

Closing the gap: How data and technology can help reduce health inequalities in London

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Reform was delighted to host a policy roundtable on harnessing data and technology to reduce health inequalities in London, in partnership with Imperial Policy Forum. The discussion was introduced by Professor Kevin Fenton, Public Health Regional Director for London at the Office for Health Improvement and Disparities and Professor Paul Aylin, Professor of Epidemiology and Public Health at Imperial College London.

Health inequalities in London are pervasive and persistent, with the biggest gap in life expectancy between local authorities of any region in England. For example, women in Tower Hamlets live for 56 years in good health compared to 70 years in Richmond.

The COVID-19 pandemic exacerbated these systemic differences, laying bare health inequalities related to race, ethnicity, and socio-economic status. With a cost-of-living crisis and public services are under increasing strain, vulnerable groups will be hit the hardest, threatening to further magnify health inequalities.

A digital and data driven approach is by no means a silver bullet for long-term systemic challenges such as health inequalities. But, by helping policymakers better understand determinants of health, strategise public health interventions, and build effective partnerships, data and technology can play a crucial role in helping close London's unacceptable health gap.

A positive legacy

The exposure of deep health inequalities during the pandemic and the recognition that disparities leave us highly vulnerable to future health shocks has created a burning platform for change and accelerated the policy agenda.

Nationally, the Government has established the Office for Health Improvement and Disparities (OHID), Integrated Care Systems (ICSs) have been given a duty to tackle health inequalities, and NHS England has launched 'Core20PLUS5', a strategy to address inequalities across targeted groups. At the London level, the Mayor's Health Inequalities Strategy Implementation plan lays out specific actions to drive progress in the aftermath of the pandemic.

Action taken during the pandemic showed us the potential of new ways of working to meet the needs of marginalised communities. Making use of community and faith leaders to promote vaccine uptake, the development of innovative partnerships between the VCSE sector and local government, and the harnessing of community knowledge to identify vulnerable families and individuals all exemplify the value of new approaches. Rather than seeing data and digital as 'solutions' to the health inequalities challenge, policymakers should consider how these tools can help facilitate and reinforce new ways of working.

Realising the potential of data

The robust collection and use of data can help us better understand health inequalities, target approaches and interventions, and evaluate their impact.

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Significant progress is already being made in this area. The launch of OHID's Segment tool, which provides local level trend data on the drivers of inequality in life expectancy, and its CHIME tool, which monitors health inequalities related to COVID-19, stand out as exemplars.

However, attendees argued that despite this progress, barriers remain to realising the full potential of data .

The first of these barriers concerns the quality and volume of data collected. For example, many healthcare data sets either exclude or inconsistently code ethnicity, a problem that is worse in London than in other regions. This limits our understanding of how different groups access and experience health care.

Second, while efforts to join up health care data have paid dividends in recent years across London's care systems, effective data sharing on the wider determinants of health remains an issue. This is the case *between* the NHS and local authorities, but also *within* local authorities where public health teams often struggle to access relevant information on health determinants such as housing and employment data.

Establishing trust

Problems in data collection and sharing are exacerbated by a lack of public trust and understanding in how data is used. This is a particular issue in vulnerable population sub-groups who often have lower trust in local authorities and health services.

Attendees noted instances in which individuals were reluctant to share information about protected characteristics - these might include their ethnicity or sexuality - due to concerns about how this may be used. Low public trust in these cases hampers the ability of healthcare providers and wider public services to provide high-quality care and improve health outcomes.

Attendees agreed that a higher level of public involvement in the process of data collection was vital to support the ongoing collection and use of health-related data. This is particularly important given the wealth of data collected during the pandemic, much of which the public felt unaware of.

To establish trust, local authorities and health services must work more closely with their partners in the voluntary, community and social enterprise sectors who tend to be more trusted and connected with vulnerable groups..

From insight to action

While the collection, linkage, and analysis of health inequalities data is a crucial enabler of effective interventions, attendees were concerned that data-driven insights were not optimally informing the decisions of policymakers. The development of more national and local level tools and dashboards is only useful if they lead to real change.

ICSs, who are responsible for the management of their population's health, could use insights on inequalities, social determinants of health and health outcomes to inform commissioning and strategy. However, attendees expressed concern as to whether this was occurring in practice.

Strengthening the data function in ICSs, and improving governance arrangements to give more voice and influence to local authorities who have a greater degree of control over the social determinants of health, were seen as possible strategies to make progress in this area.

