Topic : Health and Social Care

Paper Type : Coursework

Word Count : 4000 Words

Pages : 16 pages

Refrencing Style : Harvard Referencing

Education Level: Graduation

Health and Social Care

[Name of the Writer]

[Name of the Institution]

[Date]

Health and Social Care

Task 1

Effects of Socioeconomic Influences on Health

There is no denying the fact that socioeconomic factors are a major reason behind the poor health outcomes. Previous researches suggest that individuals with lower socio-economic status suffer inexplicably from various diseases, and as a result of this they have higher mortality rates as compared to the people with good socio-economic status. Social and economic drivers such as; education, social connectedness and income have a direct impact on the health. These socio-economic factors strongly influence the health of an individual (Adler, & Ostrove, 1999). An improvement in any of these factors can simply result in the improvement of both the health behaviours and the economy outcomes of the individuals or groups living in a society.

It has been observed that people with low incomes, often lack access and resources to health care , adequate housing, nutritious food, and working conditions all of these can have a negative impact on their health. Along, with that they might also face some life and financial stress, which in long term can have negative consequences over their health. They might have to face issues such high blood pressure, circulatory and immune complications. Whereas, on the other hand many studies revealed that people with adequate employment and income are more likely to have positive health outcomes, because of the fact that they are less dependent on the materialistic needs. Generally, the extent to which people have control over their circumstances and life is related to how healthy they are. High level of stress, along with lack of skills, social

support, and resources might lead towards poor health behaviours, and less healthy coping skills such as smoking, and unhealthy eating habits.

The structure of society can also influence the health of an individual through the factors such as distribution of goods and resources. Previous researches revealed that the populations in which these resources are shared equally have a positive impact on their health. Activities such as providing social support and cultural connections can provide an individual protection against various health related issues (Braveman et.al, 2005). Research reveals that adults today have to face various challenges such as; obesity, criminality, literacy, and other mental health issues. These issues can be resolved by providing them with an environment that is supportive, and stimulating during the first six years of their life. All of these factors can have a positive influence on the health and lifestyle of an individual and at the same time allow them to mitigate poor health outcomes in the future.

Relevance of Government Sources in Reporting on Inequalities in Health

In United Kingdom health inequalities are defined as the structural and systematic differences in the health status among the social groups living within the population. Health inequality is closely associated with the social determinants of health, due to the multiple influences that it have on health status, which includes various factors such as; education, diet, housing, employment, diet, and the socio-economic status (Marmot, 2005). The United Kingdom's government sources are highly relevant in reporting the inequalities in health. The United Kingdom tackles the issue of health inequalities with the help of two The Acheson report; the report with the help of weighing scientific evidence supports a socio-economic explanation of health inequalities inside United Kingdom (Mitchell, & Popham, 2008). The model that is

followed by the report is based on various layers which includes; socio-economic environment and lifestyle of the individuals. The report briefly addresses the social determinants such as; education, poverty, transport, housing, employment, ethnicity, gender, health care and life course. Thus, it could be said that health inequalities are now on the policy agenda of the government of UK (Shaw, 1999). The Acheson Report has helped the government to raise the profile of health inequalities across the government and at the same time has enabled the government to identify some pitfalls. Some of the pitfalls that are still present in-front of the government includes; negligible proof of effective interventions, poor integration mechanism for the implementation of health inequality in the mainstream, along, with that there is also limited amount of evidence on the outcomes.

In order to cope up with these issues the Acheson report has made the following recommendations:

1. All the relevant policies that are expected to have an impact over the health of the individuals should be evaluated in terms of the impact that they had on the health inequalities.
2. High priority should be given to the policies related to the health of children and their families.
3. There is an urgent need to take some further steps in order to reduce the inequalities in the income of the people living in United Kingdom, as it will automatically result in raising the living standards of the people.

