Diabetes obesity cvd reference terms health and social care essay

To outline the demography and culture of the local areaTo review diabetes, obesity and cardiovascular diseases (CVD) impact on health, and how they interact with one another. To explore and attempt to understand perceptions and aspects of health relevant to the local community

Aims

To analyse and explore how Hamara Centre can incorporate a holistic and integrated chronic illness package. To identify health activities run by the Hamara centre and its role in providing holistic and integrative healthcare in tackling diabetes, obesity and cardiovascular diseases.

Introduction

Great Britain has been enriched by large-scale immigration that has taken place over the past 60 years, making it a multi-ethnic and multi-cultural society (James and Underwood, 1997). The 2001 consensus found that around 7. 9 percent of the total population of the United Kingdom is from ethnic minorities (Office of National Statistics, 2003). As a result, different views and cultural beliefs exist within the UK, which impact health and illness. The Hamara centre is a multi-cultural and faith community centre in Beeston, Leeds. It provides various preventive and primary care facilities, and works on building healthier lifestyles for the community. These interventions play a great part in progression of chronic illness, such as, cardiovascular diseases (CVD), diabetes and obesity. All three of these chronic illnesses should not be seen as separate predicaments, since they are interdependent and can mediate the progress of each other (Visscher et al., 2004). Therefore interventions which integrate these illnesses together would have greater impact on health.

Leeds: Beeston and Holbeck profile

Table 1: 2001 Census

Ethnic Group

Ward

Metropolitan District

% of Leeds's ethnic group in Beeston and Holbeck

Beeston and HolbeckLeedsAll People217937154023. 05White201576570823. 07Asian or Asian British1026322903. 18Asian or Asian British: Indian328123032. 67Asian or Asian British: Pakistani595150643. 95Asian or Asian British: Bangladeshi5025371. 97Black or Black British222103182. 15Black or Black British: Caribbean12367181. 83Black or Black British: African7724353. 16

Total population of Beeston and Holbeck

21793

Total population of Leeds

715402Source: ONS 2001In the 2001 census, Pakistanis were the largest minority group, followed by Indians, in the Beeston and Holbeck ward of Leeds. A higher than average section of people living in Leeds are amongst the 20% most deprived nationally, while in some wards it is even higher. In fact, Beeston is among the most deprived wards accounting for 25% of England's population (Department of Health, 2006). It is estimated that Leeds's adults are more likely to smoke, binge drink, or not follow healthy eating advice than the national average. Moreover, hospital admissions in Leeds for alcohol related conditions are also higher than the national

average (Department of Health, 2007). The distribution of Leeds's ethnic groups living in this area is also illustrated by Table above. As it clear from Table 1, just over 3% of Leeds's population live in the Beeston and Holbeck area. The comparable figures for Leeds's Indian, Pakistani and Bangladeshi population living in this ward are 3. 18, 2. 67 and 3. 95 respectively.

Literature Review

A literature review on cardiovascular diseases, obesity and diabetes was conducted to determine the current cost and impact of theses chronic illnesses on Health. The key finding of these studies have been outlined below.

Cardiovascular Diseases

Financial cost

An estimated £15. 7 billion are spent each year on CVD-related healthcare, comprising 21% of overall NHS expenditure. Where as cardiac rehabilitation programmes only accounts for 1. 7% (Luengo-Fernández et al., 2006).

Disease Burden and vulnerable groups

" Coronary heart disease (CHD) is the UK's single biggest killer" (Department of Health/British Heart Foundation, 2004, p. 6). In fact, around one in five men and one in six women each year in the UK die due to CHD. Preventive strategies need to tackle linguistic and cultural barriers, as well as environmental factors, such as unemployment and poverty, if healthcare services and interventions are to successfully reach ethnic minorities (Bhopal et al., 1999). Individuals from South Asian backgrounds are 50 percent more

likely to die prematurely from CHD that rest of the population (Department of Health/British Heart Foundation, 2004).

Diabetes

Financial cost

Total annual cost of Type 2 diabetes healthcare is estimated to increase to about £2. 2 billion in 2040–50, this is an increase of around 25% from 2000 figures (Bagust et al., 2002).

Disease Burden and vulnerable groups

Around 1. 8 million people in the UK have been diagnosed with diabetes, and a further 1 million are estimated to be undiagnosed (Department of Health/Diabetes Team, 2005). A man of South Asian (Indian subcontinent) backgrounds living in the UK is more than 4 times likely to have Type 2 diabetes (D'Costa et al., 2000). In fact South Asians develop the disease 10 years earlier than their white counterparts, as well as being at significantly higher risk from ‘ diabetic complications’ and mortality (Raleigh et al., 1997).

OBESITY

Financial cost

Obesity is costing the British economy around £2. 5 billion each year (Department of Health, 2003). Of which, £0. 5 billion is spent on the NHS’s obesity treatment programme (NAO, 2001). These cost figures are however just for the present adult generation, and do not take into account obesity in children (Royal College of Physicians, 2004). Without a doubt, child obesity will have ramifications on the future economy, in terms of employment and earning (Foresight, 2007).

