gmphnetwork
Greater Manchester
Public Health

Healthy Economics
Economic Investment in our Population
A Perspective from Greater Manchester

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GM Commission for New Economy

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Working with partners towards a healthier and happier Greater Manchester

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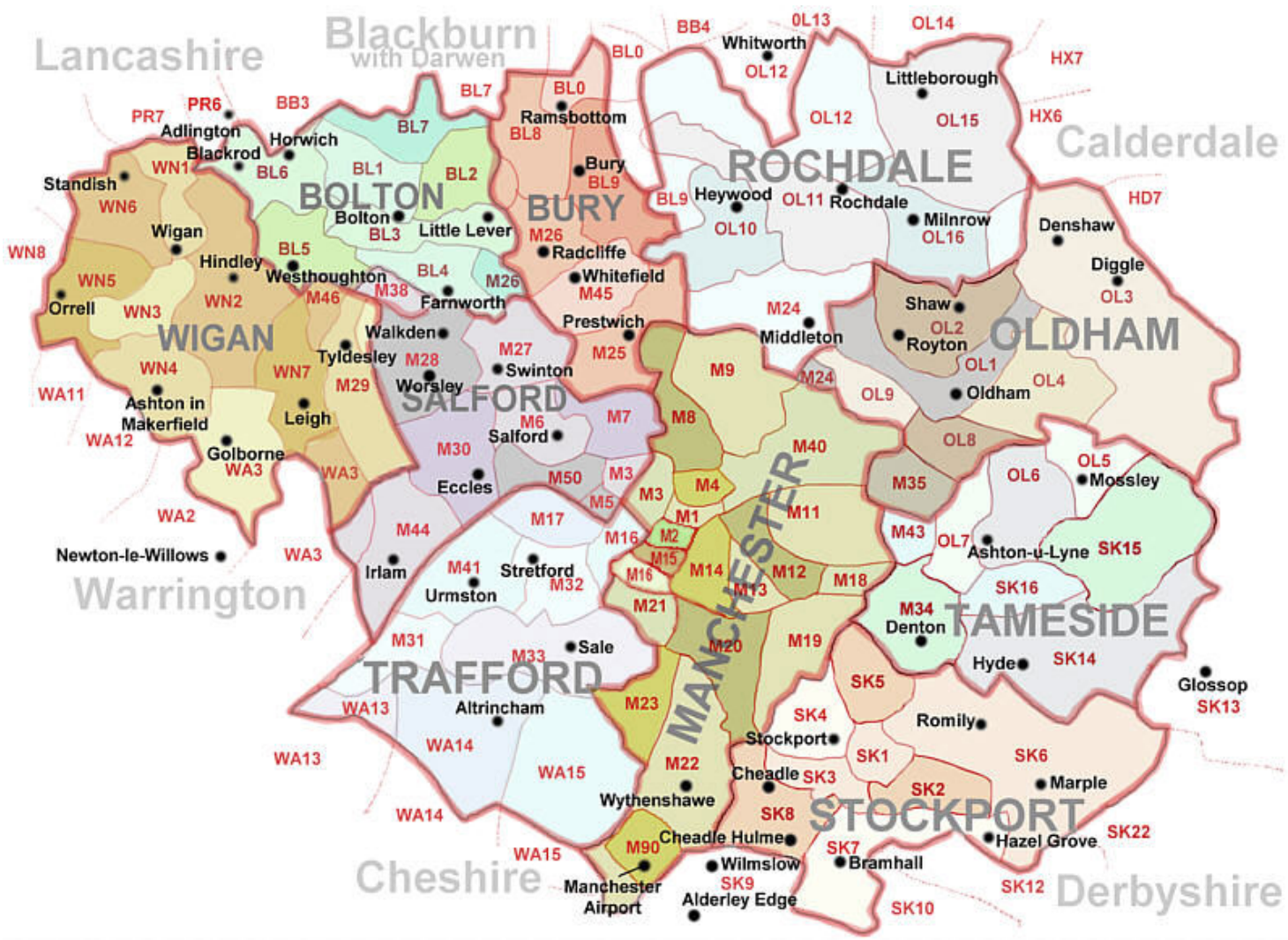
GM Organisational Coherence



Greater Manchester Fire and Rescue Service

GMCVO
Greater Manchester Centre for Voluntary Organisation

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Greater Manchester: an introduction

Most significant economic agglomeration outside London

- A single functional economy
- 2.5 million residents across 10 boroughs
- 1.7 million working age population
- £40 billion GVA annually (5% of UK GVA, 40% of North West)
- 94,000 workplaces – 79,000 of which <10 employees

