Tackling health inequalities

Here we examine what is known about tackling health inequalities, and how local work can be informed by examples of good practice from elsewhere in the UK.

health inequality

... a difference in health outcome between different population groups

2.1 How we can tackle health inequalities

2.11 Background

The *Independent Inquiry into Inequalities in Health* [1] reviewed the evidence for health inequalities and made recommendations for reducing them. This evidence supported the development of the *Saving Lives: Our Healthier Nation* White Paper [2] and *The NHS Plan* [3] which both address health inequalities directly. *Tackling Health Inequalities: A Programme for Action* [4] published in 2003, sets out a plan to tackle health inequalities. It establishes a structure to attain by 2010 national targets for raising life expectancy in the most disadvantaged areas faster than elsewhere and reducing the present gap in infant mortality rates between different social groups.

Interventions to close the life expectancy gap:

- reducing smoking in manual social groups
- preventing and managing other risks for coronary heart disease and cancer such as poor diet and obesity, physical inactivity and hypertension through effective primary care and public health interventions – especially targeting the over-50s
- improving housing quality by tackling cold and dampness, and reducing accidents in the home and on the road

Short-term interventions to close the infant mortality gap:

- improving the quality and accessibility of ante-natal care and early years support in disadvantaged areas
- reducing smoking and improving nutrition in pregnancy and early years
- preventing teenage pregnancy and supporting teenage parents
- improving housing conditions for children in disadvantaged areas

Long-term interventions impacting on health inequalities:

- improved early years support for children and families
- improved social housing and reduced fuel poverty among vulnerable populations
- improved educational attainment and skills development among disadvantaged populations
- improved access to public services in disadvantaged communities in urban and rural areas
- reduced unemployment and improved income among the poorest

2.12 Tackling health inequalities: themes

The programme has four themes:

1. Supporting families, mothers and children – to ensure the best possible start in life and break the inter-generational cycle of ill-health
2. Engaging communities and individuals – to ensure relevance, responsiveness and sustainability
3. Preventing illness and providing effective treatment and care – making certain that the NHS provides leadership and contributes to reducing inequalities
4. Addressing the underlying determinants of health – the long-term underlying causes of health inequalities.

2.12.1 Supporting mothers, families and children

The *Acheson Inquiry* said that *... while there are potentially beneficial interventions to reduce inequalities in health in adults of working age and older people, many of those with the best chance of reducing future health inequalities ... relate to parents, particularly present and future mothers, and children. Action at this level is also essential to break the cycle of deprivation through the generations* [4].

Sure Start is a key component of the Government's health inequalities programme.

The **Euston** Sure Start Home Visiting Team offers home visits to any local family with a child under four. Families can request the service by telephone, through a friend or other professional. Interpreters are provided when needed. Home visitors divide their time between visiting families and working for their own agency. These links allow them to make referrals to their own organisation as well as Sure Start's other services, so that families can access a wider range of services more easily.

2.12.2 Engaging communities and individuals

Health Inequalities are part of a pattern that often combines social exclusion, low income, poor mental and physical health and poor access to services [4], and can affect whole communities throughout life [1]. Several community-led projects across the country recognise this link [4].

In **Penwerris** (Cornwall), **Wren's Nest** (Dudley) and **Farley Bank** (Hastings), the health and local authorities and voluntary agencies have collaborated to train and empower local people, and to improve the physical environment, enhance well-being and boost community morale. As one long-term resident puts it*: time was when Farley Bank was as low as you could go. Once you were put here you'd reached the end of the line. These days there's a waiting list for houses.*[4]

Drug Treatment services have been expanded, while access has improved and waiting times for treatment are shorter. Youth Offending Teams, the Connexions service and other specialist youth agencies are now providing early support for over 170,000 young people with drug problems.[4]

2.12.3 Preventing illness, providing effective treatment and care

The NHS Plan [3] set out the responsibilities of the NHS to provide effective prevention and treatment, and to tackle health inequalities.

