Health Inequalities, Community Development and Community Pharmacy

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Introduction

In its Constitution the World Health Organisation (WHO) advocated a holistic model of health defining it as 'a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.'[1] Other definitions capture the idea that health is a much more dynamic process. For example, the 1986 Ottawa Charter for Health Promotion described health as 'the extent to which an individual or group is able to realize aspirations and satisfy needs, and to change or cope with the environment. Health is a *resource for everyday life*, not the objective of living; it is a positive concept, emphasizing social and personal resources, as well as physical capacities.'[2]

Such definitions come with profound implications in seeking to improve the wellbeing of individuals, communities and populations. It is the need to improve living conditions, to tackle the inequalities in the distribution of power, money and resources and to measure and understand the problem and assess the impact of action.[3]

In September 2000 world leaders came together at United Nations Headquarters in New York to adopt the United Nations Millennium Declaration, committing their nations to a new global partnership to reduce extreme poverty and setting out a series of time-bounded targets - with a deadline of 2015 - that have become known as the Millennium Development Goals (MDGs).[4] Three MDGs relate directly to health; to reduce child mortality by two thirds (MDG 4), to reduce maternal deaths by three quarters and achieve universal access to reproductive health (MDG 5), and to halt and reverse the spread of HIV/AIDS, achieve universal access to treatment for HIV/AIDS by 2010, and halt and reverse the incidence of malaria and other major diseases (MDG 6). Other MDGs have an indirect influence on health.

Table 1. Millennium Development Goals

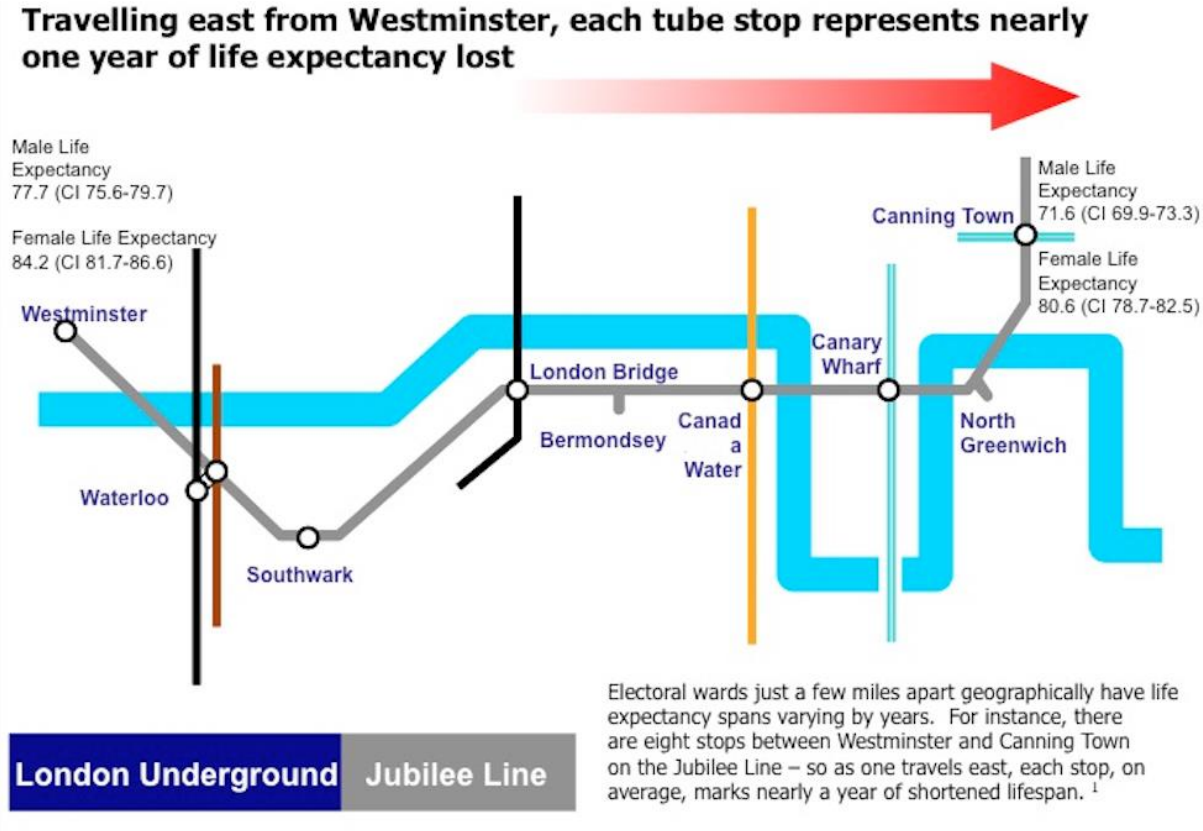
1. Eradicate extreme poverty and hunger
2. Achieve universal primary education
3. Promote gender equality and empower women
4. Reduce child mortality
5. Improve maternal health
6. Combat HIV/AIDS, malaria and other diseases
7. Ensure environmental sustainability
8. Develop a global partnership for development

