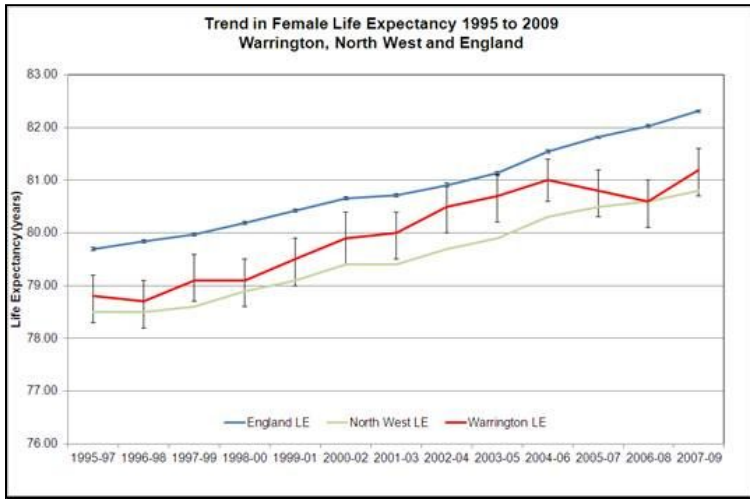
Chart 1: Trend in Male Life Expectancy, 1995 to 2009



Source: National Statistics, Compendium of Clinical and Health Indicators,

The NHS Information Centre for health and social care. © Crown Copyright

Chart 2: Trend in Female Life Expectancy, 1995 to 2009



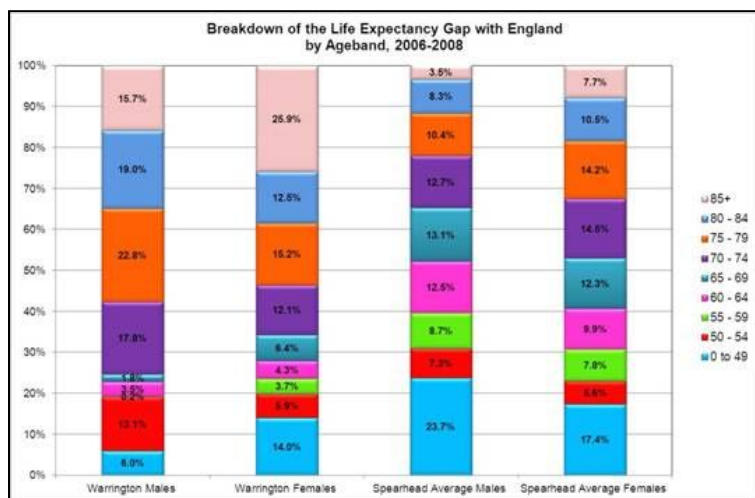
Source: National Statistics, Compendium of Clinical and Health Indicators, The NHS Information Centre for health and social care. © Crown Copyright

2.2) Breakdown of the Life Expectancy Gap, by Age: The London Health Observatory have developed a Life Expectancy Spearhead Tool (London Health Observatory 2011), which is aimed at helping areas better understand the drivers of local, low life expectancy. The tool enables us to disaggregate the life expectancy gap by age and sex.

Within Warrington the biggest excess burden in terms of the life expectancy gap is amongst older population groups. For males and females under the age of 9 years, the calculated contribution to the gap with England is negative, i.e. death rates are lower in these age-bands than the average for England. For each 5 year age-band, up to 50, the contribution to the life expectancy gap, where there is one, is small for both males and females. In the 50 to 54 age-band the contribution is much greater for males, and exceeds the average for other similarly disadvantaged boroughs (the Spearhead Areas). (*Spearhead Areas are a fixed list of 70 local authority areas which experienced similar levels of disadvantage in 1995-1997. An area was classified as a Spearhead if it was in the bottom fifth nationally in 1995-97 for three or more of five health indicators.*)

The most substantial contribution to the gap is amongst the 70+ age groups. As chart 3 illustrates, contribution to the gap for both Warrington males and females in these age-bands far exceeds Spearhead averages.