Mitigating digital risk

Alongside the use of health inequalities data to inform policy making, attendees also reflected on the use of digital technology both as an opportunity to address, and a risk to exacerbating, health inequalities. Some expressed concern that technological

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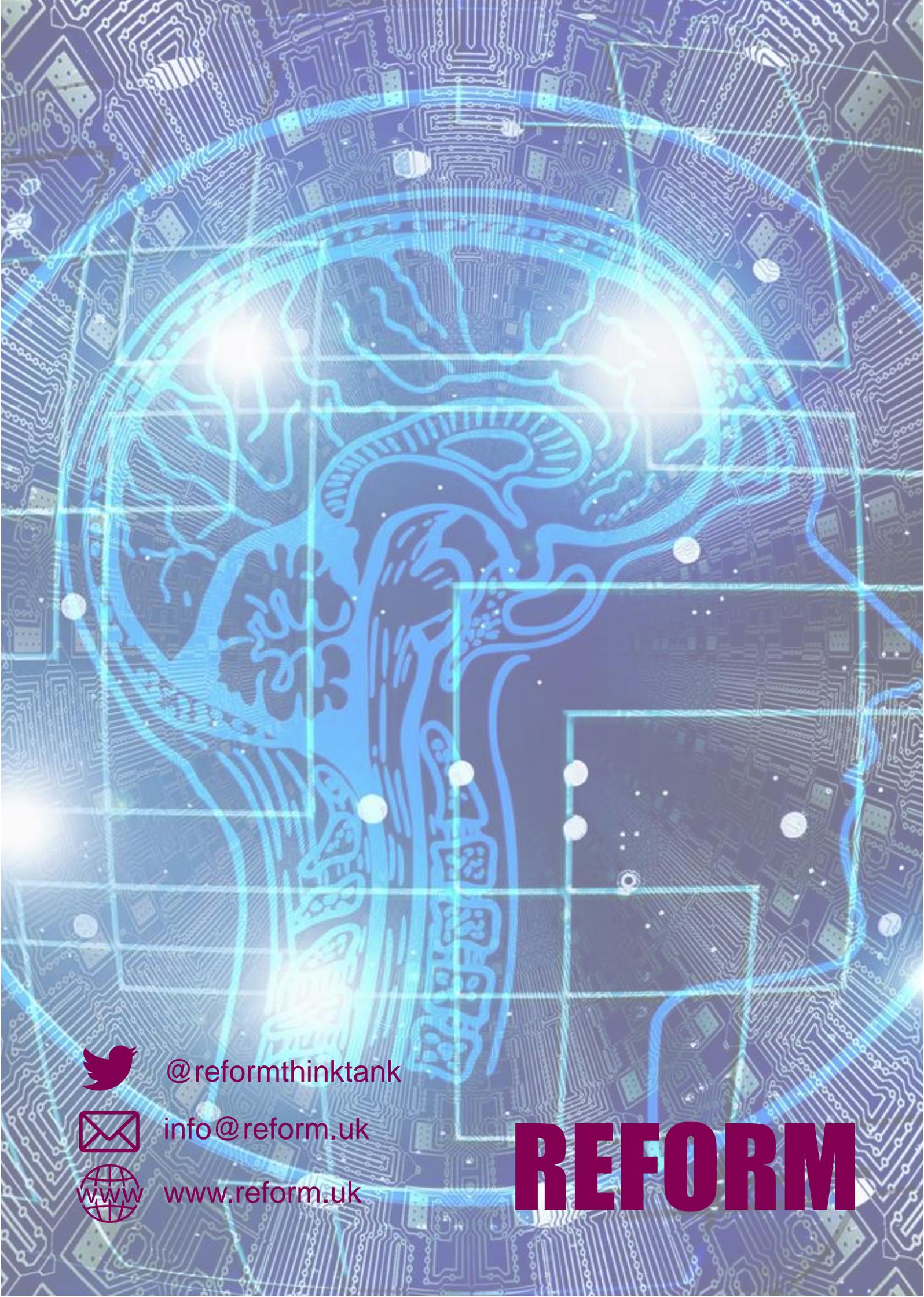
advancement and the rise of “digital-first” approaches to care could widen inequalities, given the higher likelihood of digital exclusion among vulnerable populations. For that reason, improving digital literacy was seen as a core focus area for care providers going forward, as was the principle that high-quality non-digital options must continue to be available.

Just as importantly, attendees reflected that new technologies could be a powerful tool for inclusion. In the first instance, the more widespread use of technology in health care can provide easier and better access to care than

before. One example of this is patients with mobility issues being able to speak to their GP from home.

In addition, if low-risk patients can be served by digital services, resources and staff time can be freed up for higher-risk or more vulnerable patients. One example given was in relation to maternity care, where health inequalities are particularly pronounced. Attendees reflected that many low-risk mothers could use at home tests and virtual appointments, creating greater capacity in the system for high-risk mothers to receive more personalised and relational care.





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