

# Health Inequalities: *Progress and Next Steps*



**DH INFORMATION READER BOX**

<b>Policy</b> HR/Workforce Management Planning Clinical	Estates Commissioning IM & T Finance Partnership Working
<b>Document purpose</b>	Policy
<b>Gateway reference</b>	9852
<b>Title</b>	Health Inequalities: Progress and Next Steps
<b>Author</b>	Department of Health
<b>Publication date</b>	09 Jun 2008
<b>Target audience</b>	PCT CEs, NHS Trust CEs, SHa CEs, Care Trust CEs, foundation Trust CEs, Medical Directors, Directors of PH, Directors of Nursing, Local Authority CEs, Directors of Adult SSs, PCT PEC Chairs, NHS Trust Board Chairs, Special HA CEs, Directors of HR, Directors of Finance, Allied Health Professionals, GPs, Communications Leads, Emergency Care Leads, Directors of Children's SSs
<b>Circulation list</b>	
<b>Description</b>	Health Inequalities – Progress & Next Steps serves two purposes. Firstly it sets out progress on the current health inequalities strategy, focused around the PSA targets. Secondly action to two timescales: redoubling efforts to deliver the 2010 targets; and the process of developing ambitions, structures and systems for beyond 2010.
<b>Cross reference</b>	Tackling Health Inequalities: A Programme for Action, 2003
<b>Superseded documents</b>	N/A
<b>Action required</b>	N/A
<b>Timing</b>	N/A
<b>Contact details</b>	Mark Davies Health Inequalities & Partnership 502A Skipton House 80 London Road, London SE1 6LH 23702 www.dh.gov.uk
<b>For recipient use</b>	

# Contents

<b>Foreword by the Secretary of State</b>	<b>3</b>
<b>Executive summary</b>	<b>4</b>
<b>1. Introduction</b>	<b>12</b>
<b>2. Meeting the 2010 target</b>	<b>18</b>
Setting the first ever national health inequalities targets	19
Evidence of what works and supporting delivery	21
Next steps: maintaining the focus to 2010	24
<b>3. The influences on health</b>	<b>28</b>
The challenge	29
Early years and parenting	31
The impact of equality	36
Using work to improve well-being and tackle health inequalities	39
Promoting mental health to tackle health inequalities	41
Co-ordinating action on the influences on health	42
<b>4. The lives people lead</b>	<b>44</b>
The challenge	45
Smoking	47
Alcohol	50
Obesity	53
Multiple risk factors for poor health	56
Health literacy	57
<b>5. The services people use</b>	<b>60</b>
The challenge	61
The role of primary care services in reducing health inequalities	62
Commissioning in partnership	65
Empowering individuals	67
Engaging communities	69
Making services equitable	71

<b>6. Meeting the future challenges</b>	<b>74</b>
The challenge for 2010	75
The strategic challenge beyond 2010	77
Getting the system right – levers, tools and incentives	77
Building the evidence base	79
Health inequalities as a focus for all	80
Working more closely at government level	80
The future	82

# Foreword by the Secretary of State



I am determined that the Department of Health makes its contribution to creating a fairer society, where place of birth and parental occupation doesn't determine a child's future. Physical or mental ill health can remove every prospect of a fulfilled life. The fact that poorer people have the worse health remains an indictment on our society. Reducing health inequalities would mean that children in disadvantaged areas would be less likely to have decayed teeth, more likely to be a healthy weight and to live a long and healthy life.

A fair society means helping people to make healthier choices in many different aspects of their lives. It doesn't detract from personal responsibility or impose a nanny state. I believe there is a middle way, where we acknowledge that some people live in circumstances that make it much harder for them to choose healthy lifestyles. We can't ignore the facts – people living in deprived areas are more likely to smoke, to eat less nutritional meals, take less physical exercise and be more susceptible to drugs and alcohol abuse. We want to ensure better health for everyone irrespective of social class. But the most disadvantaged are the least assertive and are experiencing the worst health outcomes. They require more help.

What happens in childhood lays the foundations for our health throughout our lives. Whilst we must continue to focus on increasing life expectancy and reducing infant mortality, our objective beyond 2010 must be to create incentives to act early in the life of children and to give everyone the best chance of leading a healthy life. By doing so we can create a fairer and healthier society. This document sets out how we can all work together to achieve that vision.

A handwritten signature in black ink that reads "Alan Johnson". The signature is written in a cursive, flowing style.

Alan Johnson  
Secretary of State for Health

# Executive summary

## Chapter 1

1. As a nation, we are healthier now than we have ever been. Nationally, life expectancy has improved year-on-year over the past decade. This is a tremendous achievement, a testament to the capacity of individuals, families and communities to change and to the effectiveness of public services in helping people lead healthier lives.
2. However, the health of the most disadvantaged has not improved as quickly as that of the better off. Inequalities in health persist and, in some cases, have widened. Such differences are often avoidable and always unjust. In a fair and prosperous society, everyone should have the same chance to lead a long and healthy life and enjoy the same opportunities for education, employment, recreation and fulfilment that good health brings.
3. The current strategy on health inequalities focuses on the wider determinants of health, the lives people lead and what the NHS can do. The government will continue on this path, as set out in *Tackling Health Inequalities: A Programme for Action* in 2003. There will be strengthened support to meet the 2010 Public Service Agreement (PSA) targets, and more action on the factors that drive inequalities. Beyond 2010, this document signals a commitment to develop new ambitions for reducing health inequalities

along with the structures, systems and actions to sustain their long-term delivery.

## Chapter 2

4. For this government tackling health inequalities is at the heart of its determination to tackle the root causes of ill health. The Government signalled its commitment by developing a cross-government health inequalities plan, *Tackling Health Inequalities: A Programme for Action*, which set out how the Government planned to take action on the wider determinants of health and the national targets for health inequalities it had set for the first time.
5. In 2008 the final independent report assessing this programme showed almost all policy commitments were achieved.
6. There have been significant absolute improvements in the health of people in disadvantaged groups and areas. Life expectancy for men living in the target Spearhead areas has increased by over two and half years in the period since 1995–97. Mortality rates for those aged under 75 years suffering from cardiovascular disease or cancer have fallen faster in the Spearhead areas than in England as a whole.

