Who cares? With services overburdened by growing demand and restricted supply, what opportunities for health creation are there to improve the accessibility and sustainability of health services in the UK?

An opportunity for positive health for all

Introduction

The health problems facing the UK have undergone huge change over the past century, with old epidemics replaced with new challenges. We may be living longer but we are spending more time in poor health and health services have to cope with increasingly complex and frail patients under severe resource constraints (1). As demand on the health and social care sector grows, we need a new approach to promoting health that goes beyond disease prevention and lifestyle advice. To enable healthy ageing for the whole population we must tackle the complex, deep-rooted inequalities within our society and create environments that promote positive health and well-being. Specifically, we should address the holistic well-being of older people, provide low-level support and create truly health promoting settings in order to enable healthy ageing for all.

Tackling the root causes of poor health

Ill health continues to be concentrated amongst poorer and more vulnerable populations because while the specific health threats may have changed over time, the conditions underlying poor health remain (2). Without action to tackle the great inequalities that persist in the UK, we will continue to struggle to manage the consequences. The clustering of disease and unhealthy lifestyle behaviours in particular groups suggests that rather than focus on downstream health services, we need to be tackling the broader causes of poverty and isolation (3). People do not choose to be unhealthy, nor do they wilfully ignore medical advice. Instead, behaviour is determined by a whole range of factors, from job security and housing to education and advertising. These in turn are the consequence of inequalities in the distribution of power and resources (3).

The limitation of traditional approaches to health education and self-care is that the uptake is highest among those with the lowest risk of disease (4), thus widening health inequalities. A young mother working night shifts on the minimum wage and living in a council estate may smoke because it is her only way of coping and finding some form of enjoyment and relaxation. She is unlikely to respond to a 'Stop Smoking' campaign in her doctor's waiting room because targeting the smoking behaviour alone is failing to appreciate the impact of the wider environment.

These inequalities within society persist into later life and it would be a mistake to consider older people as a homogenous population. 14% of pensioners live in poverty (5), which is one of the key

drivers of poor mental health in older people (6). Another major cause is social isolation, which also has a steep socioeconomic gradient (7). Those from lower socioeconomic groups may live in poor quality housing and fear of crime may prevent them from leaving the house (6). Given that 25% of older people suffer symptoms of depression (6), it is clear that interventions targeted at preventing specific diseases are insufficient for healthy ageing. Not only are they unlikely to be successful but they also neglect the need to promote health in its more holistic sense, incorporating psychological and social wellbeing.

A similar problem has been observed in residential and domiciliary care, where there is a tendency to neglect the social aspects of people's lives that are so essential in maintaining well-being in later life. Home care workers are increasingly contracted to provide time- and task-centred care, leaving them little opportunity to be flexible or simply have a chat and a cup of tea (8). We seem to place less value on interventions to promote mental health, despite the fact that lack of social contact and loneliness are associated with poor well-being and quality of life (9). This is particularly counterintuitive, given that social isolation and poor mental health may contribute to worse physical health outcomes (7).

An alternative approach

Instead, we need to change the environments in which we are raised, live and work (3). The settings approach to health promotion provides an excellent model, where the focus is not on preventing individual disease but promoting well-being for the whole population (10). The movement started with health-promoting schools but the model has been adopted in prisons, hospitals and whole cities. It involves empowering communities, creating healthy policies and changing environments in a way that is sustainable (11). In a health promoting community fruit and vegetables would be cheaper than chocolate, walking would be easier than taking the car and working conditions would be improved, to reduce the huge burden of workplace-related mental health problems (12). Social isolation in older people would be prevented by affordable and accessible transport, tackling antisocial behaviour and providing appropriate housing.

Supporting independence

We know that as people age, maintaining their independence is a primary concern (6). To achieve this, many will require what has been termed 'low-level' support to overcome problems such as limited mobility and sensory impairment (13). Rather than formal health and social care, older people want help with gardening, changing light bulbs and deciphering bills (13). Such low-cost practical tasks should be seen as an essential component of a preventative approach to healthy

ageing and yet constricting budgets mean that local authorities tend to focus only on those with the highest level of need (1). Add to this a lack of knowledge amongst older people about the services available and a reluctance to ask for help and we are left with a large amount of unmet need. One successful strategy introduced a checklist to be used by all partner agencies when older people accessed services (14). This enabled them to identify whether the older people would benefit from other forms of support, such as financial or housing advice or a home security check.

We must also ensure that mainstream services are accessible to older people and sensitive to their needs. Relatively low-cost adaptations and raising awareness amongst staff would enable older people to remain active in their communities and access shops, leisure and social activities, which are so vital for maintaining independence and societal engagement (6)(14). The key to this is involving older people in planning decisions, service design and development plans. For example, representatives from the Manchester Valuing Older People Board were involved in discussions with local architects and leisure services in Hartlepool introduced concessionary rates and low-level exercise classes for older customers (14).

We do not need to reinvent the wheel. There are plenty of examples of excellent practice in supporting healthy ageing and enabling older people to remain independent in their own homes. Some have specifically reached out to the most vulnerable and isolated and have succeeded in building social networks, increasing access to services and providing an opportunity for older people themselves to be involved in establishing and developing services (15).

However, most of these projects are available only to a small proportion of those who could benefit and in specific areas of the country. Those that receive any funding at all are constantly threatened by cuts to local authority budgets and a lack of long-term financial stability. What we need to do is urgently roll-out those projects that work and move to more stable and sustainable financing structures. The Joseph Rowntree Foundation has already identified a 'Baker's dozen' of low-level services that were most valued by older people and these should be commissioned by all local authorities in England (13).

A challenge for the medical profession

Many would argue that this is not a job for the health sector and should not concern doctors. I would disagree. Since learning more about social services, commissioning arrangements and local government policy through a Masters in Public Health, it is clear to me that without securing the wider social, economic and environmental determinants of health, we will never be able to achieve truly preventative services. When a ninety year old lady consults her family doctor for a medication

review, we should be asking whether she is eating properly, can get out of the house, has any social contact, is having any difficulties with her finances or domestic tasks. As doctors we have a duty to care for our patients and that means ensuring that they have access to all the foundations of good health, regardless of which 'sector' they fall under. We can also act as their advocates, campaigning for better services where they are currently inadequate and raising the profile of unmet needs.

In conclusion, we need to move away from traditional health promotion that targets individual health behaviours without recognising the broader social and environmental contexts in which we live and age. By employing a settings-based approach, we can create healthy communities and ensure that health benefits are equitably distributed across society. This must incorporate action at a policy and service delivery level that promotes independence and well-being in later life, with all professionals and sectors taking collective responsibility for health.

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