Smoking is the main avoidable risk factor for CHD and cancer. In 2001/2, 120,000 people had quit smoking at the 4-week stage, following support from NHS services.[4]

Progress in early cancer diagnosis has been achieved in inner city areas through improving screening rates for breast and cervical cancer. Services were made more responsive to cultural and language needs, together with improved training, and spreading good practice.

Poor diet and obesity are important risk factors for CHD, some cancers and other conditions such as diabetes, and significantly affect life expectancy. Eating at least five portions of fruit and

vegetables a day is an effective strategy to reduce risk of cancer. But fruit and vegetable consumption is lowest in low-income groups. The New Opportunities Fund supports the National School Fruit Scheme and the 5 A DAY programme which aim to increase fruit and vegetable consumption in schools in 66 of the most deprived PCTs.

Over 3000 Personal Medical Services schemes offer greater flexibility in service provision through the NHS. Many are in deprived communities.

New services have been established in previously under-served areas – e.g. the £300m invested in Blackpool, Liverpool, Central and South Manchester, Southampton, Leeds and Plymouth.

2.12.4 Addressing the underlying determinants of health

The *Acheson Inquiry* report [1] emphasised the need for effective interventions to address the wider influences on health inequalities discussed in section **1**. Some examples of initiatives in this area are given below.

257 Healthy Living Centres in England address the underlying causes of ill-health in their own communities, as well as their effects on behaviour through a diverse range of activities and services. Some of these include skills training, ICT facilities and support, food co-ops and parenting skills, and fitness and exercise programmes.

The number of fuel-poor households (households spending more than 10 per cent of total income heating their homes) has fallen from 4.3 million in 1996 to 1.8 million in 2001. This has been an important step towards the reduction of excess winter deaths.

The Social Exclusion Unit's report *Making the Connections (2003)*, introduced the need for accessibility planning. This will help eliminate the obstacles faced by disadvantaged groups and communities in accessing work, schools, health care and shops.

The Employment Retention Project in **Walsall** works with people who are employed but off work because of illness and who are at risk of losing their job. The project is based in GP surgeries and local hospitals, offers individuals advice on welfare benefits, housing and other issues.

These themes are underpinned by five principles that will guide how health inequalities are tackled in practice:

1. Preventing health inequalities getting worse by reducing exposure to risks and addressing the underlying causes of ill health.
2. Working through the mainstream by making services more responsive to the needs of disadvantaged populations.
3. Targeting specific interventions through new ways of meeting need, particularly in areas resistant to change.
4. Supporting action from the centre by clear policies effectively managed.
5. Delivering at a local level and meeting national standards through diversity of provision.

Achieving this plan nationally will require local partnerships and local solutions. The rest of this section describes some ways in which we can develop local actions and partnerships in order to reduce health inequalities in Harrow.

2.2 What the NHS can do locally

Tackling Health Inequalities: A Programme for Action identifies three main roles for the NHS in tackling inequalities [4].

1 A lead role for PCTs driving forward work on health inequalities with a range of local partners, with a responsibility to lead, support and influence partners so that their services support improvements in health, thus narrowing health inequalities.