Barriers in Accessing Health care

Geographic barriers

Resident living in the rural areas needs to travel long distances in order to access different points of health care delivery system. Health care facilities in such area are not adequate enough to fulfil the requirements of the people, as they are often small and can only provide limited services. Along, with that these health care facilities tend to be understaffed and face various challenge in the recruiting process, as not many health care providers prefer living and working in remote rural communities (Bentley, 2003). Mostly because of the geographical distance, climatic barriers, lack of public transport, and extreme weather condition the rural residents are prohibited from gaining access to health care services.

Communication barriers

Effective communication between a patient and health care provider is essential in a health care setting. Thus, language barriers present intimidating obstacle in adequate access to the health care. Language differences among people belonging to various ethnic and cultural backgrounds have proved to be major communication barriers. Along, with that culture also serve as a major barrier, because even if the provider and patient have the same language, the cultural values of the patient might influence the procedure in which they communicate the symptoms and how the feedbacks are perceived regarding the health status of the patient.

Socio-Economic Barriers

People with low incomes, often lack access to health care; it has been notified that socio-economic status has a huge impact of the ability of an individual to obtain adequate healthcare services (Neale et.al, 2008). In United Kingdom the health care is based on a tiered system of insurance coverage. Thus, access to health care is greatly affected due to the socio-economic status.

Task 2

Methods for Reducing Number of Patients that Smoke

Smoking is the leading cause of various respiratory diseases and one of the most important risk factors for cardiovascular disease, cancer and many other diseases (Russell et.al, 2004). Worldwide more than 4 million smokers die each year in our country and the consumption of snuff is responsible for over 15,000 deaths annually, which means an average of 41 deaths per day.

Public policies aimed at treatment of tobacco have a relatively small effect on the overall prevalence of smoking in a population, achieving reductions of about 1-2 percentage points. However, its availability and development are very important to all smokers, but especially for those who have more difficulty quitting, and for those who already have some secondary pathology consumption of snuff and should quit.

Currently, the best knowledge of psychopathology of addiction to snuff and motivations for behavior change, provides insights smokers and improve the psycho-social support can provide. Moreover, tools such as motivational interviewing and cognitive behavioral strategies have proven useful to increase and enhance motivation and increase the success of those trying to quit smoking (Niaura et.al, 2002).

These developments, along with the development of new and more effective drugs, should encourage and professional health team especially doctors take a more active in providing support and treatment for all smokers to manifest intention of quitting role. Barriers have been identified [50] than in the past hindered this role: fear of damaging the doctor-patient, lack of

knowledge on how to help patients and belief that prove ineffective relationship. But the evidence is now different and can do much to help smokers.

5 A Model

The model that I will use for reducing the number of patients that smoke is the 5A model. Following are the five stages that are constituted in this model:

1. Ask
2. Advise
3. Agree on the type of intervention
4. Assist
5. Accompany

This model basically consists stimulate and promote the intention of quitting and help those already motivated in smoking cessation. Brief counseling should be done in consultation with any health professional, independent of the complaint. A trained professional should not take more than two or three minutes in your application. I will use the delivery of self-help materials along with brief counseling, but there is no evidence to show an additional benefit. Yes there is evidence, discrete but significant that materials tailored profile of each person is more effective than general.

Ask

In this phase I will inquire patients regarding their smoking habits. What is the pattern in which they smoke? How many cigarettes do they smoke daily?

Advice

Once the questioning process is complete in the next step will advise my patients to stop smoking, for the advice to be effective it is essential that the board should be clear and firm, customizing convincing arguments: teen, you should insist on the effect of smoking on exercise capacity and poor school performance; pregnant is concerned your child and the risks of childbirth; the adult is more afraid of diseases that could be developed by the snuff and damage it can cause to children and those around him.

Agree on the type of intervention

After analyzing the condition of the patient I will propose different types of interventions, depending on the stage of change where the patients are.

a) *If the patient does not want to quit now:* explain how harmful consumption of snuff and offer support for the future.
b) *If the patient is unsure:* discuss their fears and encourage motivation explaining the advantages of not smoking. I invite you to leave the snuff when ready.
c) *If the patient is decided:* to offer help and plan a strategy to quit.