7. However, the PSA target, based on relative change, remains challenging as the health of everyone in England continues to improve rapidly.

8. The Department of Health will therefore scale up what has been shown to work locally in reducing health inequalities through many actions including:

- scaling up the National Support Team (NST) for Health Inequalities, and developing new support teams for infant mortality and alcohol and refocusing the Tobacco Control NST to improve services for routine and manual workers;
- providing an improved version of the Health Inequalities Intervention Tool, which will model how health inequalities can be reduced both between and within local areas;
- developing programmes to support leadership development for reducing health inequalities and continuing to support and extend other initiatives such as Communities for Health; and
- investing in third sector organisations locally to increase their capacity and capability to contribute effectively to reductions in health inequalities.

### Chapter 3

9. Health inequalities are a reflection of wider inequalities, which in turn are linked to inequalities in opportunities and aspirations. To get to the root of health inequalities the Government must tackle these wider inequalities.

10. The Department and wider government will therefore focus on five key areas: investing in early years and parenting; using work to improve health and well-being; promoting equality; developing mental health services further; and co-ordinating action – both nationally and locally.

11. What happens to people in their earliest years – the circumstances in which they are born and brought up – has consequences throughout their lives. The Government has taken significant steps to break the inter-generational cycle of health inequalities by supporting parents and families to help to improve their health but also to become resilient to the impacts of their environment on their lives.

12. But it will now go further. It will develop amongst other initiatives:
  - a new Child Health Strategy later this year, jointly developed with the Department for Children, Schools and Families (DCSF), which will provide a long term vision for improving health services and outcomes for children and young people; and
  - more support and promotion of breastfeeding to give all children the best start in life by committing new resources to support the Baby Friendly Initiative.
13. Delivering on wider commitments to promote equality and tackling inequalities that result from damaging discrimination is also an essential part of addressing health inequalities.
14. The Department of Health's Single Equality Scheme for 2008–2011, to be published in summer 2008, will spell out the Department of Health's actions to meet statutory duties under race, disability and gender legislation, all of which include a requirement to have due regard for the need to eliminate unlawful discrimination and promote equality of opportunity. The Scheme also covers other aspects of equality relating to age, religion or belief and sexual orientation.
15. Progress on health inequalities will be judged against how public services treat especially vulnerable groups. The recent Disability Rights Commission report made it clear that people with learning disabilities often receive a poorer level and quality of service from the NHS. If services and health outcomes are improving for people with learning disabilities, they are likely to be improving for other groups at risk of health inequalities.
16. Health is good for work, and good work is good for health. In her report *Working for a Healthier Tomorrow*, Professor Dame Carol Black set out a compelling case to act decisively in order to improve the health and well-being of the working age population.
17. The government's response to *Working for a Healthier Tomorrow* will be published later this year, and Lord Darzi's report on the NHS Next Stage Review, due for publication shortly, will also address this issue.
18. The Government will:
  - develop Dame Carol Black's recommendation to create a new Fit for Work service and pilot this service in less well off areas where there is the most significant potential to prevent worklessness arising from ill health; and

- develop a new partnership between the NHS and Jobcentre Plus to help benefit claimants who misuse drugs to access the right advice and, if necessary, refer them to specialist treatment and employment support.

19. In further work to support mental well-being, the Department of Health will amongst other things:

- provide additional support to those suffering with mental illness through the expansion of the Improving Access to Psychological Therapy programme, which will cover a further 900,000 people by 2010–11. The programme will ensure that access is equal for groups who traditionally miss out, for example, older people and those from black and other ethnic communities; and
- develop a new vision to address mental health, to follow from the previous National Service Framework for Mental Health, which will include as a core theme the need to address inequalities in access to services and inequalities in mental health itself.

## Chapter 4

20. Many inequalities in health are a preventable consequence of the lives people lead, the behaviours and lifestyles that cause ill health, many of which show

a stark relationship with social-economic factors.

21. Smoking is responsible for one sixth of all deaths. It is the one area where behaviour change would make the greatest impact on health inequalities.
22. The Government will take further action to tackle smoking, building on the recently launched Tobacco Consultation. This will include supporting communities with the highest smoking rates to implement new multi-agency, community-based tobacco control programmes. These will combine effective social marketing campaigns and more accessible smoking cessation support with action to reduce the number of young people who start smoking; enforcement of legislation on under age sales of tobacco and reduce the availability of counterfeit and non-duty paid tobacco.
23. Within localities, individuals facing the greatest disadvantage have four to fifteen times the greater alcohol-specific mortality and four to ten times greater alcohol-specific admissions to hospital than the most affluent. In order to accelerate progress on reducing such inequalities, a programme to reduce, and in time halt, the rise in alcohol-related admissions to hospitals.

24. Obesity is one of the most important long-term challenges facing the nation's health. The government has already announced an investment of over £370 million in a cross-government strategy to halt and turn the tide of obesity in children and adults. *Healthy Weight, Healthy Lives* set out the Government's long-term plans for tackling obesity.
  25. Child and adult obesity rates are higher in lower socio-economic groups and also in some ethnic communities. Policy on obesity needs to tackle inequalities in obesity if it is to be successful. In addition to existing commitments, the Government will identify the areas where the "full service" model of local programmes and services, to both prevent and tackle child and adult overweight and obesity will be tested.
  26. Finally, we know that some people are more likely to have multiple risks, such as obesity, smoking and alcohol problems, which is very detrimental to health.
  27. Therefore the Department of Health will commission a broader research programme to understand the reasons why multiple health behaviours, both good and bad cluster, what affects how hard these behaviours are to change, and how to intervene effectively to help people make positive changes and reduce their risky behaviours.
- ## Chapter 5
28. As the Government renews the focus on achieving the 2010 target, it is important that services – in particular the NHS – are designed and targeted so that they work effectively for the people who need them most.
  29. The NHS has an important role in reducing health inequalities yet, in some cases, the people most in need of healthcare have the most difficulty accessing it. Action has already begun to tackle these issues, and the NHS Next Stage Review, when completed, will have more to say in this area. There are four areas where it is vital that progress is made: primary care; commissioning services in partnership to reduce health inequalities; creating services which reach out to individuals, groups and communities in order to meet their needs; and using NHS services actively to promote equality.
  30. As part of the work on the NHS Next Stage Review, the Department is developing a Primary and Community Care Strategy, which will set out how the Government can support the NHS and clinicians in achieving more personalised, integrated and better quality services within a more enabling environment created by the Government.