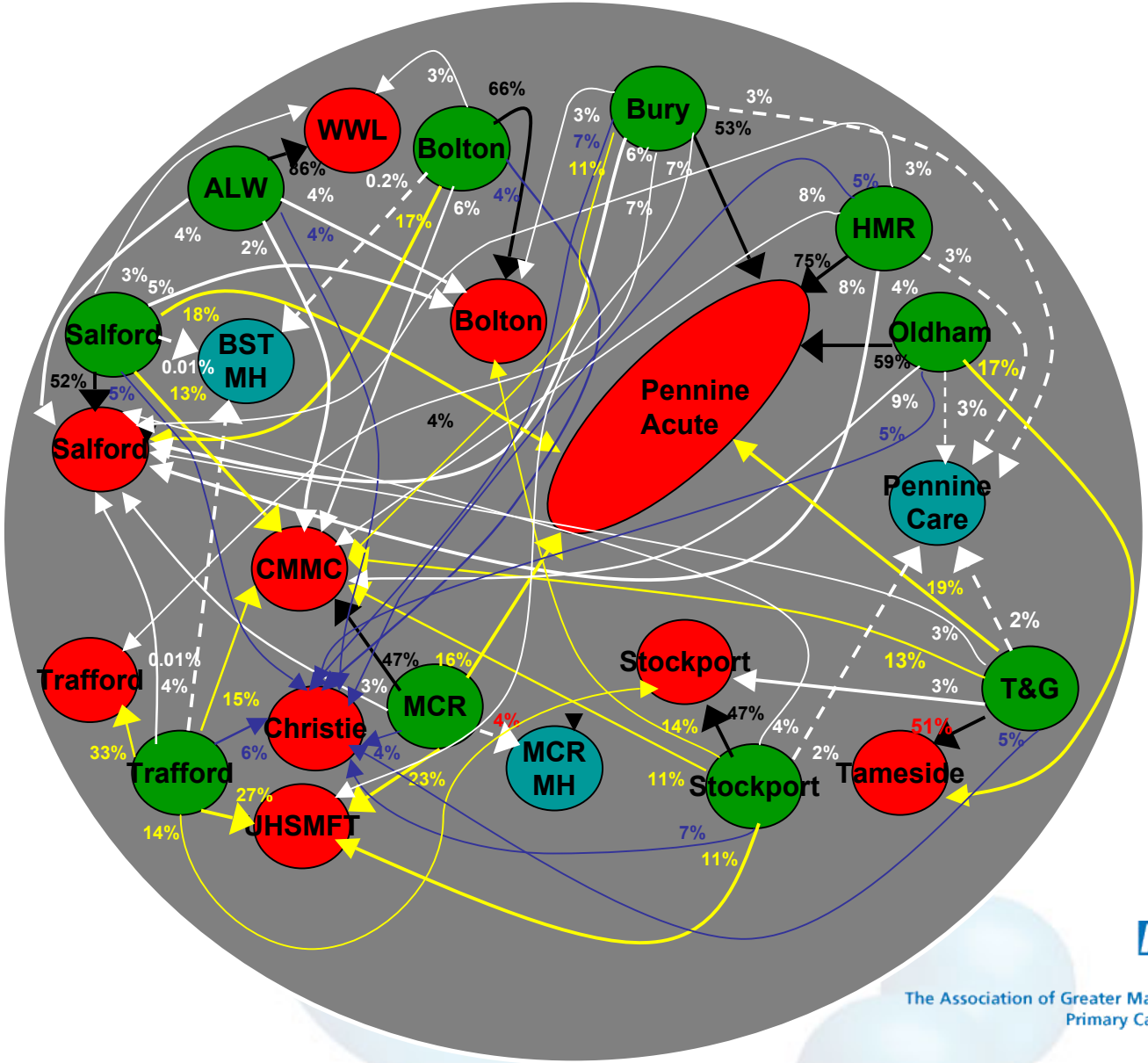
And a health system to match

- Interdependent Hospital System mirrors economic flows
- NHS in GM: a £6 billion annual spend
- £600m collaboratively commissioned
- Progress on narrowing wide health inequalities

Developed and strengthening city-regional governance

- Strong Health Commission / New Economy partnership

GM – Acute Patient Flows (2007/08)