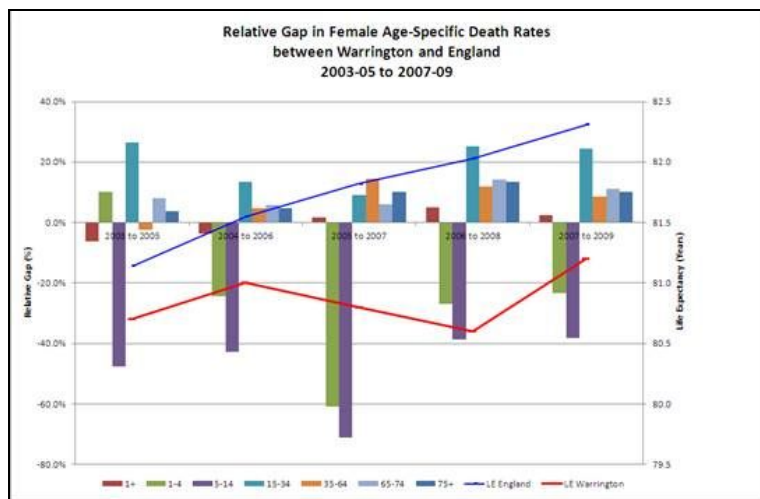
Chart 3: Breakdown of the Life Expectancy Gap, by Age-Band, 2006-2008



Source: London Health Observatory

Analysis of the trend in age-specific death rates for Warrington and England suggests the decrease in life expectancy for females observed in 2005-07 appears to be predominantly a result of a substantial increase in death rates amongst women aged 35-64 and 75+. This increase was sustained again in 2006-2008 for females aged 75+ and there was also an increase in rates for women aged 65-74 over this time period. Chart 4 shows the trend in the relative gap in age specific death rates between England and Warrington for women since 2003. A negative relative percentage indicates that the age-specific rates are better than those of England.

Chart 4: Trend in Female Age-Specific Mortality Gap between England and Warrington, 2003 to 2009



Source: London Health Observatory

2.3) Major Contributors to the Life Expectancy Gap: The London Health Observatory Life Expectancy Spearhead Tool also enables us to break down the specific diseases that contribute to the gap in life expectancy between Warrington and England.

Within Warrington, the biggest contributor to reduced life expectancy for males is by far coronary heart disease, which accounts for almost 51% of the gap in life expectancy between Warrington and England. Heart disease is also the major contributor for females, accounting for 24% of the gap.

Stroke is another major contributor, accounting for 9.1% of the gap for males and 13.3% for females.

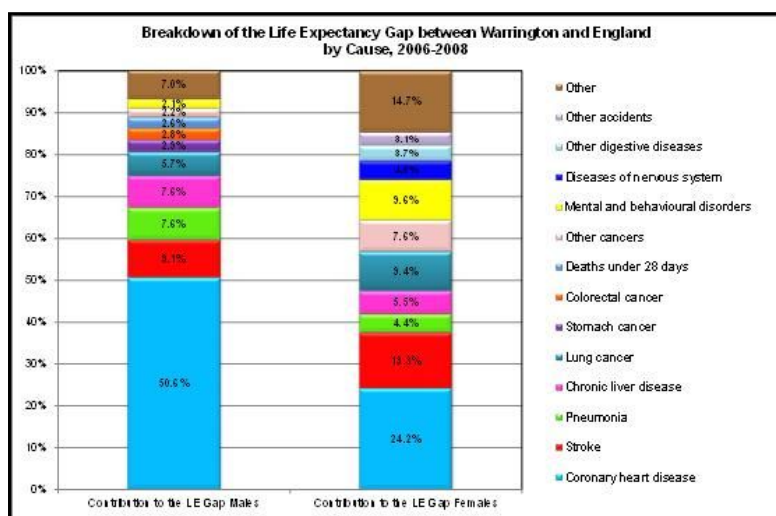
The percentage contribution of both heart disease and stroke to reduced life expectancy in Warrington is greater than that of other similarly disadvantaged areas in England.

As a whole, the contribution of cancers to reduced life expectancy is 13.6% and 17.0% for males and females, respectively. This is slightly lower than the average for other Spearhead areas. Looking at specific cancers, lung cancer is the biggest contributor, accounting for 5.7% of the gap for males and 9.4% for females.

Chronic liver disease also contributes to reduced life expectancy in Warrington, accounting for 7.6% amongst males and 5.5% amongst females. As with heart disease and stroke, the percentage contribution within Warrington is greater than the average for other Spearhead areas.