2 PCTs should ensure that service modernisation narrows health inequalities.

3 The NHS should be a good corporate citizen by contributing to the local regeneration agenda.

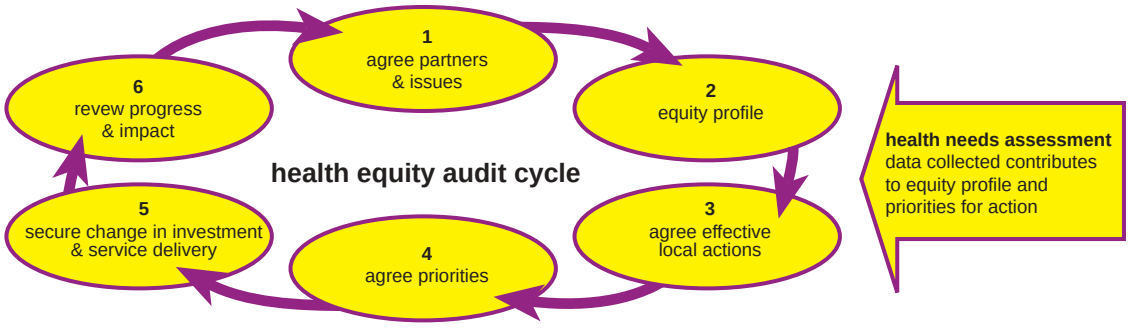
The Priorities and Planning Framework 2003–06 stated that NHS improvement, expansion and reform should narrow the health gap by:

- ensuring that the distribution of health benefit from service expansion and development consistently favours individuals and communities that have been traditionally under-served,
- tackling the wider determinants of health – agreeing a single set of local priorities with local authorities and other partners, contributing to regeneration and neighbourhood renewal programmes, and ensuring the NHS makes a full contribution to support the Sure Start programme,
- building capacity for public health improvement and protection in PCTs.

2.21 Ensuring that service modernisation narrows the health gap

The PCT is responsible for ensuring that service planning is informed by an equity audit and supported by an annual public health report. Figure **2.1** illustrates the health equity audit cycle, which uses evidence about health inequalities to inform service planning and delivery.

Figure 2.1 Health equity audit cycle



Source *Tackling Health Inequalities*

A Health Equity Audit addresses *how fairly resources are distributed in relation to the health needs of different groups.* [5] It is a process by which local partners:

- systematically review inequalities in the causes of ill-health, and inequalities in access to effective services and their outcomes, for a defined population,
- ensure that action required is agreed and incorporated into local plans, services and practice,
- evaluate the impact of the actions on reducing inequalities. [6]

Harrow PCT Corporate Objective: **two equity audits will be established by June 2004**

2.22 The NHS as a good corporate citizen

The NHS is the largest single organisation in Britain, investing huge sums of money in health services. As a large employer, and significant purchaser of goods and services, the NHS can shape its employment and procurement practices, capital building programmes, training and skills programmes to achive a link between health and regeneration – thereby getting a *double-hit* for its money. A King's Fund report, *Claiming the health dividend: Unlocking the benefits of NHS spending*, identified eight key areas for putting this into practice. [7]

Key area	*Possible NHS action*
Employment *the NHS has recruitment difficulties*	Skills development initiatives, in collaboration with other sectors, may both ease problems filling posts and assist local employment.
Purchasing policy *the NHS spends more than £2.4 billion a year in London*	NHS trusts have some choice over whether to buy from local or national suppliers and whether goods are more or less sustainable in terms of environmental and community impact.
Childcare services *three-quarters of NHS staff are women, two-thirds with caring responsibilities*	Childcare provision enables parents to take paid work or training but is also a major source of employment.
Food *the NHS is the largest single purchaser of food in the country*	Diet, nutrition, and food safety all directly impact on the health. The ways in which the NHS produces, processes and distributes food has societal, economic and environmental impact.
Waste *the NHS spends £42 million a year on waste disposal (mainly landfill with clinical waste incinerated)*	By reducing the volume of waste, redirecting waste into recycling and buying recycled goods the health care sector can make a real environmental impact and achieve considerable savings.
Travel *the NHS is a major contributor*	Road traffic is a significant cause of ill-health. 'Green travel plans' can reduce road mileage.
Emissions *hospitals produce 7.5 million tonnes of carbon dioxide annually, a major contributor to global warming*	Hospitals designed for energy efficiency would consume 50 per cent less energy than buildings of standard design.
New building design *a key issue for the NHS, affecting workers, patients and productivity*	The potential contribution improved design could make will only be realised if health improvement and sustainable development are ranked equally with health service needs at the onset of every project.