Assist

It will be beneficial for me to help the patient in case he/she is looking to quit smoking. In case the patient is willing to give up smoking, I will give the patient a date to stop smoking within the next 2-4 weeks which is called the "D Day" (Witschi et.al, 2000). It is not advisable to do so in periods of high stress, and moreover, it is necessary to consider that there is no ideal time to quit, but before rather than after. To strengthen the commitment to sign a contract

specifying the agreed-commitment and where the therapist is also committed to provide full support to the patient is suggested date.

Accompany

The patients who are in the action stage, that is are already following the program, and are under monitoring. I will ask them to visit at least once two weeks after "D-Day". A second follow-up visit should be agreed one month after the first, as far control.

My Role during Intervention

During this intervention my role would be to conduct interviews with the patients in which I will inquire about their smoking status. Then once I have collected all the data regarding their smoking habits, the next step would be to propose appropriate intervention strategy, and provide assistance in the creation of a plan to enable them to quit smoking. One of the essential tasks that I will perform during this intervention is the identification of the patients that have been diagnosed with chronic illness due to smoking. It would be immensely important to assist these sort of patients on overcoming there smoking habits, as this might result in some serious consequences for them that could be life threatening. Along, with that I will also develop certain strategies that will be helpful in the limiting the prevalent use of tobacco among youngsters.

Task 3

Obesity in United

In United Kingdom obesity has become a serious health issue, according to the officials it is one of the leading causes of preventable deaths in the UK. In February 2012 experts predict that by 2020 a one-third of the UK could be obese (Reilly, & Dorosty, 1999). According to Forbes, UK ranks 28 on the 2009 list of the fattest countries and has more overweight people in Europe. Adult obesity rates have nearly quadrupled in the last 25 years, with 26% of Britons now obese. South East of England is considered the thinnest region in the UK, with a level of obesity of 18%, which is fairly high as compared to Sweden which has 16% of the obese population. Birmingham is considered the fattest city in the EU, in which 29% of adults are classified as obese, while the European average is 14%. A quarter of the population from 11 and 12 years of Birmingham are considered obese.

Causes

An unhealthy diet has been cited as one of the major causes of obesity in the UK. The main reasons for unhealthy diet are the amount of pre-prepared foods Britons eat, lack of fruit and vegetables in the British diet and culture of heavy drinking. Obesity in the UK is generally in lower socioeconomic areas. It is important to note that while unhealthy diets and lack of adequate physical activity are considered causes of obesity, these are not the only causes. There are a number of genetic, medical and psychological factors that play an important role in the culture of the nation, and have a direct impact on obesity (Rennie, & Jebb, 2005). Medical conditions such as diabetes, hypothyroidism and endocrine disorders may be factors that

contribute to weight gain. Medications such as antidepressants, steroids and contraceptives are also examples of a long list of pills that can cause excessive weight gain. Attention must always be given to a classic cause: comfort eating, a complex psychological problem in its own right.

Providing Relevant Health Related Information to The public

The impact of obesity on society is so great that it has now transcended from a medical problem to social, demographic and economic problem. According to estimation the medical costs attributable to obesity in British children during 2006-2050. The authors modelled a hypothetical cohort of obese children aged 5-11 years old. Based on prevalence, incidence and clinical course, considering costs only type 2 diabetes mellitus and hypertension. The results indicate that the first cases of type 2 diabetes mellitus and hypertension would be presented in 2015. When the first group of children meets 40 years, significantly increase the complications of obesity. By 2050, 67.3% of the cohorts have obesity. The cost of care for obesity will be 57,678 million pounds (Challis et.al, 2004).

Obesity is interconnected with other diseases such as type 2 diabetes, asthma and hypertension; there are complex interactions between individuals, families and communities suffering from the disease, being an interesting aspect that although each of these levels is handled independently, actually all three have strong interconnections, from the molecular level to the social; in this case is very clear that the lifestyles called health impact to the level of molecules and vice versa.

In this regard, it is important to recognize that the abrupt increase in obesity in recent decades, and its presence in all latitudes, due to changes in the lifestyle of the people, which are summarized below:

Food:

- Increased consumption of energy-dense foods and low in nutrients and fiber.
- High consumption of foods and beverages with simple sugars and refined carbohydrates.
- High intake of saturated fat, monounsaturated fatty acids "trans" and cholesterol.
- Increase the size of food rations, especially in restaurants and "fast food chains".
- Lower consumption of fresh vegetables and fruits.