Health Inequalities

Such goals give emphasis to the huge disparities that exist in the world, not only between nations but also within nations. For example, of the nearly 300,000 women who die in pregnancy or childbirth annually, almost two thirds of these die in sub-Saharan Africa, where a woman has a 1 in 38 lifetime risk of maternal death. By comparison, women living in developed regions have a 1 in 3700 lifetime risk.[5] Similarly, the developing regions of the world have an under-five mortality rate of 50

deaths/1000 live births whereas across the developed regions it is 6 deaths/1000 live births.[6] About 80% of non-communicable diseases are in low- and middle-income countries.[7] Disparities are similarly evident even within a limited geography and particularly within cities, as illustrated by life expectancy within a small area of London (Figure 1).[8]

Figure 1. Differences in life expectancy within a small area of London



Health inequalities are defined as 'differences in health status or in the distribution of health determinants between different population groups',[9] for example, the differences in mental function between elderly and younger populations or differences in access to health care between people from urban and rural communities. Some health inequalities are attributable to biological variations, for example, genetically related disease (cystic fibrosis) or personal choice (smoking) while others are associated with the external environment and largely outside individual control, e.g. housing or sanitary conditions. In other words they relate to the uneven distribution of health and health resources as a result of the above factors or the lack of resources.[6] On the other hand inequity refers to unfair, avoidable differences arising from poor governance, conflict, corruption or cultural exclusion.[10] Inequity – as opposed to inequality – thus has a moral and ethical dimension, resulting from avoidable and unjust differentials in health status.[11] The Commission on Social Determinants of Health has summarised the situation - 'The poor health of the poor, the social gradient in health within countries, and the marked health inequities between countries are caused by the unequal distribution of power, income, goods, and services, globally and nationally, the consequent unfairness in the immediate, visible circumstances of peoples lives – their access to health care,

schools, and education, their conditions of work and leisure, their homes, communities, towns, or cities – and their chances of leading a flourishing life.'[3]

As indicated above, the determinants of health include the social and economic environment, the physical environment, and the person's individual characteristics and behaviours. Recent evidence from the USA provides a national perspective of the impact of these determinants on health status.[12] The healthiest counties, for example, have better access to healthy foods, parks, gyms and other exercise facilities and more people with enough to eat. Conversely, the least healthy counties have higher rates of smoking, obesity, physical inactivity, teen births and sexually transmitted infections. Those in the healthiest counties have better access to health care and fewer, preventable hospital stays. The social and economic influences are evidenced in higher educational attainment in the healthiest counties whereas in the least healthy counties there were higher levels of unemployment, violent crime and poverty. In the least healthy counties households were more crowded and had less adequate facilities to cook, clean and bathe. According to this study, social and economic issues accounted for 40% of health outcomes, health behaviours for 30%, clinical services for 20% and the physical environment 10% (Figure 2). The import of this is that health is affected much more by factors other than the nature and availability of clinical care.