Disease Burden and vulnerable groups

The National Audit Office (2001) estimated that 30, 000 people die every year in England from obesity. In fact this accounts for six percent of all deaths in England (Royal College of Physicians, 2004). England has one of the worst obesity figures in Europe, and it’s increasing rapidly at an alarming rate (NHS, 2006; House of Commons, 2004; Kopelman, 2000). Moreover, an estimated 12 million adults, and 1 million children are predicted to be obese by 2010 (O'Dowdu, 2006). Infertility, menstrual abnormalities, and miscarriages are also risk factors closely associated with obesity (Pasquali, 2006; Parihar, 2003). These are detrimental risk factors which may not have physical impacts in the long-run, however they will have lifelong psychological and social implications on a person’s health (WHO, 1948).

Analysis

Obesity has been associated with various chronic morbidities, which do not necessarily lead to immediate death, nevertheless it lowers the quality of life (Visscher et al., 2004). Consequently, obesity is a lifelong burden on individuals, and healthcare resources. Furthermore the risk of other chronic diseases is also higher among obese individuals. For example, cardiovascular diseases and type 2 diabetes in children and adults (Goran et al., 2003; Rippe et al., 1998). Coronary heart diseases, strokes and diabetes all have different affects on the human body, nevertheless all of these diseases share common risk factors; such as obesity, physical activity and smoking (Department of Health, 2008). These points are very useful as they highlight that there is a dire need to tackle obesity, which in turn will also lower the risks of other chronic illnesses as well. What is more an integrative approach

which encompasses both CVD and diabetes management would be valuable. Over the recent years, obesity has increasingly gained recognition as one of the most prevalent health problems faced by the world (WHO, 2006). In fact according to the health report on obesity published by the House of Commons (2004), there is an " obesity epidemic" in the United Kingdom. Obesity greatly raises the risk of ill-health and premature death (Kopelman, 2000).

Interventions

Gain in weight is more closely linked to a lifestyle where there are low levels of physical activity, rather then an unhealthy diet (Prentice and Jebb, 1995). However there is much evidence that if a combination of both, a low fat diet and a physically active routine is maintained, then as a result, not only does it lower the health risks of obesity, but this also lower the risks of cardiovascular diseases, depression, and may even prevent or control type 2 diabetes (Avenell et al., 2006). Regularly exercising and eating a healthy diet are few ways ways to control weight. Many studies have shown that by lowering the intake of calories in ones daily diet over a long period of time can lower weight (Atkinson, 1998). However, attempting to rapidly reduce weight can also result in lowering of muscular weight, rather the fat (NHS Direct, 2007). Therefore professional support and advice should be provided for effective and healthy weight control. According to the National Institute for Clinical Excellence (2006) most of the interventions tackling the obesity problem are on individual level, as result they have little impact on national obesity figure. Therefore for greater impacts, all levels need to be addressed to successfully tackle the national obesity problem. Furthermore, Greig

(2007) argues that grand government interventions, like the five-a-day and exercising more campaigns have also been ignored for the most part by the general population. In fact, in Department of Health's (1992) " The health of the nation", the government set targets to combat the rapid rise of obesity. However the proposed ambitious targets were never reached. Between 1980 and 2002, the obesity rate in adult women has virtually trebled, while in adult men it has almost quadrupled (Royal College of Physicians, 2004). As it is obvious from these figures that the obesity crisis is getting worse, and unless something effective is done to tackle this issue, the health of nation maybe at risk. So why have these interventions not been as effective? This maybe partly explained by the differences in belief between patients and healthcare professionals, in regards to what causes obesity. As well as, language and cultural barriers that may impede effective healthcare delivery and access, however proficient interpreters may help bridge the language gaps (Jacobs et al., 2006; Gerrish et al., 2004). As we have already observed that the Leeds's locale is diverse and rich in culture. Hamara can play a key part here, as it has multicultural team, who are able to converse in a range of South Asian languages. As well as having already developed links within the local community, which can be utilised to influence healthy behaviour and provide a comprehensive heath education campaign. The figure below illustrates various illnesses and diseases which it have been related to obesity. As it is clear from the diagram, obesity affects the whole body.

Figure 1: Physical effects of obesity

Source: Campbell (2003)

Figure 2: Problems and Interventions

Level

Problem

How it affects the health

Approaches

Suggestions

Hamara's Services

Individual

Unhealthy dietMay lead to obesity, and various other chronic illnesses, cancer, CHD etc. Educational and Behavioural ChangeEducate people5 a day schemeProvide skills to carry out healthy behaviourNutrition and healthy cooking classesLack of physical activity in daily routineMay lead to obesity, and various other chronic illnesses, CHD etc. Educational and Behavioural ChangeTackle obesity in childrenActive Kid ZoneTackle obesity in adultsPhysical activity programme. E. g. Self Defence classes. Tackle obesity in womenWomen's Aerobics sessionsSwimmingTackle obesity in ElderlyWalking groupsHigh blood pressureRaised cholesterol levelsOverweightLow blood-sugar levelIf these indicators are not screened regularly, then cases of disease go undetected, therefore both primary & secondary prevention are impeded. It also becomes hard to manage illness. E. g. Diabetes diet and blood sugar control. Biomedical(screening)Vascular checks to prevent heart attacks and strokes. Diabetes ScreeningDiabetes Screening (to bedeveloped)

Schools

Unhealthy school mealsMay lead to obesity, and various other chronic illnesses, cancer, CHD etc. Educational and Behavioural ChangeDrop in session at schools, provide health education.

