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Segmentation in communities with the greatest health inequalities: so what for public health interventions?

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1. Background

A lifestyle survey elicited baseline health data from four Healthy Halifax wards (pop 2,430), areas within the most deprived national quintile based on Indices of Multiple Deprivation (IMD) [2]. Healthy Foundations Lifestyle segmentation model [2] was incorporated into survey design to categorise individuals into five attitudinal segments:

- Healthy: Lives well with their health
- Hedonistic: Lives for the moment
- Deprived: Lives for the moment
- Conscientious: Lives to a healthy standard
- Low: Lives for the moment

All segments can be found across deprived and affluent social strata. Socio-economic deprivation is linked to poorer health attitudes, behaviours and outcomes [3]. Targeting resources where they are most needed may help reduce health inequalities. Research has mainly been nationally focused. Local application of the model is engaging to inform public health interventions. Research within a population skewed in ethnicity and deprivation covers new ground and sheds light on some limitations in generalising the assumptions of the Healthy Foundations model.

2. Aims

- Enhance understanding of health attitudes and behaviours in deprived populations experiencing greatest health inequalities
- Contrast findings with Healthy Foundations model and synthetic estimations
- Interpret data for public health planning.

3. Respondent profile: is the data representative?

<table>
<thead>
<tr>
<th>Household income profile</th>
<th>Age profile</th>
<th>Ethnicity profile</th>
</tr>
</thead>
<tbody>
<tr>
<td>Income Group</td>
<td>Over 50% of respondents are in each ward by household income below £40,000 (n=2,778) Age profile: 44 of respondents aged between 18 &amp; 29 (n=1339) Ethnicity profile: 42% are of other, unknown, or mixed ethnicity (n=1339)</td>
<td>Age profile: Median age of respondents is 44 for both Healthy Halifax Healthy Foundations segmentation (n=1339) Male: 44.8% female: 55.2% Ethnicity profile: 42% are of other, unknown, or mixed ethnicity (n=1339) Gender profile: male: 55.2% female: 44.8%</td>
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</table>

4. Ethnicity profile

Healthy Halifax segmentation profile by gender differed to the national profile, suggesting the gender biases assumed within the model cannot be generalised to local population. The high proportion of males in Healthy Halifax Healthy Foundations segmentation profile could suggest poor family health in some households if the woman is the main decision maker [3].

5. Healthy Halifax segmentation profile differs from Calderdale, deprived quintile and national profiles

6. Healthy Halifax ward level segmentation profiles differ from deprived quintile

7. Discussion

Healthy Halifax segmentation profile by gender differed to the national profile, suggesting the gender biases assumed within the model cannot be generalised to local population. The high proportion of males in Healthy Halifax Healthy Foundations segmentation profile could suggest poor family health in some households if the woman is the main decision maker [3].

Commissionsing decisions and health intervention planning based on estimates may not reflect and need the needs of a locality. Demographically representative local lifestyle surveys provide more localised and specific profiles.

The Healthy Halifax ward level segmentation profiles differ from one another and from segmentation profiles of Healthy Halifax Healthy Foundations national and estimates for Calderdale and the most deprived quintile. Therefore generalising from national to local sample is problematic and fails to capture the specific local profile and local needs. Further analysis will involve augmenting segmentation profiles with postcode data to map and plan for local needs using Geographic Information Systems (GIS) technology [4]. This could offer greater precision for planning local social marketing and health interventions.

References

[11] Centre for Health & Social Care Research, University of Huddersfield, UK

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