Section **4:** *Working together to tackle health inequalities*, includes a number of reports about how local work in Harrow 'runs with the grain' of a wider health improvement agenda.

2.3 Working together

Because the roots of health inequalities often lie in the wider determinants of health, initiatives to tackle inequality need to span across sectors such as health, housing, education and transport. Local Strategic Partnerships (LSPs) offer a new way to co-ordinate local action across statutory agencies, the voluntary and private sectors.

An effective LSP needs representation from:

- primary care trust,
- local authority,
- voluntary sector,
- communities,
- private sector.

2.31 Experiences of partnership working across the country

Partnership working is not new. The Health Development Agency, the Improvement and Development Agency, Solace, the Local Government Association, and others have reported on partnerships across the UK. There is much to learn from this work and in Harrow we can model our activity by drawing on examples of successful practice.

2.31.1 Key themes of partnership studies

Hamer and Smithies found a considerable amount of consensus about the key issues for integrated planning and delivery of local services, and actions to improve health and well-being of local populations [8]. These were:

- Working across boundaries
- Partnership arrangements and accountability (structures)
- Planning arrangements (strategies)
- Community involvement and consultation
- Member involvement
- Reducing inequalities and tackling deprivation
- Using the flexibilities – pooled budgets, joint posts and integrated services
- Joint priorities, indicators and targets, performance management

They highlight examples of practice from various areas:

Developing a broad-based membership of the LSP as the platform for effective integrated planning (**Isle of Wight**)

The benefits of pump-priming community involvement and partnership development (**Ashfield**)

Plan and partnership rationalisation (**Croydon**)

Establishing joint planning officers and units working across sectors to identify common agendas, priorities and targets (**Shropshire**)

Involving members in strategic planning and scrutiny across sectors (**North Tyneside/St Helens**)

Having a vision and strategic objectives for the community strategy (**Bradford**)

Providing baseline data on inequalities and deprivation to aid planning (**Leicester**)

Co-ordinating community involvement experience from across sectors with a clear role for the voluntary sector (**Waltham Forest**/**Blaby**)

Neighbourhood level needs assessment and initiatives which help to build a common agenda across the LSP (**New Forest/Staffordshire Moorlands**)

Local authorities' role in health impact assessment and health strategy development (**Barnet/Kirklees**).

2.31.2 Key elements of working together

From the studies and reports six key elements are identified:

1 having joint vision and strategy statements,

2 linking health and well-being,

3 consulting jointly,

4 local authority scrutiny of health,

5 setting joint targets, and

6 learning together.

1 Vision and strategy statements

Joint vision and values statements are a powerful symbol of commitment to partnership working. *Changing partners: local government and health in the 21st century* [9] provides many examples:

Test Valley, the corporate plan is entitled *Health, Wealthy and Wise.*

Wiltshire has five aspirational goals, which include *to enable Wiltshire people to live healthier and safer lives by working with health, police and other services.*

King's Lynn and **West Norfolk** have *improved health and well-being* as one of six corporate themes.

Barnsley community plan envisages the town as being *a place of good health* within ten years.

The **Kirklees** partnership has a five-year vision and strategy for the area with six themes, one being – *a healthy, safe and well-housed population.*

2 Linking health and well-being

The incentive for partnership working is greater when local bodies recognise the link between health and well being. A study of community strategies, found that health figures significantly in community strategies but that the way health is described covers a continuum. [8] In rank order of frequency:

- Health and social care
- Environmental protection and lifestyle
- Community safety
- Anti-poverty
- Access to goods and facilities
- Social inclusion and regeneration
- Lifelong learning and education
- Employment and economic regeneration

3 Consulting together

Where the Local Authority and PCT consult jointly they not only achieve greater co-ordination cost-effectively but also they help avoid consultation fatigue – where community organisations and groups are approached repeatedly by different agencies. There are many examples of councils and health bodies running joint consultations. *Changing Partners* quotes the following examples. [9]

In 1994, **Kirklees** set up a representative citizen's panel jointly with the health services. The panel has 1,200 members – representative of the local population – who are consulted three times a year, achieving an 80-90% response rate.