Some of these conditions and associated risk factors are considered in more depth in other JSNA Chapters: Smoking, Alcohol, Cardiovascular Diseases and Cancer.

Chart 5: Breakdown of the Life Expectancy Gap, by Cause, 2006-2008



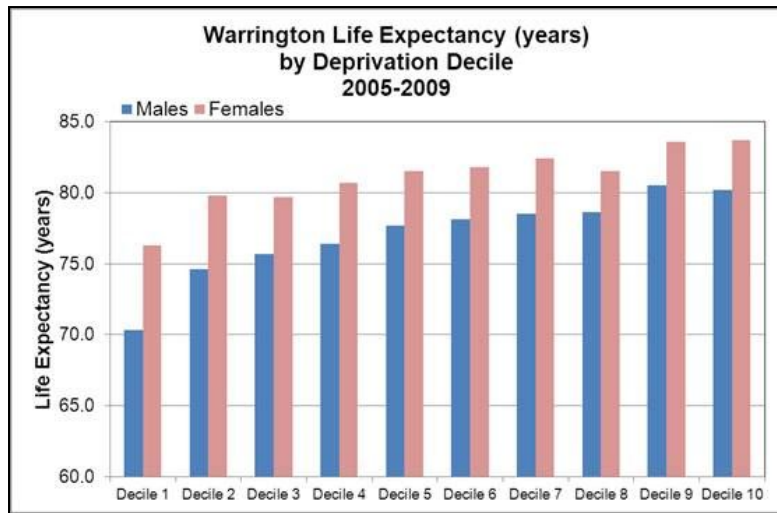
Source: London Health Observatory

2.4) Slope Index of Inequalities for Life Expectancy: The Slope Index of Inequalities (SII) provides a description of the extent of inequality in each local authority, as it measures the steepness of the gradient in life expectancy between socio-economic groups within a borough. The measure is broadly comparable between boroughs, with a smaller slope index score representing a less steep gradient, and thus narrower internal inequalities. Some local authorities have more diverse populations than others, in terms of deprivation. As life expectancy and deprivation are so strongly correlated, authorities with a wider range of deprivation will tend to have greater ranges of life expectancy and therefore a large Slope Index.

There are substantial differences in life expectancy within Warrington, with the pattern following the pattern of deprivation. For males, there is an absolute difference of 9.9 years between the most and least deprived 10% of areas within Warrington. For females, the difference is 7.4

years. For example, males living within pockets of Bewsey and Whitecross, Fairfield and Howley, Orford, Poplars and Hulme, and Latchford have a life expectancy which is almost ten years less than males living in pockets of wards such as Appleton, Grappenhall and Thelwall, Stockton Heath, Birchwood and Lymm. The slope index of inequalities is a more comprehensive measure of internal inequalities as it takes into account inequalities across the entire population.

Chart 6: Warrington Life Expectancy at Birth, by Deprivation Decile



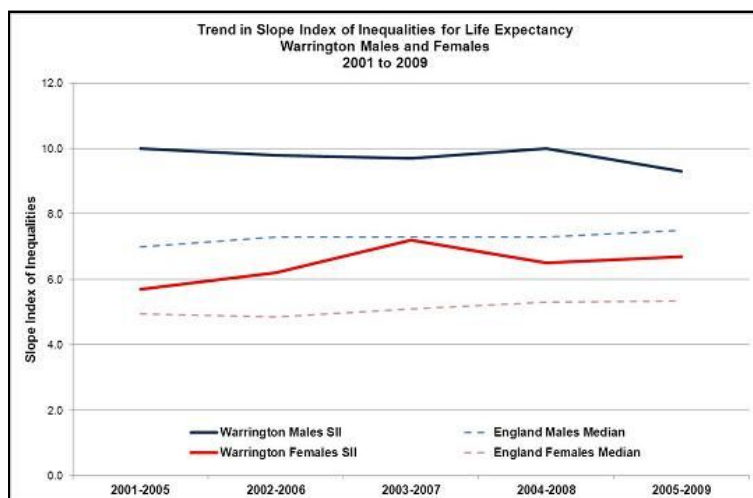
Source: Association of Public Health Observatories (APHO)

The gradient between the least and most deprived areas is a useful measure which can be used to compare areas. The gradient within Warrington for males is the 87th highest (worst) of the 324 local authority districts for which we have data. For females, Warrington has the 88th highest gradient for life expectancy inequalities. (Data is not available for City of London LB or Isle of Scilly UA as Slope Index cannot be calculated due to the small populations.)