Physical activity:

- Working with less physical effort.
- Increasing use of motorized transport.
- Automation of vehicles and energy reduction in operating machinery and vehicles.
- Use of elevators and escalators.
- Reduced time spent playing outdoors.
- Preference for electronic games and television.

Promotional Campaign for Tackling Childhood Obesity

The promotional campaign will be name “60 Minutes or More a Day”. This promotional will campaign will promote the habit of performing various physical activities for the Kids. Today, most of the children are obese specifically because of the fact that they do not have any sort of physical activities in their daily life. Most of the children spend their time playing video games or on social media sites, which are making them more prevalent to obesity. Thus, through this promotional campaign we will introduce various exercises which will prove to be beneficial for the physical health of the child, and we will also educate children regarding the benefits of healthy eating habits. The promotional campaign will focus the children in schools, and it will

introduce various programs to enhance the physical activity of children. Along, with that it will also provide classroom interventions to the children in order to educate them with the benefits of physical exercises.

Exercise will help to improve the health and quality of life of children. Studies evaluating physical activity, caloric expenditure and energy intake, show an inverse association between the degree of adiposity and energy expenditure through physical activity. The Framingham study pre-schoolers also directed a relationship indirectly between the level of physical activity and body adiposity. Moreover, physical activity promotes their growth, their motor skills as well as their development and self-esteem. Researches have revealed that children who regularly practice physical activity are more likely to be active adults, as there is a tendency to maintain physical activity from childhood to adolescence and adulthood (Hilton et.al, 2012).

According to a research conducted by the government of UK it was found that that 35.2% of children are active, 24.4% children are moderately active, and children 40.4% are inactive. With regard to downtime, 27.6% of teenagers spend more than 21 hours / week in front of a television screen or video games. Data from these studies helped us to conclude that only a third of British adolescents (35.2%) take time recommended levels of physical activity. The combination of low moderate or vigorous physical activity and excessive time spent in sedentary activities, partially explain the increased prevalence of overweight and obesity in this age group in UK.

Thus, through our promotion we will recommend that children and adolescents accumulate at least 60 minutes per day of moderate to vigorous activity. Along, with that our promotion also recommends that not only increase in the moderate and vigorous physical activity is required, but along with that there is also an essential need to reduce the time spent in