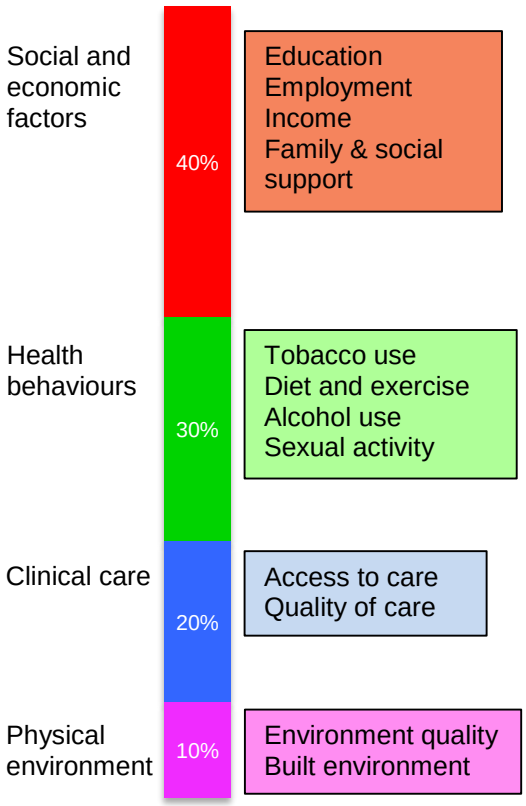


Figure 2. Factors contributing to health outcomes

Across the world childhood underweight, unsafe sex, alcohol use, unsafe water and sanitation, and high blood pressure are responsible for one quarter of all deaths and one fifth of all disability-adjusted life years (DALYs). Reducing exposure to these risk factors would increase global life expectancy by nearly 5 years.[13] Sixty one percent of cardiovascular deaths are attributable to eight risk factors - high blood pressure, tobacco use, harmful use of alcohol, high serum cholesterol, high body mass index, high blood glucose, low fruit and vegetable intake, and insufficient physical activity. Combined, these same risk factors account for over three quarters of ischaemic heart disease, the leading cause of death worldwide.[13]

Lifestyle Change

Much emphasis has therefore been placed on reducing lifestyle risk factors given their impact on morbidity and mortality particularly using approaches that seek to inform and persuade people about the negative effects on health of different risk factors, so that they are motivated to change their lifestyle and make healthier choices. Yet, it needs

to be recognised that healthy choices are most likely to be made by motivated people, who generally have higher levels of wellbeing.[14]

This approach does, however, need to take into account that the above listed individual lifestyle factors are frequently more apparent amongst people with lower educational attainment, occupational status and income, that is, those affected more keenly by the wider determinants and therefore often those less able and motivated to make changes. It could also be argued that those feeling marginalised from society, may make unhealthy choices as a way of coping with stress or difficult living conditions.[15]

Consequently, this reinforces the importance of taking into account the social and economic environments in which people live when planning interventions to promote healthier lifestyles or indeed manage individual morbidities.[16] For example, encouragement to better nutritional habits needs to take account of the individual's ability to afford healthier food. Similarly, the management of a childhood asthma patient needs to consider that the child's living conditions may not be conducive to his/her condition and may in fact exacerbate it, rather than merely relying on drug therapy. So, it is to think about the barriers to change, the available, or lack of available, choices and the ability to change or modify individual circumstances.

Community Development

Recognising the multi-faceted nature of health and the inequalities that exist, it is fundamentally important that there is an informed engagement with individuals and their communities in order to plan effective services or interventions. One way of addressing this is through community development.

The United Nations has defined community development as "a process where community members come together to take collective action and generate solutions to common problems."[17] Community development is about strengthening and bringing about change in communities. It is a way of working which seeks to encourage communities to tackle for themselves the problems which they face and identify to be important, and which empowers them to change things by developing their own assets i.e. skills, knowledge and experience, utilising and extending their networks and by working in partnership with other groups and agencies. On the one hand community development is about defining needs from a local perspective and on the other, it is about the movement from being involved **in** to working **with** local people to address their health needs. It often has a focus towards the disadvantaged and impoverished in society.

As such, this 'assets based' approach to community development offers the potential to enhance both quality of life and longevity by focusing on resources that promote self-esteem, resilience and coping skills of individuals and communities.[18] It is closely linked to the idea of building social capital. That is, how well people are connected within their own communities, connected beyond their communities and how well they are connected to service providers and policy makers. This is often known as bonding, bridging and linking between people and with groups.[19]

Social capital thus consists of the stock of active connections among people; the trust, mutual understanding, and shared values and behaviours that bind the members of human networks and communities and make co-operative action possible.[20]

Sir Harry Burns, the former Chief Medical Officer for Scotland, has commented, “We must not concentrate on deficits but on assets, skills and capacities. We must build social capital so individuals can offer each other friendship and mutual support.”[21]

The term co-production, links closely with the idea of social capital. It has evolved to embrace the idea of professionals and citizens sharing power, planning and working together to make public services more effective and improve the quality of life for individuals and communities.[22]