31. Commissioning is one of the most powerful levers the Department of Health has to reduce health inequalities. The Department will improve the support it gives to commissioners to reduce health inequalities including:
- building upon World Class Commissioning Competencies and vision, the Strategic Health Authorities are leading on making support and development resources available to Primary Care Trusts;
  - working across departments to consider how investment in improvement systems can most efficiently support local change; and
  - considering how Health Impact Assessments can be used more systematically and consistently.
32. There are many ways to reach out and improve the health of different groups and individuals, for example through providing high quality work (as in Chapter 3), and through improving health literacy (Chapter 4). Health Trainers and social marketing are also ways people can be reached by adapting the way services are provided. Amongst other initiatives the Department of Health will roll-out Health Trainers to every community, and extend their reach with an additional network of health champions who will operate as an outreach team facilitating uptake of health trainer services and other interventions, as appropriate.
33. Third sector organisations are particularly well placed to engage with those that are hardest to reach. Their strength at a local level to work within the community and engage with individuals and statutory organisations for the benefit of individuals, cannot be underestimated.
34. The Empowerment White Paper to be published by the Department for Communities and Local Government later this year, will emphasise and take forward the Government's commitment to ensuring that local people have more power over their lives.
35. Alongside this, the Government will invest in support for voluntary and community sector organisations to develop community engagement programmes.
- Chapter 6**
36. The strategic challenge for 2010 is to consolidate the gains from our current approach, by scaling up learning and support. Chapter 2 of this document sets out how the Government will strengthen support to local areas so that this can be achieved and Chapters 3 to 5 have demonstrated the commitment to reducing health inequalities across the wider determinants of health, the lives people lead and the services they use.

37. Many of the tools locally are now in place. Joint Strategic Needs Assessments (JSNAs), Local Strategic Partnerships (LSPs) and Local Area Agreements (LAAs) are the right tools to support delivery on the ground between local partners. NSTs are being scaled up and local areas will be expected to use the improvement architecture detailed in the National Improvement and Efficiency Strategy to develop systems of effective leadership to drive and support change.
38. The Department and wider government will continue to build a sustainable system that has a rigorous focus on reducing health inequalities across the NHS and wider government, at all levels. This will be achieved through:
  - further enhancing the tools, incentives, accountabilities and leadership required to reduce health inequalities;
  - building and making the evidence base widely available;
  - ensuring all communities focus on reducing health inequalities and setting a new objective for post-2010; and
  - working more closely at government level to focus on reducing inequalities in health.
39. The Spearhead approach, focusing effort in the most disadvantaged communities, was clearly the right place to start. Over the next few years all areas must continue to focus and prepare to tackle inequalities within their own communities.
40. Given the current target only lasts until 2010 it is important to refresh the strategic objective for reducing health inequalities. The current targets have been successful in creating momentum and innovation to reduce health inequalities. But with the right tools and levers, evidence and learning in place, there is now a strategic opportunity to go further.
41. It is also ever clearer that the Department of Health and the NHS cannot reduce health inequalities in isolation from other public services. *Tackling Health Inequalities: A Programme for Action* provided a good model which improved the coherence of government programmes. The new duties around JSNA and the development of LAAs and LSPs have made it easier to deliver jointly designed public services.

42. The Department of Health will now lead further work across government to:

- develop the right incentives for organisations so that they feel able to invest in programmes that reduce health inequalities where the benefit is realised elsewhere, or many years later. The Department will lead joint work to develop incentives and levers which help and encourage organisations to work together;
- develop the case for a future coherent and consistent PSA and funding strategy for the reduction of health inequalities; and
- develop a joint approach to accountability for any future PSA. The Department of Health can support the NHS to improve the way it commissions, designs and delivers services but the ultimate causes of health inequalities lie in the circumstances of people's lives and their lifestyles, which the Department cannot improve alone.

# 1. Introduction



- 1.1 As a nation, we are healthier now than we have ever been. Nationally, life expectancy has improved year-on-year over the past decade. This is a tremendous achievement, a testament to the capacity of individuals, families and communities to change and to the effectiveness of public services in helping people lead healthier lives.
- 1.2 But the health of the most disadvantaged has not improved as quickly as that of the better off. Inequalities in health persist and, in some cases, have widened. Such differences are avoidable and unjust. In a fair and prosperous society, everyone should have the same chance to lead a long and healthy life and enjoy the same opportunities for education, employment, recreation and fulfilment that good health brings.
- 1.3 Social inequalities are an important driver of health inequalities. While other factors such as biological or genetic predisposition or age influence the prevalence of ill health, there is a pattern of reduced life expectancy and higher levels of illness, which is linked to socio-economic status and the gradient between socio-economic groups.
- 1.4 At the same time, those services which can mitigate the impact of social inequalities on health – for example, access to healthcare or effective support and advice – are not always available to those who most need them. This means that some groups face a double disadvantage. For example, people with learning disabilities are more likely to suffer socio-economic disadvantage or less likely to have access to effective health services.
- 1.5 The current strategy on health inequalities is focused on the delivery of the Public Service Agreement (PSA) targets and actions on the wider determinants of health. It is right that the Government continues on the path which was set out in *Tackling Health Inequalities: A Programme for Action* in 2003.
- 1.6 This is now the time to review the current position. Progress has been made on tackling life expectancy and infant mortality – but more needs to be done to narrow the gaps if the 2010 target is to be achieved; and the target matters because it is about saving lives and avoiding premature death. Following reviews of the health inequalities targets in 2006 and 2007, more is known about what works to tackle health inequalities. It is now vital to scale up action and invest in successful programmes to drive progress towards 2010.
- 1.7 At the same time, it is important to think beyond 2010: to take stock of the experience of the last decade of work on health inequalities; consider the ever-increasing body of evidence on how the wider causes of health inequalities are influenced; and develop a consensus on what, in a fair and just society, is the right approach to tackling health inequalities.