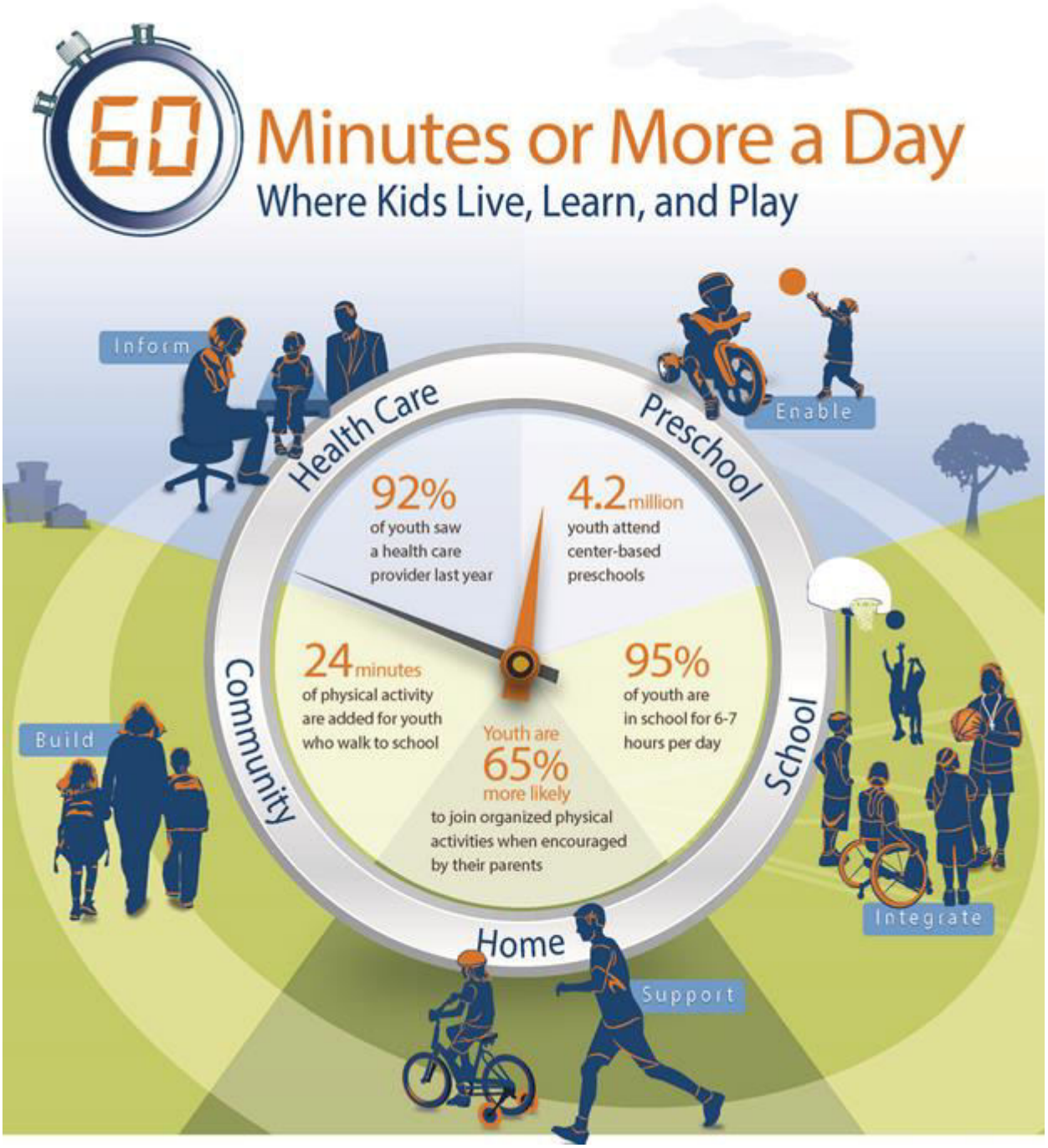
sedentary activities. The promotion of moderate or vigorous will result in decreasing the sedentary lifestyle and promoting a healthy diet, physical activity are essential actions for the prevention and control of overweight and obesity in adolescence and, therefore, the risk of chronic diseases in children of UK. Thus, the activities that will be included in our promotional includes; enhancement of the school environment, home and community as a whole.

A major part of our campaign is classroom intervention through which we will aim to educate children regarding the benefits of health eating habits, benefits of physical activities and promotion of healthy lifestyles. It is assumed that all of these measures will help us in reducing the low current obesogenic environment that promotes a sedentary lifestyle and consumption of energy-dense foods, high in fat and simple sugars, and fiber. Promoting physical activity and healthy lifestyles in children and adolescents should become a priority for the government and civil society.

Currently, there are internationally concrete recommendations on the type and level needed to maintain health in children and adolescents in different programs of physical activity in Canada, USA, UK, These strategies focus mainly on the school environment, but are also aimed at families, community and social environment. UK , have initiated programs in schools to prevent obesity as so-called "Movement and Welfare" in which the National Commission for Physical Culture and Sports (CONADE) involved, Refreshment industry (Coca-Cola of UK) which need to know their results. In this regard, the Consumer Power AC (civil organization, independent of political parties, business and religious groups, whose aim is to defend the rights of consumers and promoting their responsibilities and is a member of Consumers International and the Advisory Council for the consumption of the Federal Consumer) warned that no progress in combating obesity if policies are based on industry self-regulation, and refers to the campaigns

of the soft drink industry at the school level rather than promote activity physical, aim to strengthen the sale of their products.