Community Pharmacy

From the standpoint of co-production community pharmacists are a case in point. The Chemist shop was historically the term widely used to describe a local pharmacy practice. Today they are referred to as community pharmacies, a description that not only reflects location but the relationship with the communities they serve. The 2012 International Pharmaceutical Federation (FIP) global sample shows that, on average, 55% of pharmacists work in community pharmacy environments. The European region has the highest proportion of the pharmacy workforce working in community settings, the lowest being in Africa and South East Asia.[23]

Community pharmacies are characterized by their accessibility to the public. For example, there are around 11,400 community pharmacies in England, almost 1 pharmacy/5000 people, located where people live, shop and work.[24] Community pharmacy is consequently a socially inclusive healthcare service that enables access to healthcare advice and medicines and to a healthcare professional without the need for appointment. Many community pharmacies now have a private consultation area specifically for confidential or sensitive discussions.

Community pharmacists form part of the infrastructure of a local community, not only by offering services but through the investment they have made in their practices and the employment they offer. They could be, therefore, termed ‘embedded practices’ with evidence to indicate that a significant number are located in disadvantaged areas.[25] Their contact with the public is both with the healthy and ill giving them a greater interface with members of the public than any other healthcare professional. In Northern Ireland, for example, it is estimated that 123,000 adults visit community pharmacies every day (approximately 8% of the population) and they are seen as the “open door” of the Health Service, providing a welcoming and supportive environment with high levels of public satisfaction.[25] In Australia, on average, there are more than 14 visits to a community pharmacy per year for each man, woman and child. Out of a population of approximately 24 million, 3.9 million Australians ask their pharmacist for health-related advice every year.[26] Commonly, the most regular users of the pharmacy are those most vulnerable to poor health - the poor, the elderly, those with young children, and other marginalised groups such as those with disabilities, mental health problems and their carers.

Across Commonwealth countries there are, of course, considerable differences in the distribution of community pharmacies, in the services they offer and the way in which the public can access and use this provision. Although not universal, they share many similar characteristics that make them particularly well suited to partnerships that utilise community development (Table 2). However, it does demand a new understanding of

the relationship with the public - individuals and groups - not simply by providing services but by people being empowered to negotiate their own needs and facilitating them to make informed choices allied to their health and social care.

Table 2. Some common characteristics of community pharmacies

Located in, and have longstanding commitment to, local communities
Knowledge about their local communities and their health and social care needs
Enjoy a positive reputation among the public – satisfaction and trust
Accessible – long opening hours and no appointment needed for professional advice
Interface extensively with both healthy and ill people
Provide contracted (funded) and private services
Operate from regulated premises and with regulated professionals
Provide for medicines supply, clinical advice/monitoring and health promotion
Responsive to local needs and adaptable to offering new services

Community Pharmacy and Community Development

Building the Community-Pharmacy Partnership (BCPP) Programme

Reference has already been made to the idea of professionals and citizens working collaboratively to improve the effectiveness of public services and the quality of life for individuals. Building the Community-Pharmacy Partnership (BCPP) is a long-established, evaluated, community development programme established in Northern Ireland.[27] The programme, based on partnership working between local communities and community pharmacists is facilitated though the Community Development Health Network (CDHN) and is supported through public funds. CDHN is a regional network organisation that seeks to tackle health inequalities through community development by building capacity and influencing policy. [28]

The partnership works towards:

- Increasing local people's understanding of health and issues that impact on health;
- Encouraging local people to engage in their communities to improve lives, health and well-being; and,
- Utilising and developing people's skills, knowledge and experience in their local community.

Key Features

A number of key features characterise the programme:-

1. Partnership working between local communities and community pharmacists.
2. Central co-ordination but with local ownership and reflection of local needs.
3. Shared funding between partners.
4. Engaging with a core group of participants over a given period of time
5. Strong facilitative support from CDHN.
6. Projects subject to criteria based assessment before funding.

7. Projects cognisant of government/health service policies and strategies.
8. Projects subject to project management standards and outcome based evaluation.
9. Projects can seek further funding depending on initial outcomes
10. An expanding range of partnerships and target issues

More particularly, success is a function of joint planning of the project from the outset, working together in the operational delivery and evaluation of the project and involving the participant group at all stages of the initiative, as such, co-production.