1.8 This document therefore describes action on two timescales:

- up to 2010 – focusing on the current targets and redoubling efforts to prevent avoidable deaths; and
- beyond 2010 – developing new ambitions for health inequalities and the structures and systems that support delivery and sustainable improvements.

1.9 In the work to 2010, the emphasis is firstly on using the evidence of what works, increasing investment and refocusing activities on the target. This is described in Chapter 2.

1.10 At the same time as scaling up activity that will help deliver the 2010 targets, it is important to continue to take action on those factors that drive health inequalities. Chapters 3, 4 and 5 address the three domains of activity where intervention will have the greatest impact on health inequalities:

- the influences on health – the importance of early years and family life, the relationship between work and health, the impact of wider inequalities and discrimination, and the impact of the environment and wider social factors;

The influences on health

The lives people lead

The services people use

- the inequalities in the lives that people lead and the risks that they take with their own health – especially smoking, alcohol and obesity – and the information that people need to live healthier lives; and
- the services that people use where inequalities in access and outcome lead to health inequalities. This includes the importance of primary care, local authorities, the role of commissioning and partnership working and engaging people and communities to influence services.

#### 1.11 Common themes run across these three areas for action:

- Action must be taken at all levels – national, regional, local and down to ward and practice level. The role of central government is crucial – but limited. The most important actors are local: including local authorities, primary care trusts (PCTs), primary care practices, schools, housing providers, employers, Jobcentre Plus and community midwife teams.
- Empowering people and communities to take control of their own lives, whether upon the wider determinants of health – such as the environment or housing – or on their own health and that of their families. People and communities that invest in their own future are more likely

to see that future as one in which they take healthy decisions and act accordingly.

- The crucial role of local government in tackling health inequalities. Local government provides leadership and the structures within which citizens can make their voices heard. It can support advocacy for those who struggle to be heard. It can understand the needs of its citizens beyond those for healthcare and meet those needs in a way that drives out inequality. As important, local government is responsible for many of the services that will address the wider influences on health inequalities: housing, environment, schools, crime and disorder, and regeneration – all have a vital part to play in tackling inequalities.
- There are many areas where the NHS has a key role. Ensuring that the NHS takes its responsibility to treat all of the communities it serves equally and fairly is essential. Getting primary care right – accessible to all and reaching out to communities – is vital. The NHS works best in partnership with local government. Understanding the needs of local communities and agreeing how to address them will drive local improvement.

- The need to support disadvantaged communities. In many areas, the most disadvantaged communities are also those that experience the most discrimination. At the local level, it is important to understand the needs of those communities and take action to meet them. At the same time, all services need to understand and take action on their duties under equality legislation.

1.12 Work to drive progress on the 2010 target builds on the important work set out in the Government's *Tackling Health Inequalities: A Programme for Action*, which is described in Chapter 2.

1.13 Chapter 6 describes the work that the Government will undertake in order to consolidate and build on the current strategy, to go beyond 2010. It sets out a challenging programme of work that aims to transform the way that government approaches health inequalities, with a comprehensive and cross-cutting approach to:

- take action where interventions, including direct health interventions, will have the greatest impact on health inequalities;
- work on the social determinants of health inequalities, as part of a broad approach to inequalities;

- understand and address the barriers that prevent organisations and institutions from looking at the whole needs of individuals, families and communities; and
- ensure that any future PSAs reflect the cross-government and interdependent nature of the factors that drive health inequalities.

1.14 This is a challenging programme of work. It is founded on the successes of the last decade and aims to develop a new consensus on how to build a fairer and more equitable society.



## 2. Meeting the 2010 target



2.1 For the new government elected in 1997, tackling health inequalities was at the heart of its determination to tackle the root causes of ill health. The independent Acheson Inquiry was appointed in July 1997 to review the extent of the problem and to make recommendations for new government policy. Its landmark report highlighted the need for action across a broad front, including poverty, education, employment, housing and the environment – as well as through the NHS.

### Setting the first ever national health inequalities targets

2.2 In 2001, the Government signalled its commitment by setting national targets for health inequalities for the first time. These are set out in the box below. Having a national target has galvanised people and organisations into action and stimulated

the development and gathering of new knowledge and evidence. In addition, an inequalities element has been introduced into national targets for cancer, cardiovascular disease (CVD) and smoking.

2.3 The cross-government health inequalities plan, *Tackling Health Inequalities: A Programme for Action*, published in July 2003, set out how the Government planned to deliver the target and to take action on the wider determinants of health. The plan sought to ensure that a concern for health inequalities was embedded in all public policy and that services were more responsive to the needs of disadvantaged communities.

#### **The national health inequalities Public Service Agreement target**

By 2010 to reduce inequalities in health outcomes by 10% as measured by infant mortality and life expectancy at birth.

This is underpinned by two more detailed targets:

- starting with children under one year, by 2010 to reduce by at least 10% the gap in mortality between routine and manual groups and the population as a whole; and
- starting with local authorities, by 2010 to reduce by at least 10% the gap in life expectancy between the fifth of areas with the worst health and deprivation indicators (the Spearhead group) and the population as a whole.

- 2.4 The *Programme for Action* included an undertaking to monitor the health inequalities target, the 12 cross-government headline indicators and the 82 cross-government commitments included in the plan through a series of independent status reports, produced by a scientific reference group chaired by Professor Sir Michael Marmot.
- 2.5 The final status report, *Tackling Health Inequalities: 2007 Status Report on the Programme for Action*, published in March 2008, showed progress against the indicators, with almost all of the commitments wholly or substantially achieved. Since 1997, there have been significant absolute improvements in the health of disadvantaged groups and areas. This is a tremendous achievement. 41% of Spearheads are on track to reduce the gap between their life expectancy and the England average by 10% by 2010, for either males or females or both.
- 2.6 Differential progress is to be expected, however, as the causes of health inequalities vary from area to area. Some drivers, such as population change, are beyond the control of the NHS and local government. The status report also showed that, despite the absolute improvements, inequalities remain stubborn and persistent. The national target, based on relative change, remains challenging.
- nationally, life expectancy is increasing for both men and women, including in the Spearhead areas. But it is increasing more slowly there, so the gap continues to widen, and it is widening more for women than men. In 2004–2006, for males the relative gap was 2% wider than at the baseline, while for females it was 11% wider;
  - for infant mortality, the health inequalities gap between routine and manual groups and the whole of the

### Progress in absolute health inequalities outcomes

The 2004–2006 infant mortality rate for routine and manual groups is the same as the rate for the whole population in 1997–1999.