Barnsley has a citizen's panel, *Barnsley Voice*, with about 1,600 members, run jointly with the health bodies. It is consulted quarterly with feedback to members through a regular newsletter.

Test Valley BC has held workshops, forums and surveys to secure residents' views on a wide range of issues including crime and disorder, leisure, tourism, housing and health.

Calderdale MBC has undertaken joint surveys with health and the police service.

4 Local Authority scrutiny of health

The role of health scrutiny acting as a lever to improve the health of local people was outlined recently in the HDA's *Local Government Scrutiny of Health: Using the new power to tackle health inequalities.* [10]

Local authorities can now scrutinise NHS arrangements for:

- hospital and community health services and the services provided
- public health, health promotion and health improvement (including tackling health inequalities)
- planning health services, including plans made with local authorities to improve the health of the local population
- consulting and involving patients and the public.

Committees can scrutinise health issues, systems, or health economies, not just services commissioned by the NHS. Thus health scrutiny has a remit to examine health improvement in the widest sense, promoting social, environmental and economic well-being.

There are already examples of scrutiny tackling issues around health inequalities [10]:

causes of health inequalities (housing repairs and health impacts in **Camden**)

specific populations (inequalities in men's health in **Stockport**, health of Pakistani women in **Sandwell**)

an area-wide focus (impact of regeneration initiatives on health in **Bristol**, local authority contribution to reducing health inequalities across **Greenwich**)

specific health issues or diseases which increase health inequalities (tuberculosis in **Newham**, teenage pregnancy in **Ealing**)

inequity of access to services (access to primary care in **Greater London**)

inequity in provision of services (coronary heart disease, prevention and rehabilitation services in **Derbyshire**)

service re-development and their possible impact on inequalities (children and women's hospitals, services in **Kirklees**) service planning and performance (use of health and inequalities performance indicators in **Bristol**)

5 Setting targets together

LSPs allow the various partners to reshape their services to narrow the local health gap [4]. Once a broad strategy has been agreed with partners and policy options selected, specific targets and a timeframe can be set [11]. Progress towards targets needs to be measured using an agreed local basket of indicators [4]. Local authorities are also encouraged to establish Local Public Service Agreements (LPSAs) that deliver on locally developed targets that tackle health inequalities [4].

Some examples of setting targets together are [11]:

North Tyneside Community Plan, Health Improvement Plan, Sure Start programme and Health Action Zone have jointly agreed to reduce health inequalities and give special consideration to the health of children and families.

Cotswold Council has a target to commission research on health inequalities through the community strategy.

Manchester aims to increase consumption of healthy food by improving access and awareness-education. It has set inequalities targets for priority areas, such *halving the number of food deserts in the city within five years* and to *developing parental food education* projects in poorer areas of the city.

A more detailed account of how to set targets to reduce health inequalities is given in Appendix **3**.

6 Learning together

We know from *Community Strategies and Health Improvement: a review of policy and practice*[12] that learning networks can be established among local authority and NHS staff, and others involved with community strategy (such as the police service, probation, and the voluntary sector).

Some elements of learning together include:

- use of health impact assessments,
- producing local health profiles of needs and service use,
- evidence of effectiveness of joint efforts to reduce inequalities,
- evaluation of initiatives including health and social impact.

Learning networks enable effective communication between organisations working locally, and promote the development of synergy and mutual respect between various services trying to deliver the same broad goals for the community they serve.

2.4 Conclusion

It is anticipated that as local structures evolve, and partnership working becomes an integral part of our local service planning and delivery, the PCT and local agencies will adopt some of the examples described here into local initiatives working towards reducing health inequalities in Harrow.