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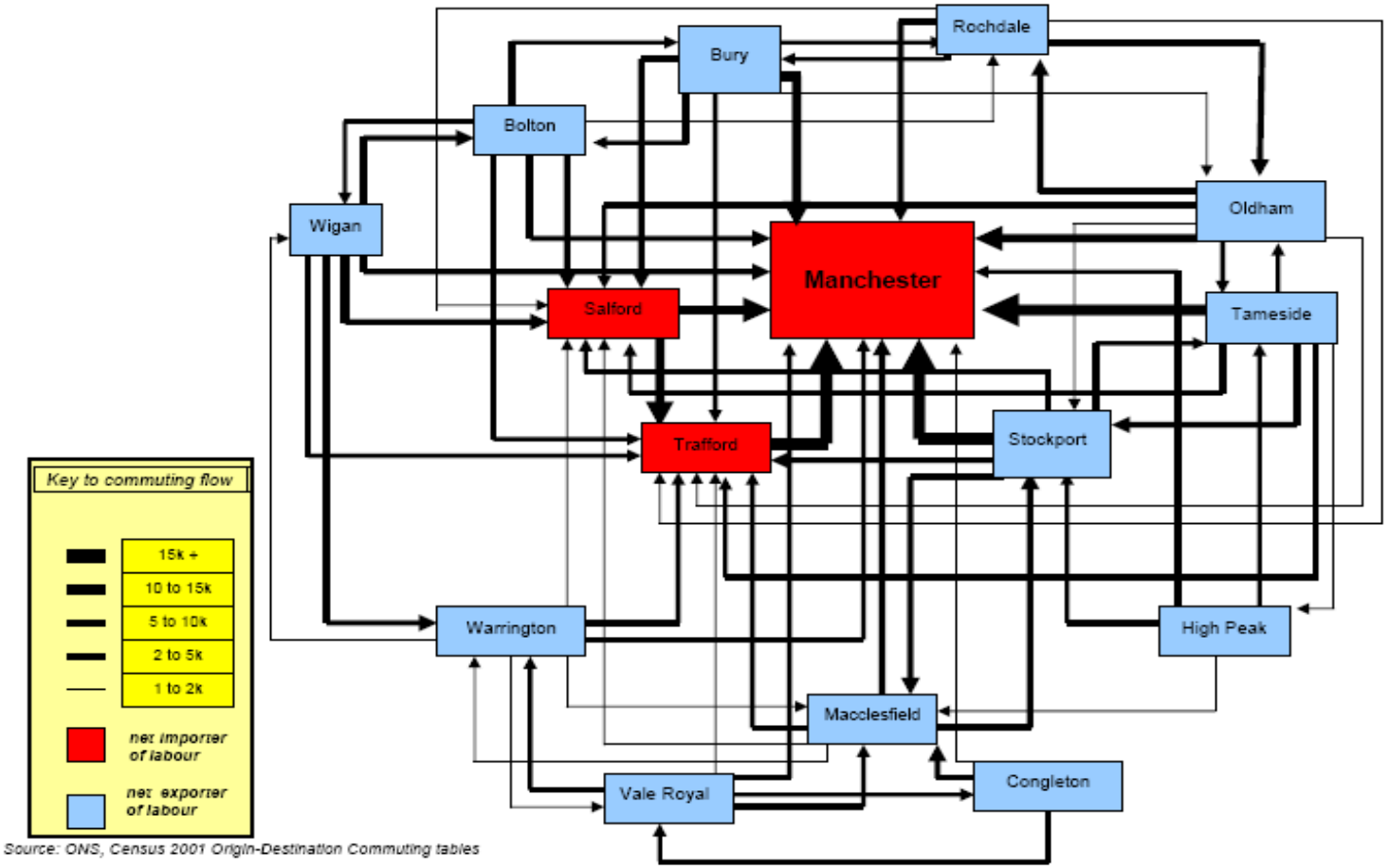
GM : Commuting Flows in to Conurbation Core



Source: ONS, Census 2001 Origin-Destination Commuting tables

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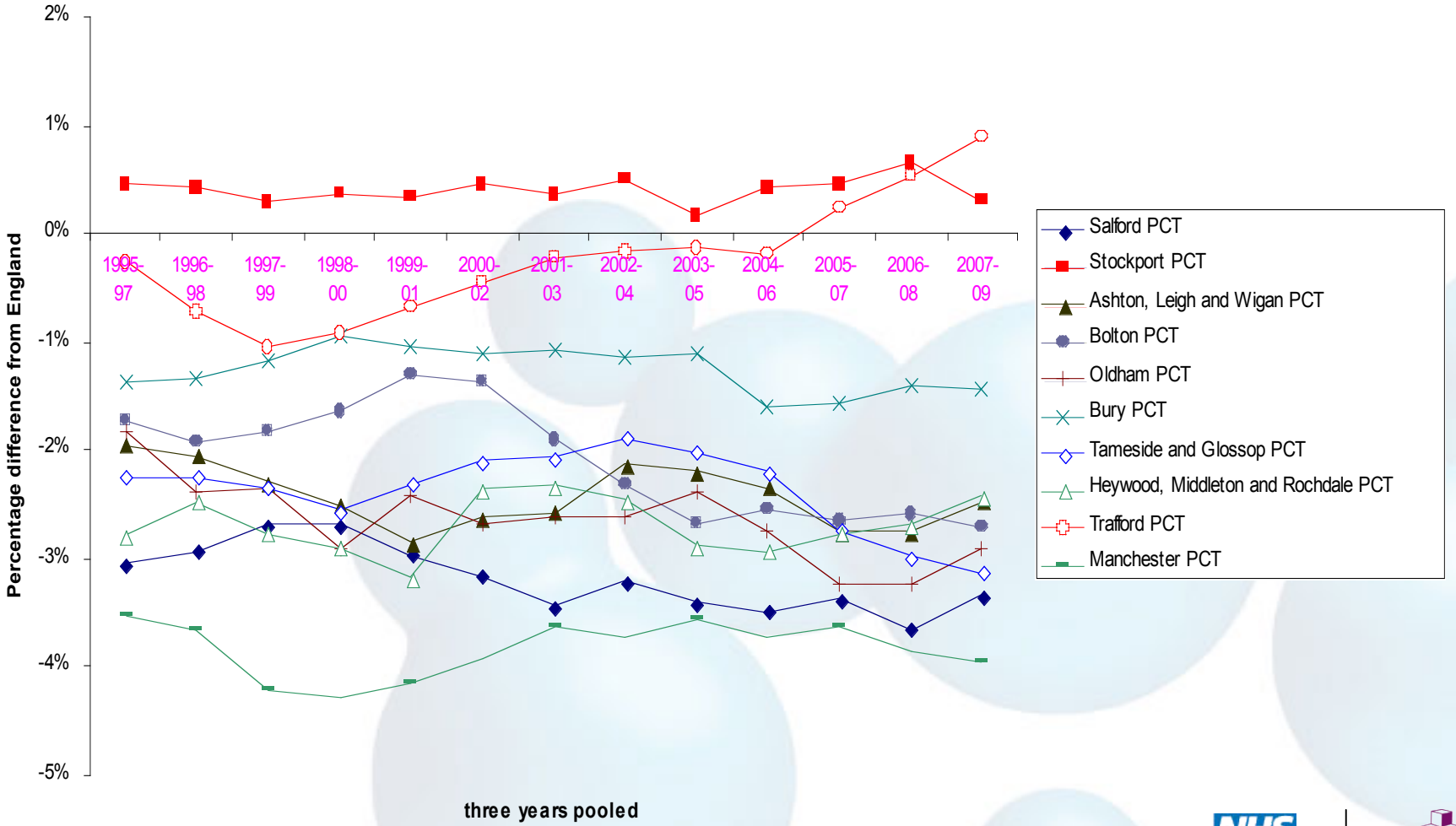
Female Life Expectancy Gaps in Greater Manchester
Primary Care Trusts: 1995-97 to 2007-09