Life expectancy for men in the target Spearhead group has increased by over two-and-a-half years in the period since 1995–1997, and by over one-and-a-half years for women.

CVD rates and cancer mortality rates for those under 75 have fallen fastest in the Spearhead areas – by 32% for CVD and 11% for cancer.

population has recently started to narrow, but it is still wider than the 13% gap at the 1997–1999 baseline.<sup>1</sup>

of evidenced-based actions are expected to be implemented and are known to deliver improvements.

### Evidence of what works and supporting delivery

2.7 Setting a clear national target for health inequalities galvanised people and organisations into action and changed the climate from one where action on health inequalities was seen as long-term and aspirational, to one in which a defined set

2.8 Health inequalities are deep-rooted and driven by a complex interplay of factors. Local action must be evidence-based, strategic and of sufficient scale to make a difference at population level. The Government reviewed the evidence base for the life expectancy target in 2006 and the infant mortality target in 2007. Our current best understanding of what will

#### What works locally

- **A strategic, evidence-based approach.** Underpinned by a rigorous analysis of local data to understand the gap and what is causing it. Looking right across the patch, considering the drivers and establishing which organisation has the levers to address them, with a focus on the longer-term causes as well as the immediate needs of those already experiencing the effects of health inequalities. Ensuring NHS actions are consistent with other strategic actions, e.g. economic regeneration.
- **Scaling action to the size of the problem locally.** Developing an action plan based on the analysis set out in the Joint Strategic Needs Assessment and evidence based interventions derived from the Health Inequalities Intervention Tool, with local measures and monitoring built into operational plans and local area agreements.
- **Leading from the top,** with Chief Executives and Directors of Finance, Commissioning and Primary Care, Clinical Leadership, Housing, Planning, etc. playing their part. Public Health can advise but cannot deliver alone.
- **Ensuring that the quality and quantity of primary care** in disadvantaged areas meets local needs and is well organised. Proactive development support should be possible both generically (e.g. strengthening practice management) and for specific priorities (e.g. managing CVD, diabetes and Chronic Obstructive Pulmonary Disease programmes).

<sup>1</sup> The classification of social and economic status varies in this document. This reflects both the variations in the definitions of targets and sources which have used different proxies. For the official definitions, and previous classifications, go to [www.statistics.gov.uk/methods\\_quality/ns\\_sec/default.asp](http://www.statistics.gov.uk/methods_quality/ns_sec/default.asp)

- **Actively seeking out people who already have a disease or are at high risk but are not accessing services early enough.** Ensuring that those with multiple needs are not being 'exception reported' for the Quality and Outcomes Framework (QOF). Using a variety of local data – including the QOF, prevalence models and risk-scoring – to ensure that the health needs of disadvantaged populations are being met. Working with other services to reach vulnerable groups.
- **Capitalising on neighbourhood and community infrastructures to engage individuals, families and communities,** particularly those 'seldom seen, seldom heard' in services. Using them to ensure services are responsive to needs and to help motivate and support appropriate health-seeking behaviour.
- **Ensuring that partnerships are effective,** not only at board level but also for middle management and frontline staff. Different organisations should agree priorities, explicitly share leadership and responsibility, and take concerted action.
- **Considering and addressing workforce implications,** understanding what needs to be done locally, by whom, and the resources needed, taking into account the necessary scale of activity and balancing the skill mix to obtain cost-effectiveness and sustainability of systems.
- **Innovating** – always looking for new ways to understand problems and deliver solutions.

Source: Derived from the experience of the National Support Team For Health Inequalities' work during 2007 and 2008.

work to narrow health inequalities rapidly, based on these reviews and from practice on the ground with Spearhead communities, is set out above.

2.9 The structures and processes to support local action are in place. Local Strategic Partnerships which help local authorities, the NHS and other stakeholders to plan jointly, have led to the development of local leadership and action. Joint Strategic Needs Assessments and Local Area Agreements are used to identify need and

agree local priorities for action. Resource allocation in both the NHS and local government reflects need, and the All Age All Cause Mortality indicator forms part of the Vital Signs for the NHS and National Indicator Set for local government. Further action to build on these developments is discussed in Chapter 6.

2.10 The National Improvement and Efficiency Strategy sets out the architecture for supporting delivery of services through the local Performance Framework. The

strategy gives Regional Improvement and Efficiency Partnerships (RIEPs) a central role in identifying priorities for improvement and the commissioning and co-ordination of support to meet these priorities. Support for Local Authorities on reducing health inequalities should be

co-ordinated through RIEPs and complement actions in their regional improvement and efficiency strategies.

2.11 The box below gives details of some of the innovative programmes that are in place nationally, where the lessons learned and evaluations are shared across the country.

### Programmes

- **The National Support Team (NST)** for Health Inequalities offers tailored advice to Spearhead primary care trusts (PCTs) and local authorities on reaching the target, using evidence and local knowledge on barriers and opportunities. Other National Support Teams also focus on health inequalities, particularly the NST for tobacco control, teenage pregnancy and childhood obesity.
- **The Improvement and Development Agency (IDeA)** for local government improves the capacity of local authorities to reduce health inequalities. The IDeA Healthy Communities Programme supports work with local communities to provide leadership for health and well-being and to foster strategic partnerships across sectors (see [www.idea.gov.uk](http://www.idea.gov.uk)).
- **The Communities for Health programme** engages communities in their own health and develops their capacity to support individual behavioural change for healthy lifestyles. It builds partnerships and develops innovative practices for community-based health improvement.
- **The Improvement Foundation**, a social enterprise partner organisation, delivers a programme in some of the most disadvantaged communities to improve the early identification and presentation of people at high risk of cancer and CVD. Using the health community collaborative methodology, the programme is raising awareness of risk factors and increasing the number of people who are diagnosed at an early stage by changing the behaviour of both the public and professionals (see [www.improvementfoundation.org](http://www.improvementfoundation.org)).
- **The award of Beacon Council status for health inequalities** from 2008, demonstrating the extent to which health inequalities are now local authority business. The winners will support other councils to progress (see [www.beacons.idea.gov.uk](http://www.beacons.idea.gov.uk)).