Chart 7 shows the trend in the gradient for Warrington and compares this with the median for England.

As the chart illustrates, the trend in the slope index score for Warrington appears to be decreasing for males, suggesting a narrowing of internal inequalities. This is in contrast to the pattern for England, where the trend in the slope is increasing. For females, however, the internal gap for Warrington appears to be widening by approximately 0.23 years per each 5 year period for which we have data. England also shows an upward trend.

Chart 7: Trend in the Slope Index of Inequalities in Life Expectancy



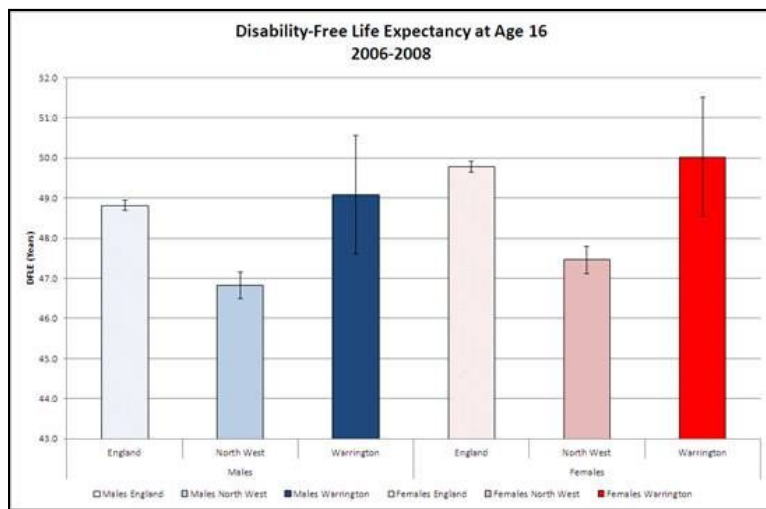
Source: Association of Public Health Observatories (APHO)

2.5) Disability-Free Life Expectancy: Comparative disability-free life expectancy figures are available at ages 16 and 65 for males and females separately. The latest available data is for the period 2006-2008 ([disability-free life expectancy data, charts and maps available here](#)).

Based on this data, at age 16, males in Warrington can, on average, expect to live a further 61.3 years; 49.1 of these disability-free. At age 16, Warrington females can expect to live a further 50 years free of disability.

Chart 8 presents figures for males and females at age 16. As the chart illustrates, at age 16, for both males and females, disability-free life expectancy in Warrington is slightly higher than the average for England, although the difference is not statistically significant. *(For England, data is available from different survey sources. To enable robust comparisons to be made with local authority and regional figures, figures from the Annual Population Survey have been used.)*

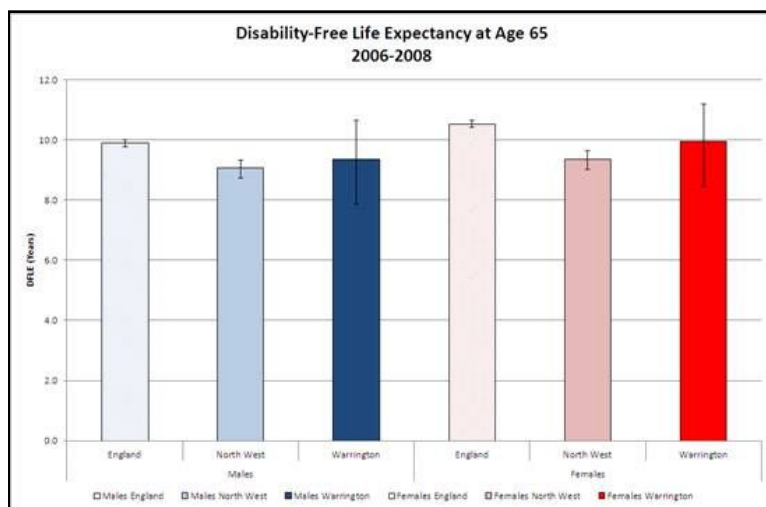
Chart 8: Disability-Free Life Expectancy Gap at Age 16, 2006-2008



Source: National Statistics

At age 65, Warrington males can expect a further 9.4 years of disability-free life expectancy. Warrington females can expect to have a further 9.9 years of disability-free life expectancy. As chart 9 illustrates, by age 65, disability-free life expectancy within Warrington is lower than the average for England.