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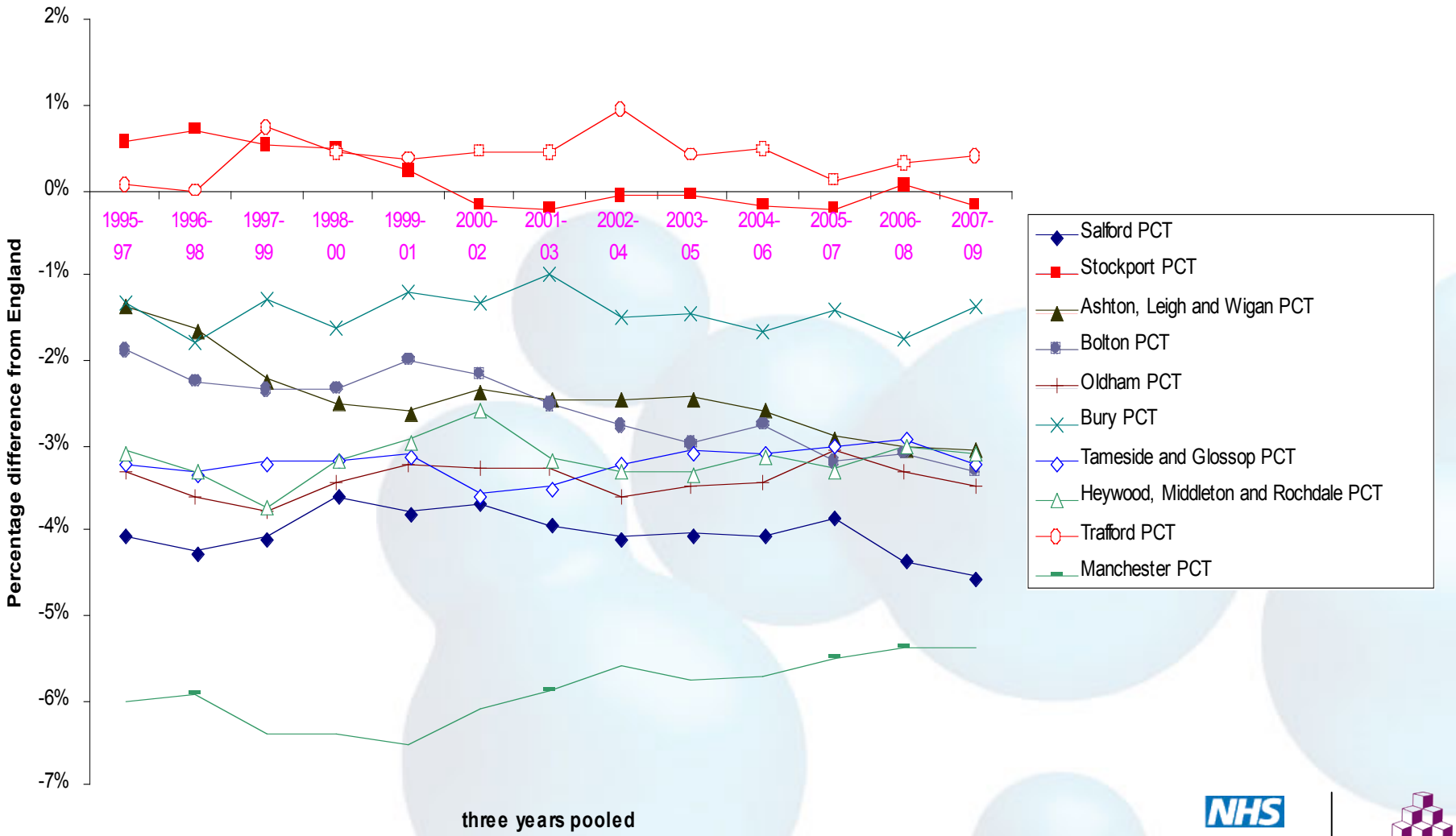