2.12 A range of information and tools to support local areas are making tackling health inequalities practical, achievable and measurable, and have attracted international recognition. They can and should be used by local partners to inform their Joint Strategic Needs Assessment and plan their actions.

2.13 Examples of local successes are emerging, where PCTs and local authorities are innovating to tackle difficult issues as shown in the case study below.

#### Next steps: maintaining the focus to 2010

2.14 While the national targets for life expectancy and infant mortality remain wider than at baseline, good progress is being made in many areas.

### Sheffield has taken a systematic, evidence-based approach to reducing city-wide health inequalities

Sheffield is not a Spearhead, but has developed a community-based, targeted and systematic approach to reducing health inequalities, which has had considerable impact on mortality rates (especially CHD and cancers). Life expectancy has significantly increased and progress has been made in closing the gap between communities across the city.

The approach combines:

- A strong focus on empowering local communities to develop and deliver activities to improve their own health and well-being. This is being realised through Enhanced Public Health Programmes that target neighbourhoods with the poorest health.
- Medical interventions and activities that are improving accessibility to primary and secondary care. This long-standing work builds on the very successful Citywide Initiative for reducing cardio-vascular disease (CIRC) programme – an initiative which involves identifying GP practices with high CHD mortality rates and providing targeted support with specialist nurses.
- Complementing this work is longer-term sustainability which involves using the city's strategic partnerships to engage all of the key stakeholders in tackling the wider determinants of health, e.g. through the World Health Organization Health City Programme which involves 1200 cities and towns from over 30 countries. Sheffield has used Health Impact Assessments on major developments in the city such as housing and transport.

2.15 The experience of the National Support Teams is that considerable scope remains in many areas to scale up action to achieve the target. The Government will step up

support to the Spearhead areas and those areas with high infant mortality rates among routine and manual groups (as detailed in the box on page 18).

### Information and tools to support local areas

- **The local basket of indicators** provides a list of measures that can be used across a range of inequalities dimensions to monitor how they are changing over time. It was developed by the London Health Observatory ([www.lho.org.uk](http://www.lho.org.uk)).
- **The Health Poverty Index** was developed by the University of St Andrews, the South East Public Health Observatory, the University of Oxford and Oxford Consultants for Social Inclusion and provides high-level summaries for every local authority area across a range of factors underpinning health inequalities. This allows comparisons between areas and ethnic groups to support priority setting ([www.hpi.org.uk](http://www.hpi.org.uk)).
- **Community health profiles** for every English local authority are published annually by the Association of Public Health Observatories, setting out local information on causes of ill health, risks and health outcomes ([www.communityhealthprofiles.info](http://www.communityhealthprofiles.info)).
- **A Health Inequalities Intervention Tool**, developed by the Association of Public Health Observatories ([www.apho.org.uk](http://www.apho.org.uk)) and the Department of Health, is designed to help Spearhead PCTs and local authorities understand the drivers of their health inequalities gap, the key interventions to reduce it and the expected impact on life expectancy of specific interventions. This tool is already helping to underpin local health inequalities commissioning strategies, Operational Plans for the NHS and Local Area Agreements in Spearheads ([www.lho.org.uk/health\\_inequalities/health\\_inequalities\\_tool.aspx](http://www.lho.org.uk/health_inequalities/health_inequalities_tool.aspx)).

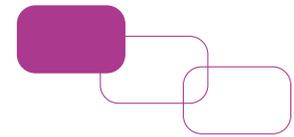
### **Increasing support to local areas to deliver the national health inequalities target**

- The **National Support Team (NST) for Health Inequalities** will be scaled up to reach all Spearheads by summer 2009. The approach and methodology used by the Health Inequalities National Support Team is shared with non-Spearhead areas.
- A new **NST for Infant Mortality** will be established, which will focus on the areas with the highest infant mortality rates in routine and manual groups.
- The work of the **NST for Tobacco Control** will be refocused to improve services for routine and manual workers, working in partnership with the NST for Health Inequalities.
- The **NST for Teenage Pregnancy** will continue to support change in areas with high and increasing under-18 conception rates.
- A new **NST for Alcohol** will be established, supplemented by further support for areas that experience the most alcohol-related hospital admissions.
- A **programme to support leadership development** for health inequalities in the NHS and local government will be developed, working with a range of stakeholders.
- An **improved version of the Health Inequalities Intervention Tool** will be launched, covering all areas. It will be able to model the reduction of health inequalities both between and within local authority areas for four areas where evidence-based, high-impact interventions are known: smoking, high blood pressure, high cholesterol and infant death (available shortly at [www.lho.org.uk/health\\_inequalities/health\\_inequalities\\_tool.aspx](http://www.lho.org.uk/health_inequalities/health_inequalities_tool.aspx)).
- The **IDeA Healthy Communities Programme** will be commissioned for a further three years.
- **Communities for Health** will be continued in the 83 areas where it is already successful and it will be rolled out to other local authorities.
- **Support for early presentation for cancer and CVD**, and for take-up of vascular checks in disadvantaged areas, will be developed, building on the early success of the Improvement Foundation. Early presentation programmes will be rolled out to a further 30 sites and the Improvement Foundation cancer programme will be rolled out to cover 20 local authority areas in 2008–09.
- **Additional investment in third sector organisations** locally to increase their capacity and capability to contribute effectively to reductions in health inequalities.