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Poor physical activity provisions, both within and outside the curriculumMay lead to obesity, and various other chronic illnesses, CHD etc. Educational and Behavioural ChangeDrop in session at schools; provide health education. After school sports classesDelivers sports activities during school PE sessions and after school clubs.

Community

Poverty and unemploymentLow socio-economic status has been often associated with ill-health. Social ChangeBenefits & Careers guidanceTackle inequalities in income and health. Benefits and Welfare Rights advice. Lack of community venues and activities to promote healthy livingDiscourages physical activities, therefore it may lead to obesity or CHD. Empowerment/ Community interventions

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Community GymSwimming poolTrips and outingsSafety and community integration. E. g. Crime, antisocial behaviour, bullying, racism etc. Discourages out-door activities. Affects social and psychological well-being of individuals. Empowerment/ Community interventionsSocial events and gatherings. Reduce crime. Reduce bulling and racism; through education and

by empower victims of racist violence. Raise awareness in schools; plays/drama, drop in sessions etc. Social events and gatherings

Hamara's Services

Recent governmental policies acknowledge that preventing obesity is not just an individual level task, but that it is also the responsibility of the community and state (Department of Health, 2007b; U. S. Department of Health and Human Services, 2007). Figure 2 highlights three key levels of Hamara's involvement, as it is clear from the table most of the interventions already in place attempt to tackle obesity on these levels. In addition, Hamara's single-sex session, such as, women's aerobics classes and women only swimming sessions, are also very useful at providing culturally sensitive healthcare and education, as some individuals would greatly benefit from such provisions (Lawton et al., 2006). Research is needed to explore the effectiveness of these interventions, as well as investigating their coverage. Moreover, further links between the local health care providers is needed. Hamara is already operating on a referral system, however the coverage and promotion of all these services to both clients and healthcare providers is required. Vascular diseases, such as, heart disease, stroke, diabetes and kidney disease affect the lives of over 4 million people. Around 170, 000 deaths a year in England, and one fifth of all hospital admissions are due to vascular diseases (Department of Health, 2008b). In fact, the Department of Health (2008) has published a new report arguing the case for vascular checks. As well as, stating that it is vital that vascular screening is available to all, including hard to reach and vulnerable groups, therefore screening needsto be offered in various setting from GP surgeries to community

centres. As this report recognised that health varied disproportionately among the population, those from deprived backgrounds and from particular ethic group, such as South Asians, were at comparatively higher risk than the rest of the populace. Hamara can play critical part in reaching these outreach and vulnerable groups within the locale. Figure 3 further elaborates Hamara's role with respect to a few nation and local health policies.

Figure 3: Policy and Hamara

Policy

Impacts

Hamara's role

Reduce levels of obesity (Department of Health, 2007d). High impact changes to reduce infant mortalityReduces health inequalitiesPrevention and control of chronic illnessesActive lifestyle programmes. Healthy diet education. Focus Health Trainers and Life Check programmes on tackling health inequalities (Department of Health, 2007c). Reduces health inequalitiesPrevention and control of chronic illnessesReaches to the local communityProgrammes are culturally sensitive. Empower disadvantaged communities to aspire to good health (Department of Health, 2007c). Reduces health inequalitiesEmpowermentReaches to the local community. Involves the community in decisions. Prioritise tackling vascular disease and smoking related illness in order to help achieve the national 2010 health inequalities target on life expectancy (Leeds PCT, 2008)Reduces health inequalitiesPrevention and control of chronic illnessesCardiac Rehabilitation programmeSmoking cessation servicesProvide incentives and support for people to look after their own health (Leeds PCT, 2008). Reduces health

inequalitiesPrevention and control of chronic illnessesHealth events and prize draws. Health education

Discussion

This report briefly attempted to explore diabetes, obesity and cardiovascular diseases. These chronic illnesses are interlinked with one another, and share common risk factors, such as lack of physical activity and unhealthy diet. Therefore interventions which impact obesity figures are also favoured from diabetes and cardiovascular diseases perspective too. Hamara provide a comprehensive range of health services, and acts as one-stop shop for health. As it was obvious from the local profile, Leeds, or more precisely the Beeston and Holbeck ward, is multiethnic and culturally diverse region. Furthermore, in most cases, minority ethnic groups, such as South Asians, appear to be at higher risk from these chronic illnesses, compare to the rest of the population. Therefore health interventions need to address these health inequities and provide health for all. Due to the chronic nature of diabetes, obesity and cardiovascular diseases (CVD) not only do are they taxing financially more each year, but are also greatly expensive in terms of human cost. Hamara’s interventions and facilities provide a great platform for preventive healthcare, however Hamara needs to promote theses assets to both clients and healthcare providers. This is the reason why a reliable referral system and pathway needs to be addressed, and researched for greater coverage and impact of health.