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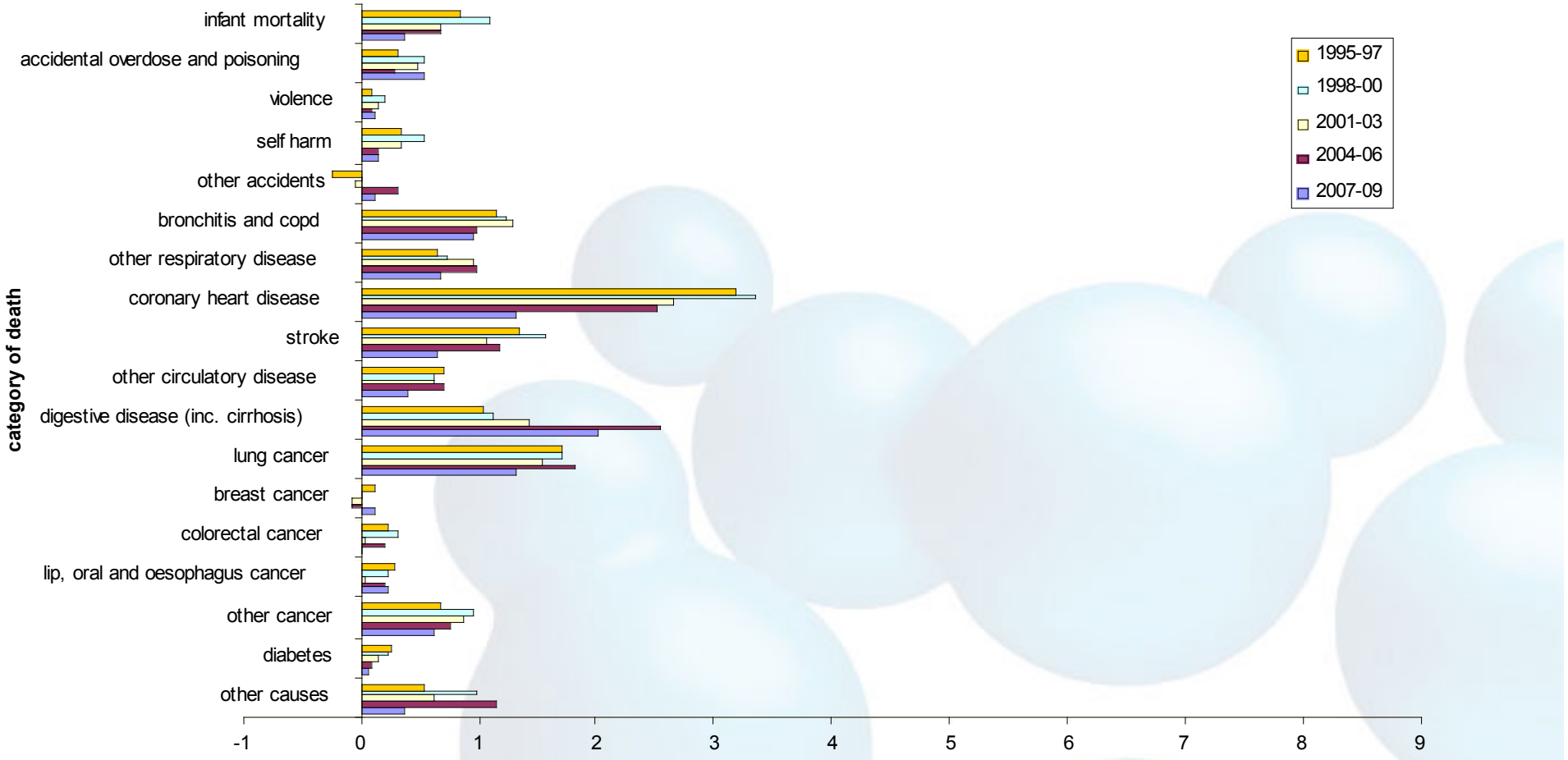
Female Reduced Life Expectancy by Cause of Death - compared to E&W average