### 3. The influences on health





3.1 This chapter sets out how the Government plans to tackle the influences and aspects of life that have an impact on inequalities in physical and mental health. It focuses on actions in five key areas: early years and parenting; health and work; equality; mental health; and co-ordinating action, both nationally and locally, on the wider social factors that influence health inequalities.

### The challenge

3.2 The evidence for the impact of social factors on the health of individuals and communities is compelling. Chapter 2 described how the Government has reviewed the wider causes of health inequalities and implemented a cross-government programme to tackle the wider causes – as set out in *Tackling Health Inequalities: A Programme for Action*.

3.3 The 2004 report *Focus on Social Inequalities* (published by the Office for National Statistics<sup>2</sup>) showed clearly that even when improvements are made for everyone, inequalities persist.<sup>3</sup> Health inequalities are a reflection of wider inequalities for example, in income, housing and education that in turn are linked to inequalities in opportunities and aspirations. So, to get to the root of health inequalities, the Government must tackle

those wider inequalities. They are rooted in the circumstances in which people are born and live.

3.4 Wider influences can have a profound impact on people's physical and mental health. For example, there is good evidence<sup>4,5</sup> that a range of environmental factors – adverse childhood experiences, poor education, poor housing, living in a workless household, exposure to violence in childhood – have a measurable impact on later mental health and individual resilience. When experienced during adult lives, such factors also have a profound influence on health and well-being. For example, people's working lives – whether they experience unemployment or job security, whether they can exercise control over the pace and content of their work – matter to their health. There is also a direct relationship between the physical environment, as measured by proximity to green spaces, and people's levels of physical activity and mental health.

3.5 On a broader scale, the Government is taking action to tackle climate change, which is likely to have the greatest impact on the most disadvantaged families and communities. Specific issues which will be addressed include working in partnerships to increase insulation of homes of vulnerable people living in fuel poverty to

2 Office for National Statistics (2004) *Focus on Social Inequalities 2004 Edition*

3 Wells, C. and Gordon, E. (2000) Geographical variations in England and Wales, 1981–2006. *Health Statistics Quarterly* 38 pp.6–18.

4 Nurse, J. and Champion, J. (2006) *Mental Health and Well Being in the South East 2006*. [www.sepho.org.uk](http://www.sepho.org.uk)

5 Marmot, M. and Wilkinson, R. (eds) (2003). *Social determinants of health: The solid facts*. World Health Organization

reduce CO<sub>2</sub> emissions, improve income and resilience in maintaining cool homes during heatwaves. The development of green spaces will also help to reduce heat islands in the centre of larger cities.

3.6 But the impact that the environment and personal circumstances can have on health is not always so direct. A family living in an area of relative disadvantage and experiencing poor health outcomes is also more likely to be subject to other environmental factors – such as feeling less safe, a poor physical environment and lower-quality public services.<sup>6</sup> Fear of crime is directly related to poor health. In addition, these factors can come together to reduce mental well-being and to limit the aspirations of individuals, families and communities – including their aspirations or ability to achieve good health.<sup>7</sup>

3.7 The UK has lower levels of social mobility than most comparable countries.<sup>8</sup> This means that the challenge facing an individual in the UK in breaking out of the environment and socio-economic group into which they were born is immense. Changing these wider influences is a task that will take time and requires effective, co-ordinated action at all levels, from central government to local neighbourhoods and individuals themselves.

3.8 The Government's immediate focus will be on actions that will begin to change lives in the short term, although the impact on health inequalities may be realised over a longer timescale. Some of the wider benefits may even be realised in the next generation. Over the medium and longer term, the Department of Health will work across government to ensure that all programmes are focused on tackling inequality and that the impact on health inequalities of each programme is understood. Reducing health inequalities may not be the goal of all policies, but it should be one of the results.

3.9 There are five areas in which early action will have the most impact:

- investing in early years and parenting;
- promoting equality;
- using work to improve health and well-being;
- developing mental health services further; and
- co-ordinating action on the influences on health – both nationally and locally.

6 Nurse, J. and Champion, J. (2006) *Mental Health and Well Being in the South East*. [www.sepho.org.uk](http://www.sepho.org.uk)

7 Chandola, T. (2001) The fear of crime and area differences in health. *Health and Place* 7(2) pp.105–116

8 J Blanden, P Gregg and S Machin (2005) *Intergenerational Mobility in Europe and North America: A Report Supported by the Sutton Trust*. Centre for Economic Performance: London School of Economics

## Early years and parenting

- 3.10 What happens to people in their earliest years – the circumstances in which they are born and brought up – has consequences throughout their lives. The material conditions of infancy and childhood – the care that parents provide, nutrition, the social, emotional and physical environment, and the early learning of healthy behaviours – are all factors which influence health throughout childhood and the adult years. The fact that children often learn from their parents the behaviours and habits they learned in turn from *their* parents means that inequalities can stretch needlessly across generations. For example, the best predictor of a person becoming overweight is having had overweight or obese parents.
- 3.11 But it is not inevitable that a child born to a family with a low income or living in a disadvantaged area will be at greater risk of poorer health in adulthood than a child born to a family with a high income or living in an area of relative affluence. The conditions of childhood and early years can be mitigated by actions that support parents and carers who live in disadvantaged areas or who are vulnerable in other ways. It is by no means inevitable that people exposed to environmental, social and emotional risks to health will have to endure poorer health. By improving life chances at all ages – but particularly in childhood – it is possible to make a difference to health inequalities. The challenge is for government – both locally and nationally – to create the environment in which that change can happen.
- 3.12 Early life experiences have a disproportionate impact on a developing child's brain, influencing long-term emotional and social skills. The ability for a mother to create an emotional bond with her child promotes long-lasting resilience, mental health and well-being. This process can be disrupted by parental mental illness, or poor or abusive parenting. However, learning positive parenting skills has been shown to reduce long-term levels of abuse, teenage parenthood and offending behaviour, and can increase education and employment outcomes.
- 3.13 The Government has taken significant steps to break the inter-generational cycle of health inequalities – by tackling child poverty and supporting parents and families to improve their health. The Public Service Agreement (PSA) on child health and well-being, which the Department for Children, Schools and Families (DCSF) and the Department of Health have committed to deliver, has five delivery priorities: breastfeeding, school lunches, child obesity, emotional health and well-being, and improving services for disabled children. In addition, PSAs in other areas highlight the importance of other elements of keeping children and young people

healthy. These include the PSA on improving access to maternity services at 12 weeks of pregnancy, reducing rates of conception among under-18s, reducing substance misuse among young people and improving take-up of sporting opportunities for 5–19-year-olds. These actions, and the principles underlying them, are aligned with the Government's renewed drive to eradicate child poverty by 2020, as set out in *Ending child poverty: everybody's business*, published by the Treasury in March 2008.