Chart 9: Disability-Free Life Expectancy Gap at Age 65, 2006-2008



Source: National Statistics

This analysis suggests that as with life expectancy, inequalities in disability-free life expectancy between Warrington and England widen with increasing age. At age 16, Warrington males can expect 0.3 **additional** years of disability-free life expectancy than the average for England. By age 65, they can expect, on average, 0.5 years **less**.

The pattern is similar for females. At age 16, Warrington females can expect 0.2 **more** years disability-free life expectancy than the average for England and by age 65 this has reduced to 0.6 years **less** than England.

2.6) Slope Index of Inequalities for Disability-Free Life Expectancy: A Slope Index of Inequalities is available for disability-free life expectancy at birth, for all upper-tier local authorities in England. As for life expectancy, this provides a description of the extent of inequality in each local authority, as it measures the steepness of the gradient in life expectancy between socio-economic groups within a borough. As the confidence intervals overlap, these observed differences are not statistically significant. However, this analysis, coupled with other work (see the JSNA Chapter on Older People's Health), suggests that health inequalities in Warrington appear to widen with increasing age.

There are substantial differences in disability-free life expectancy within Warrington. For males, Warrington has a Slope Index of Inequality of 14.1 years, compared to the median for England of 10.9 years. For females, the SII is 10.4 years, compared to the England average of 9.2 years.

The gradient between the least and most deprived areas is a useful measure which can be used to compare areas. The gradient within Warrington for males is the 29th highest (worst) of 150 upper-tier local authorities. For females, Warrington has the 53rd highest SII for disability-free life expectancy inequalities.

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3) Current Services in Relation to Need

As discussed, many factors impact on life expectancy, the majority of which are outside the scope of health services. In terms of addressing the wider determinants of health; housing, deprivation and poverty, education, regeneration, and worklessness are all considered elsewhere in other JSNA Chapters. Quantifying the impact of these policies and strategies on life expectancy would be extremely difficult. The Warrington Partnership has made addressing the geographical and social inequalities in Warrington a priority. The 'Closing the Gap' initiative aims to reduce the gaps in quality of life for Warrington's most disadvantaged communities by developing new ways of working with partners to help support the most vulnerable citizens and those living in the 10% most deprived areas (Lower Super Output Areas (LSOAs)) within the borough.

In terms of medical interventions and services commissioned to address lifestyle risk factors, whilst universal services are available, the aspiration locally is to try and ensure populations in greatest need are targeted and that enhanced services are available in the most disadvantaged areas.

For smoking cessation services, in order help address inequalities, local targets have been agreed with the service provider to ensure that a high proportion (40%) of the smokers treated will be from the 20% most deprived LSOAs during 2011/12. This will rise to 46% in 2012/13.

Targeted work for alcohol to date has focussed on identifying people attending hospital frequently for alcohol specific conditions, and working with the local Trust to review care pathways. At present, there is no geographical focus for targeted alcohol harm prevention work, with Identification and Brief Intervention work offered universally.

In terms of the NHS Health Checks programme, the aim is to target Practices that have more than 50% of their registered population living in the most deprived 40% LSOAs.

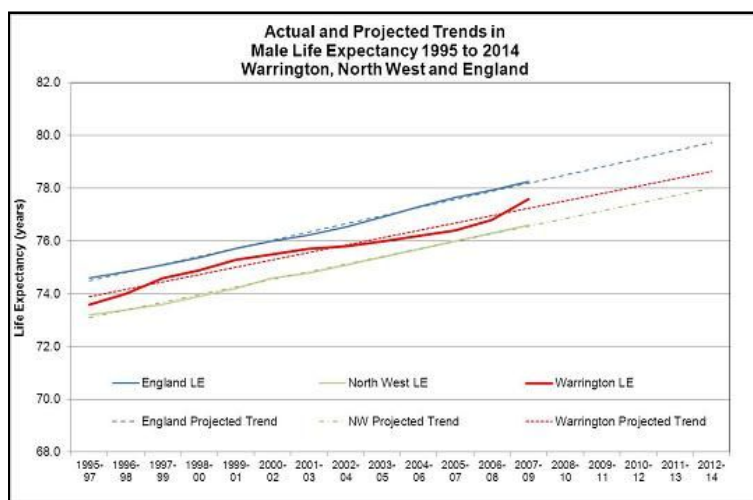
The concern is that uptake of universal services is greater amongst less disadvantaged populations and that the scale of any targeted interventions is not great enough to impact substantially on health inequalities in the longer term.