Persons under 75 dying in Greater Manchester: trend 1995-97 through to 2007-2009



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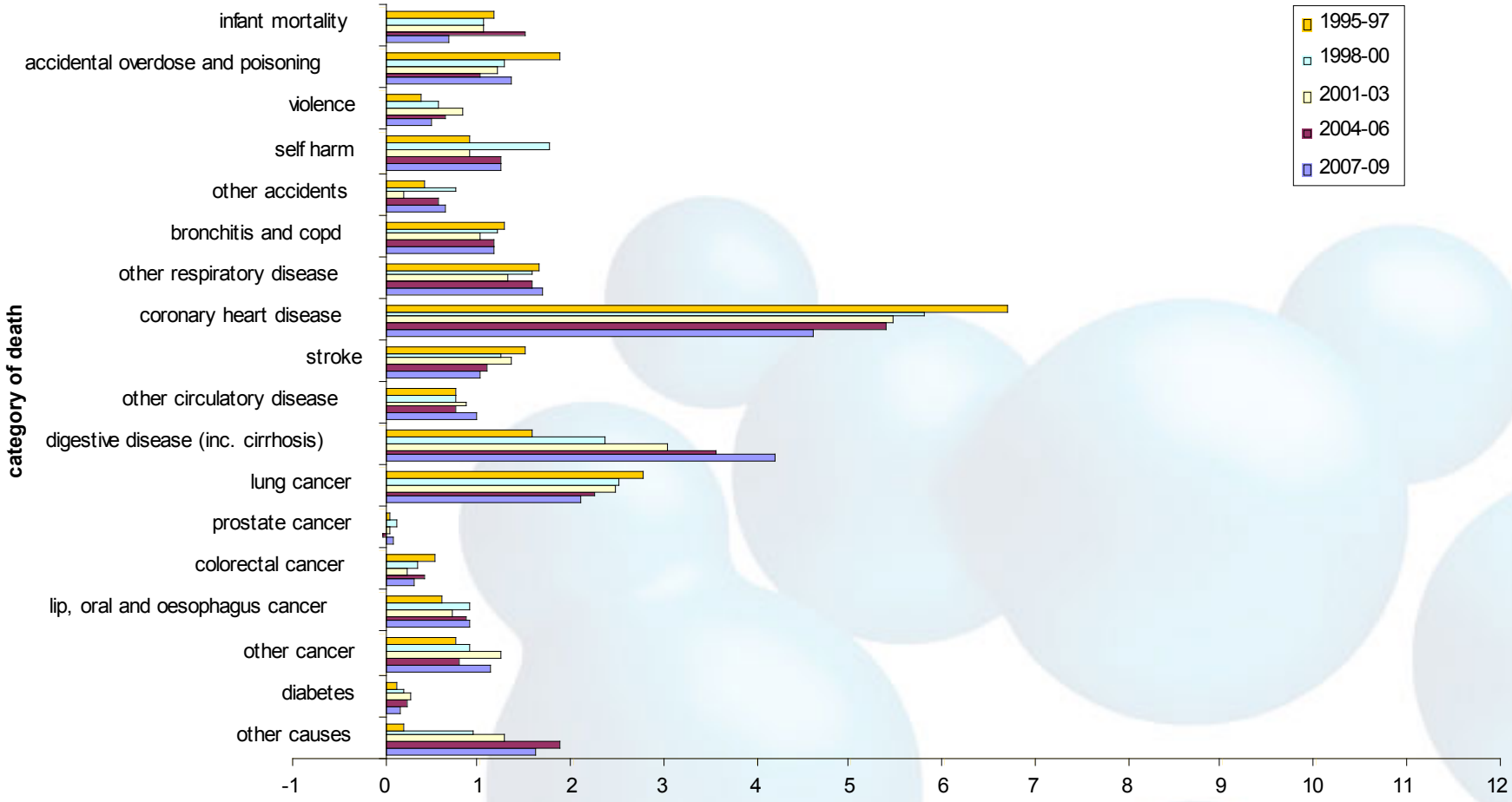

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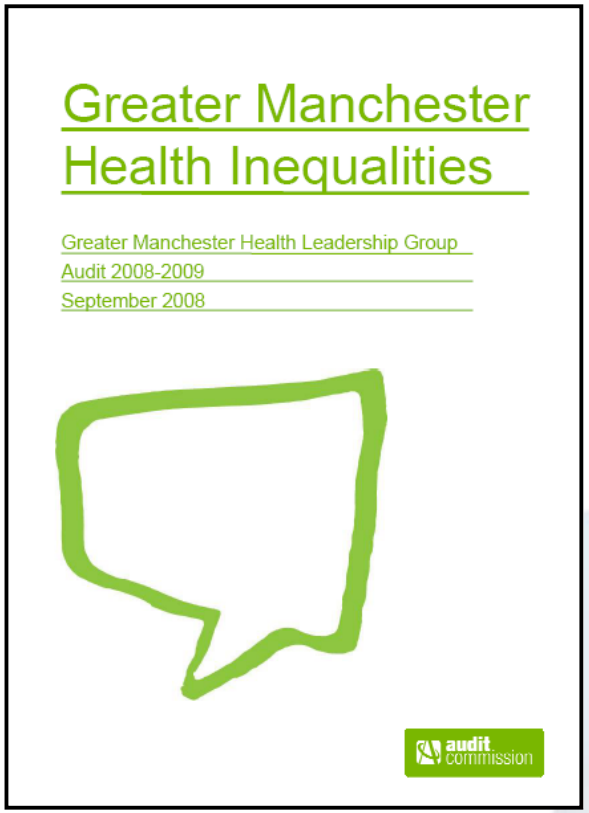
Challenge to GM on Health Inequality



"Greater Manchester knows what the health inequalities issues are –BUT There is no health vision for Greater Manchester and a lack of champions. Concerted, radical action is required to make a difference and reduce the health inequalities gap"

Audit Commission May 2006

"There is much to be proud of. We outlined at that time what we hoped our report might look like in 2008. We can report with some confidence that this is now a good description of the position as it currently exists across Greater Manchester in 2008. This is a remarkable achievement in a short space of time."