Types of Issues Addressed

A wide variety of project topics have been covered in the programme ranging from those delivered in rural villages to those in urban housing estates; from elderly people and teenagers, to those with addictions and those affected by homelessness, all customised to the needs of the locality in which they operate (Table 3).

Table 3. Examples of BCPP Community Development Topic Areas

Cancer	Mental Health
Cardiovascular Disease	Musculoskeletal disorders
Carers	Nutrition
Childhood Ailments	Obesity
Dementia	Pain Management
Dental Health	Personal hygiene
Diabetes	Poverty
Disability	Service accessibility
Drug and alcohol misuse	Sexual Health
Exercise	Skin Care
First Aid	Smoking
Housing	Suicide Prevention
Literacy	Weight Management
Managing stress	Women's and Men's Health

While many of the issues have a medication component this has not been the main thrust of any individual initiative. Rather the focus has been on informed lifestyle choices and seeking to support and facilitate members of the public to take greater control of their own health and in many cases regain their confidence and self esteem. Correspondingly, it seeks to enable pharmacists and communities to recognise the barriers people face to change and to work in partnership with others to begin to identify and address those wider issues.

To that extent pharmacists have contributed a huge educational element to the programme. In relation to direct clinical patient management other pharmaceutical services exist to provide this function. Detailed descriptions of individual projects have been reported.[27]

Outcomes

Such work provides considerable challenge in respect of assessing outcomes. For example, the difficulty of establishing measureable outcomes that could be exclusively linked to the intervention itself given that individuals are subject to many influences on their behaviour. Further, the very nature of the individualised projects mean that it is not easily possible to establish controls for comparison purposes. Evaluation has therefore focused substantially on participant (subject) reported experience. Standardised questionnaires covering three main indicators have been developed and applied across the range of projects to offer a more global picture of impact:-

- Improved accessibility and responsiveness regarding engagement in local services, particularly of more disadvantaged groups;
- Change in use and understanding of pharmacy and associated services; and,
- Perceived improvements in health and understanding of how to take increased responsibility for health.

To date, the evidence points to a strongly positive change across all three indicators.[27] In addition, participants were asked to complete General Health Questionnaire 12 (GHQ12), a subjective measure of psychological well-being.[29] It is designed to record the general level of happiness, experience of depressive and anxiety symptoms and sleep disturbance experienced over the previous four weeks. Across the projects, 34% indicated they had poor psychological wellbeing at the beginning. This reduced to 13% at the project end. [27]

Pharmacists and community groups also reported a positive impact on the way that they relate to, and provide services for, the community with the result that it has widened the involvement in the programme. [27]

Wider application

There is little doubt that such an approach is capable of being replicated in other contexts but it needs the right conditions in which to germinate, grow and mature. That there is need to address healthcare inequalities is beyond dispute. Similarly the nature of the task and the resources required point in favour of deploying existing expertise and resources in different ways. Community pharmacists are well positioned to play their part but it will involve new thinking prepared to embrace a more proactive and holistic approach to health and wellbeing as distinct from a remedial or therapeutic treatment approach. It is to find, in the context of pharmacy practice, the balance between a social model of health and a medical model of health. Partnership is, of course, key in building relationships and collaborative effort. We are stronger and more effective together than we are apart.

Undoubtedly challenges will exist, for example, learning new skills or new applications of existing skills. The practice balance or image may need to shift from that of a treatment centre to a wellness centre. There is also the challenge of sustainability that remuneration will need to be more linked to service as distinct from remuneration linked to a medicine. That the programme in Northern Ireland has been sustained for 13 years and is a vibrant element in the pharmaceutical portfolio of activity is testament to the beneficial contribution that it makes, the leadership and support offered through CDHN and the commitment and innovation shown by pharmacy and community personnel.[30]

Conclusion

The reduction or limitation of health inequalities presents a substantial challenge to healthcare systems across the world. The application of community development represents an important and successful intervention methodology through individuals and communities being informed and empowered to take greater responsibility for their own health and wellbeing. At the same time it is about embracing partnership approaches where professionals and citizens share power, plan and collaborate to make public services more effective, work to improve the quality of life for individuals and communities and begin to identify and tackle the wider issues impacting on people's health and wellbeing. Given their place in local communities and their interaction with the public, community pharmacists have significant potential to be key partners in that process. The long-term experience and evidence from Northern Ireland has demonstrated the utility of the approach and the benefits that it can deliver.

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