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4) Projected Service Use and Outcomes in 3-5 Years and 5-10 Years

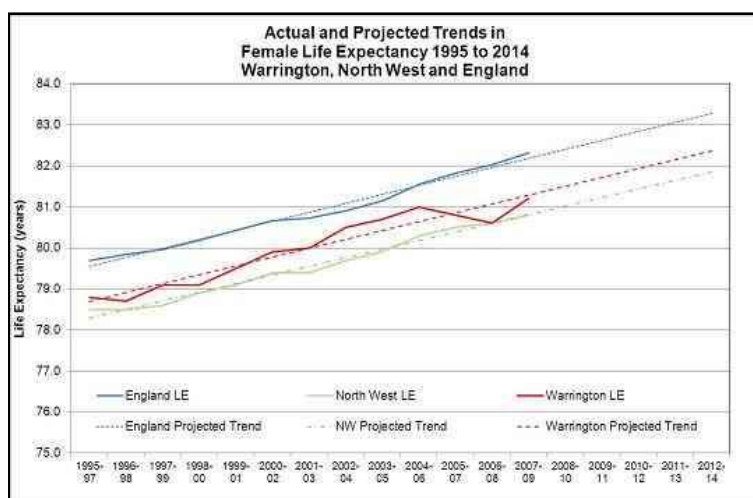
Projections suggest that, if current trends continue, male and female life expectancy within Warrington will continue to rise, but the gap between Warrington and England will not narrow within the next five years. Charts 10 and 11 present projections for life expectancy to 2014, based on extrapolated (or projected existing) trends only. These projections do not take account of the impact of any local or national interventions.

Chart 10: Actual and Projected Trends in Male Life Expectancy



Source: National Statistics, Compendium of Clinical and Health Indicators, The NHS Information Centre for health and social care. © Crown Copyright. Projections calculated locally.

Chart 11: Actual and Projected Trends in Female Life Expectancy



Source: National Statistics, Compendium of Clinical and Health Indicators, The NHS Information Centre for health and social care. © Crown Copyright. Projections calculated locally.

The London Health Observatory Health Inequalities Intervention Tool (London Health Observatory 2011) was introduced to support Primary Care Trusts (PCTs) in identifying and commissioning the interventions most likely to contribute to reducing health inequalities. The tool focuses on cost effective, predominantly medical, interventions which evidence shows can increase life expectancy quite rapidly.

Increasing the number of successful four-week smoking quitters is estimated to improve all-cause mortality by 1.1 per 100,000 for both males and females ([all age all cause mortality data, charts and maps available here](#)). The subsequent impact on life expectancy however is negligible.

Reducing the number of infant deaths would have the biggest impact on life expectancy. Because infant deaths occur at a young age, reducing the number of deaths will result in a higher number of life years saved than reducing the number of smoking quitters, for example, as a death from smoking will occur at an older age. Infant mortality rates within Warrington are in keeping with the average for England, thus the potential to substantially improve on already quite low rates may not be great. In Warrington, there are, on average, approximately 11 infant deaths per year. Halving this number would result in an absolute decrease in all-cause mortality rates of 11.7 per 100,000 for males and 8.1 per 100,000 amongst females. This would lead to increases in life expectancy of 0.2 years for males and 0.1 years for females.