Audit Commission October 2008

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Collaborative Work on Public Health in GM - Projects

- Public health underpinning of stroke service reconfiguration
- Hepatitis C Strategy
- Management of Screening Programmes
- Leadership on Alcohol
- Social Marketing and Promotional Activity
- Cancer Inequalities Strategy
- Cardiac Inequalities Strategy
- GM Suicide Prevention Partnership
- AAA Screening Implementation

More projects…

- GM Fuel Poverty Project
- Collaborative implementation of health trainers
- Pathway development for healthy weight services
- Tobacco control joint working on promotion and prioritisation of illicit tobacco
- Chlamydia Screening Programme
- Media Partnerships – “iloveme”
- Prioritisation of Domestic Violence
- Salt Reduction

Mr Thomas's fish and chip shop owner Andy Pilkington using the new shaker (Rochdale)

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Creation of Capacity

- Public Health Practice Unit
- Arts and Health Network
- GMCVO - capacity in voluntary sector
- Close working with HPA
- Regional Health Work and Well Being Programme
- Regional Health and Migration Project
- Regional A/N and N/B Screening programme

Partnerships – Building Influence

- AGMA – Commissions
- Commission for New Economy partic.
- GMP
- GM Fire and Rescue
- GM Sport
- GMPTE
- Universities
  - Manchester – e.g. obesity atlas, suicide audit
  - Salford – e.g. Child health inequality
  - MMU – e.g. CPD development

Marmot – Strategic Review of HI in England

"Being in good employment is protective of health. Conversely, unemployment contributes to poor health. Getting people into work is therefore of critical importance for reducing health inequalities."

But also

"Getting people off benefits and into low paid, insecure and health-damaging work is not a desirable option."

Developing a partnership around health and work

- It started with a phone call
- A growing national and local evidence base for shared action
  - Black Report 2008
  - Intractable employment challenges in most deprived wards, absence of a mainstream service offer
  - Health is Wealth: local DPHs
  - Marmot Report 2010

- Skeleton GM Health and Work Group from late 2008
- Population health as a limiter to economic growth - influencing the Greater Manchester Strategy

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MIER and the GMS

Manchester Independent Economic Review (MIER)

Detailed economic baseline and themed reports (innovation, skills etc)

- Outside London, GM is best placed to take advantage of the benefits of agglomeration and increase growth
- GM has the scale but punches below its weight: low productivity
- Need more spatial clustering of jobs, skills, influence, amenities
- Tighter policy focus on productivity required

Greater Manchester Strategy: 'Prosperity for All'

- Boost productivity and long term economic growth: ensure the benefits are shared across all communities
- 11 GMS Priorities, including:
  - Better life chances in the most deprived areas
  - Expand and diversify economic base
  - Increase the proportion of highly skilled people

NHS and the GMS

As a service provider

As an employer

Skills, research and innovation

Buyer of goods and services

As a strategic partner

Strong local and international evidence base shows that:

- Good employment is key to preventing ill-health
- Supporting people effective to re-enter work improves mental wellbeing
- Good health is key to maximising prosperity

Improve productivity by:

- Reducing the number of people moving out of work onto sickness benefits
- Maximising the number of people moving into work from sickness benefits
- Raising the productivity of those who are in work

GM ‘Punching below our weight’

Key causes of the GM productivity gap include

- Lower level of enterprise and micro-business
- High levels of worklessness
- Low productivity from those in work

Poor health is a drag on productivity

- 9000 GM residents move onto health benefits (ESA) annually
- 1 in 10 working age residents are out of work and claiming IB/ESA
- CIPD / CBI: absence in the NW amongst the highest nationally
- Absenteeism and Presenteeism cost GM £2.5bn annually (BITC)

Poor work (and no work) is a drag on health

- Estimate 25,000 employed GM residents have an illness caused or made worse by work (HSE)
- Sustained worklessness = raised mortality, mental health admissions, suicide (HPA)