Campaign Poster



Expected Outcomes

It is anticipated that this promotional campaign will a major role in the prevention of obesity in children and adolescents. In the great call, all participants have a role to play in improving diet and increasing exercise. Parents have the responsibility to adopt healthy lifestyles that inherit their children by example. The school must become a healthy environment, with the participation of teachers, students, parents and authorities. Likewise, civil society, particularly NGOs (Non-Governmental Organization) have to fulfil the role of managers at other organizations to prevent overweight and obesity and its comorbidities. It is also re-raise the private sector to increase production of healthy foods. With a remarkable relevance will be to involve industry media to reduce and abate if possible harmful food ads for children's health. Finally, the government sector has the ability to summon the different sectors, to coordinate activities, to promote initiatives to legislators and to evaluate the results.

For this promotional activity it is essential that it is complemented by the activities of the Department of Nutrition for Health and Development, whose strategic objectives are to promote healthy diets and improve the nutritional status of the population throughout life. The Ministry of Health of UK in a recent statement has signalled its interest in implementing this strategy, with the firm intention to prevent overweight and obesity. Since this is a complex task, determined and enthusiastic participation of the sectors is required public, private and social, as well as the responsibility of society in general. At the same time it is intended to implement strategies such as price incentives fiscal policies for families to have access to good food balance, according to the recommendations of the British Official Standard.

References

Adler, N. E., & Ostrove, J. M. (1999). Socioeconomic status and health: what we know and what we don't. *Annals of the New York academy of Sciences*,*896*(1), 3-15.

Bentley, J. M. (2003). Barriers to accessing health care: the perspective of elderly people within a village community. *International Journal of nursing studies*, *40*(1), 9-21.

Braveman, P. A., Cubbin, C., Egerter, S., Chideya, S., Marchi, K. S., Metzler, M., & Posner, S. (2005). Socioeconomic status in health research: one size does not fit all. *Jama*, *294*(22), 2879-2888.

Challis, B. G., Luan, J., Keogh, J., Wareham, N. J., Farooqi, I. S., & O'rahilly, S. (2004). Genetic variation in the corticotrophin-releasing factor receptors: identification of single-nucleotide polymorphisms and association studies with obesity in UK Caucasians. *International journal of obesity*, *28*(3), 442-446.

Hilton, S., Patterson, C., & Teyhan, A. (2012). Escalating coverage of obesity in UK newspapers: the evolution and framing of the “obesity epidemic” from 1996 to 2010. *Obesity*, *20*(8), 1688-1695.

Marmot, M. (2005). Social determinants of health inequalities. *The Lancet*,*365*(9464), 1099-1104.

Mitchell, R., & Popham, F. (2008). Effect of exposure to natural environment on health inequalities: an observational population study. *The Lancet*, *372*(9650), 1655-1660.

Neale, J., Tompkins, C., & Sheard, L. (2008). Barriers to accessing generic health and social care services: a qualitative study of injecting drug users.*Health & social care in the community*, *16*(2), 147-154.

Niaura, R., Shadel, W. G., Britt, D. M., & Abrams, D. B. (2002). Response to social stress, urge to smoke, and smoking cessation. *Addictive Behaviors*,*27*(2), 241-250.

Reilly, J. J., & Dorosty, A. R. (1999). Epidemic of obesity in UK children. *The Lancet*, *354*(9193), 1874-1875.

Rennie, K. L., & Jebb, S. A. (2005). Prevalence of obesity in Great Britain.*Obesity reviews*, *6*(1), 11-12.

Russell, T. V., Crawford, M. A., & Woodby, L. L. (2004). Measurements for active cigarette smoke exposure in prevalence and cessation studies: why simply asking pregnant women isn't enough. *Nicotine & Tobacco Research*,*6*(Suppl 2), S141-S151.

Shaw, M. (1999). *The widening gap: health inequalities and policy in Britain*. MIT Press.

Witschi, H., Uyeminami, D., Moran, D., & Espiritu, I. (2000). Chemoprevention of tobacco-smoke lung carcinogenesis in mice after cessation of smoke exposure. *Carcinogenesis*, *21*(5), 977-982.