Identifying people with previously **undiagnosed or uncontrolled hypertension**, but who do not have existing coronary heart disease or history of stroke, and prescribing anti-hypertensives would have a substantial impact on mortality rates. Identifying and treating half of the estimated number of undiagnosed hypertensives in Warrington is estimated to reduce male, all-cause mortality by 9.7 per 100,000, and female mortality by 9.4 per 100,000. **The prescribing of statins** in an appropriate sub-group of those people that are newly identified and have been treated with anti-hypertensive medication would result in a further reduction in mortality rates. *(Currently the model looks at the benefits of giving statins and anti-hypertensives simultaneously to people with hypertension who are free of cardiovascular disease. This group has been chosen as the initial focus as they are at particular risk of developing cardiovascular disease.)*

Controlling high blood sugar would have a small impact on average mortality rates and life expectancy. Treating half of the estimated number of people with high blood sugar is estimated to result in a decrease in mortality of 2.8 per 100,000 in males and 0.8 per 100,000 in females.

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5) Evidence of What Works

The development and implementation of strategies aimed at improving health and reducing inequalities needs to be underpinned by evidence of what works. This poses a challenge, in that, whilst there is substantial evidence describing and quantifying health inequalities, as stated by Macintyre (2003), the evidence-base on effective interventions to address them is small. Despite the emphasis on tackling health inequalities and significant Government effort and investment, there is still very little evidence about what interventions actually work to reduce health inequalities. A report by the House of Commons Health Committee (2009) states that this is, in part, due to inadequate evaluation of the policies adopted to address the problem. In his report on the Strategic Review of Health Inequalities, Marmot (2010) states that evaluation is crucial and that interventions should have an evidenced-based evaluation framework and a health equity impact assessment in order to help shape effective interventions and understand impacts.

The London Health Observatory Health Inequalities Intervention Tool (London Health Observatory 2011) was introduced to identify the interventions most likely to contribute to reducing health inequalities. Aimed at supporting local areas to employ interventions to help meet the life expectancy inequalities targets, the tool focuses on high impact medical interventions, particularly among the over 50s. These include reducing smoking among manual groups and the prevention, effective management and treatment of other cardiovascular risk factors through primary care, particularly control of cholesterol and blood pressure.

The tool can support commissioning and service development decisions to narrow local gaps in life expectancy between each Spearhead area and England as a whole. It shows the impact of cost-effective interventions on local life expectancy and All-Age, All-Cause Mortality.

In order to impact on internal inequalities, these interventions and other clinical interventions carried out by GPs, such as the implementation of the NHS Health Checks, need to be targeted effectively at those with the highest risk of premature death, as there is a danger that increased uptake amongst more affluent groups could actually increase health inequalities ([all age all cause mortality data, charts and maps available here](#)).

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6) (Target) Population/Service User Views

In the PCT's engagement exercise on its Strategic Commissioning Plan in 2009, the public response indicated that reducing health inequalities should be a major strategic goal for the health services. All key partners in Warrington, working through the Local Strategic Partnership, have emphasised a commitment to reducing health inequalities. Much work has been undertaken engaging with vulnerable populations on their health needs. A report describing this work and outlining findings is now available [here](#).

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7) Unmet Needs and Service Gaps

As Cardiovascular Disease (CVD) is the biggest single contributor to the gap in life expectancy in Warrington, it is essential that the NHS Health Checks Programme is on track, as this is the principal way through which individuals at risk of developing CVD will be identified. Other aspects of CVD, for example, the provision of appropriate interventions in primary and secondary care (see CVD chapter), are well provided in Warrington, but the NHS Health Checks Programme has not yet been implemented fully.

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8) Recommendations for Commissioning

Clear understanding of the needs of local populations and sensitive targeting of initiatives is needed.

There is a social gradient in health with lower socio-economic groups experiencing poorer health. Action should focus on reducing the gradient in health, rather than focussing solely on the most disadvantaged, as this will not reduce health inequalities sufficiently. As stated by Marmot (2010), "To reduce the steepness of the social gradient in health, actions must be universal, but with a scale and intensity that is proportionate to the level of disadvantage."

The implementation of effective interventions such as smoking cessation services and therapies to control blood pressure should be targeted specifically at people with the highest levels of need and their impact monitored regularly.

Required activity targets should be quantified and stipulated so that there is clarity as to the numbers that need to be treated from each area or population segment in order to reduce health inequalities.

Contract negotiations with providers should stipulate that health improvement interventions need to be appropriately targeted to address health inequalities.

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9) Recommendations for Needs Assessment Work

A programme of health equity audits, looking at all aspects of prevention and pathways of care for those conditions that contribute most substantially to the life expectancy gap, is required.

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