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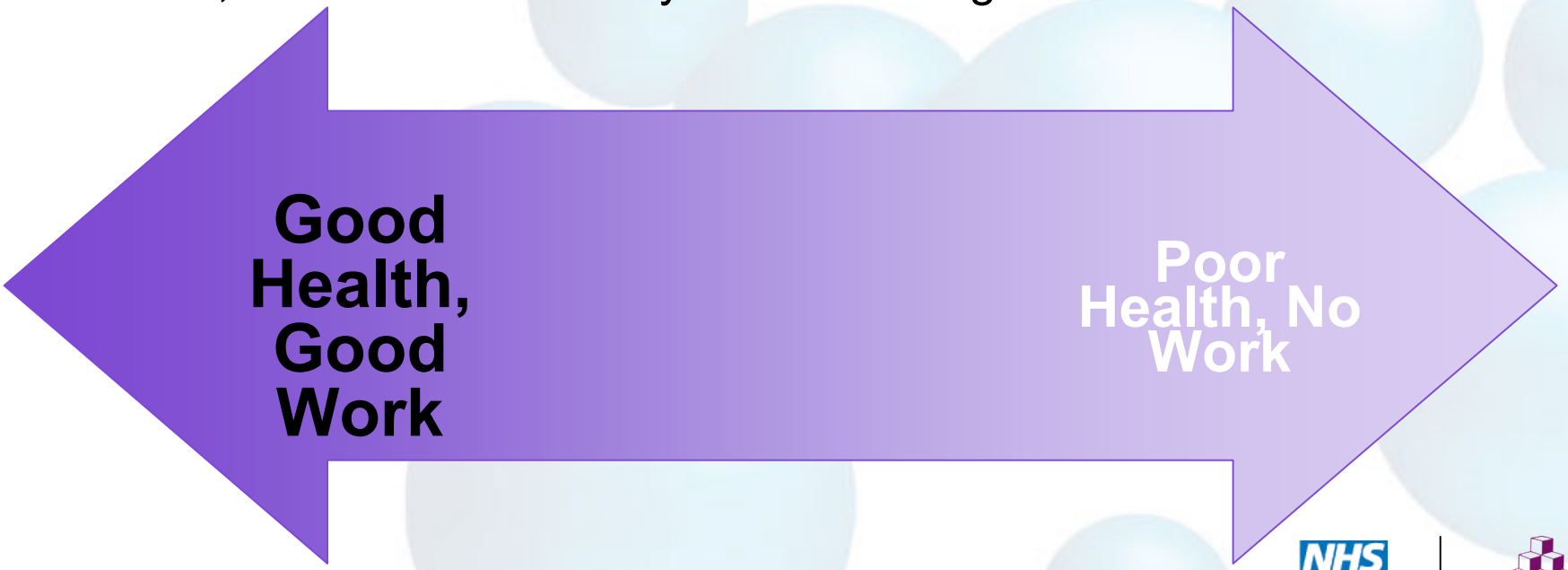
Health of the Working Age Population

- Working age population of 1.7 million
- Economically active population is 1.4 million
- Estimate 180,000 are in work but need support managing a health condition – c20K need significant support (DWP)
- 160,000 are economically inactive owing to a health condition



Poor Health / In Work

- Work needs to be good to have a positive impact on individuals' lives
- People fall out of work due to medical and social issues
- Employers often not able to address this
- Costs to individuals, business, economy and society

9000 GM residents go onto ESA annually

Most of this is preventable

Prevention is better than (costlier) cure

An emerging Greater Manchester programme, some examples…..

Fit For Work pilot

For anyone whose health condition is putting their job at risk

- Non-clinical case management, advice and support
- Referrals from GPs, employers, NHS (IAPT, diagnostics), self
- Reducing the on-flow to ESA and NHS service demand (MUPs?)

One of 11 such pilots nationally

- Prevention more effective than cure - £300 per intervention
- Only city-regional pilot: matching economic & health geography
- 600+ already supported; targeting 1500 by end March

Learning

- Knowing what works – improving and mainstreaming
- National and local research – DWP, business and NHS dividend
- Sustainability beyond March 2011 – business support, employers, GPs, link to Work Programme providers

Good Work, Good Health

Prevention and early intervention

- Review early access to alcohol, drugs and talking therapies
- Strengthen occupational health provision

Workplaces that promote health

- A GM Workplace Charter – building on existing good practice

Healthy and safe workplaces

- A consistent public health offer to employers (talking therapies, diet, alcohol, smoking, physical activity)

Training and skills

- Training and resource packages for GPs, primary care staff, line managers on job retention and mental wellbeing

DH developing a ‘responsibility deal’ for employers

An example from Bolton….Clockon2health

Healthy workplace programme for employers of all sizes

We spend 60% of our waking hours at work
Workplace is a great location for health improvement

Strong business case. Healthy staff = healthy profits
Very active business outreach
Practical advice and support
Optional award scheme
Workplace health champions

Find out more: www.clockon2health.co.uk

Poor Health / Workless (1)

160,000 GM residents out of work and claimant IB/ESA

- 46% mental health
- 18% musculo-skeletal
- Half of claimants under 45 years old

Current employment support

- Mainstream (DWP) provision only for new claimants of ESA
- But vast majority of claimants are long-term
- Small scale, council-funded, non-mandatory provision

Coalition government

- Medical reassessment of all IB claimants from Feb 2011
- Launch of Work Programme from April-June 2011
- Benefit payments conditional on participation
- Greater financial incentives to work

Poor Health / Workless (2)

Shaping the Work Programme

- Include most ESA and 75% of IB claimants (DWP)
- Potential for significant additional demand for health services
- 'Black box' commissioning
- Private/vol sector delivery – paid by results (benefit savings)
- Risk that those with most complex needs get 'parked'
- Context of benefit cuts: this is the carrot!

Key role for health commissioners and providers

- Telling the prospective prime contractors what works/doesn't work
- Shaping LSP 'asks of' and 'offers to' prospective Primes
- Identifying relevant services for shared client group that can be:
  - Aligned to the WP for free
  - Co-located
  - Co-case managed
  - Co-commissioned (to create capacity)
  - Sold (commercial deals)

Summary

- Population health and health inequality is a limiter on economic potential

and

- Sustainable economic growth will support population health and health inequality

- We've made a start – lots more to do!

- The role is about influencing and shaping – less about control and spend

- Strong partnerships are key

- Don't wait for detailed guidance

- Employment and health – mutually beneficial approaches are clear

- Make the link!

Thankyou

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