3.14 The Sure Start Children's Centres that have been developed across the country are a key delivery vehicle for the improvement of child health. Children's centres are places where children under five and their families can take advantage of integrated services and information, and where they can access help from multi-disciplinary teams of professionals. There are currently over 2,900 children's centres, and by 2010 there will be 3,500 – one for every community. Sure Start Children's Centres offer significant opportunities for improving children's health and ensuring that families are able to access the support they need to help their child to thrive and achieve their full potential. A key priority is to engage and support the most excluded families and to reduce health inequalities between the most disadvantaged families and other families. The Government will encourage joint working between primary care trusts (PCTs), practice-based

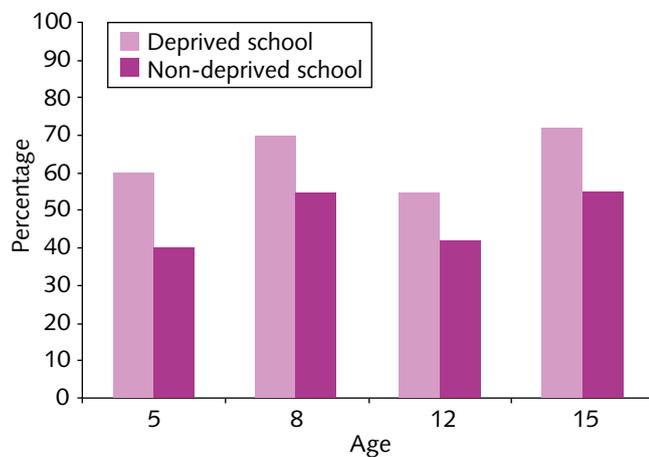
commissioners, local authorities and children's centres, to ensure that integrated support is provided to families.

3.15 The right nutrition both at the start of life and throughout life is crucial. Breastfeeding is the best form of nutrition, as it provides all the nutrients a baby needs in the first six months of life. It confers significant health benefits to both infants and mothers. Breastfed babies are at lower risk of infections – particularly gastroenteritis and respiratory infections. Breastfed infants are at lower risk of being obese in later childhood while breastfeeding mothers are more likely to achieve their pre-pregnancy weight and less likely to develop breast or ovarian cancer.

3.16 Healthy Start, a statutory scheme, provides nutritional support to pregnant women and very young children in the most disadvantaged families. As the Healthy Start programme develops, it will continue to reflect the emerging evidence on the nutritional needs of the families that are being supported. Healthy Start makes the links with the other public health policies that affect these families.

3.17 Tooth decay, which is almost entirely preventable, is strongly associated with social deprivation. Children from routine and manual socio-economic groups are twice as likely to experience dental decay as children from the highest social groups.

**Figure 3.1: Proportion of children with obvious decay experience in primary (five- and eight-year-olds) or permanent (12- and 15-year-olds) teeth by school deprivation status**



Source: J Steele, D Lader (2004) *Social factors and oral health in children: Children's Dental Health in the United Kingdom, 2003*, Office for National Statistics

3.18 However, this effect is mitigated by the fluoridation of water. The potential that fluoridation offers for reducing inequalities in oral health is well illustrated by drawing comparisons between oral health in the West Midlands and oral health in the North West. Birmingham and the surrounding areas have been fluoridated since 1964, and five-year-old children in Sandwell have on average one decayed, missing or filled tooth. Children in an area with a comparable social profile – Bolton in the North West, where the water is not fluoridated – have nearly three times more dental disease.

3.19 The Family Nurse Partnership (FNP) has been set up to make a real difference to the most disadvantaged families. It uses an intensive, structured model of nurse-led home visiting support for vulnerable first-time mothers from early pregnancy until their children are two years old. It is a preventive service and extensive research evidence from the US shows that it has the potential to change inter-generational patterns of behaviour. The FNP works from or has strong links with Sure Start Children's Centres so that families can have better access to the other support and services that they need. The Department of Health and the Department for Children, Schools and Families are currently testing this programme in ten areas in England, and are due to expand it to a further 20 areas by March 2009.

3.20 Working with the most socially excluded families to achieve positive behavioural changes and their engagement in interventions requires an integrated approach. The pioneering Family Intervention Projects (FIPs) work through a multi-agency panel, including a nominated health professional, delivering services co-ordinated around the family. In one of the FIPs, 80% of the parents had mental health problems, 47% of families had been affected by domestic violence and at least 21% of children were 'at risk', with high levels of mental health problems. Over 50% of the children were either obese or overweight. FIPs use a key

worker to signpost families to appropriate services. Early outcomes from this programme have resulted in over 80% of the families engaged having the tenancies on their homes stabilised and 85% of the children now being back in school. These successes have led to a commitment to establish an additional 14 FIPs.

3.21 To underline the commitment to improving health outcomes for all children and young people, and as announced in the Children's Plan, the Department for Children, Schools and Families and the Department of Health will develop jointly a Child Health Strategy. Due to be published in the autumn, it will set out a vision – building on the National Service Framework for Children, Young People and Maternity Services – for improving children's and young people's health. It will consider how the Government can achieve greater consistency and a higher quality of services and will have a particular emphasis on dealing with the inequalities in health outcomes for children. This will build on the recent *Child Health Promotion Programme* published by the Department of Health in April 2008.

3.22 In addition, the Government will:

- support and promote breastfeeding to give all children the best start in life. Our main challenge is to focus on interventions that will encourage more and more mothers, particularly teenage mothers and other mothers from low-

income groups, to initiate and continue breastfeeding. The Government would like to see all relevant hospitals and community settings adopting the UNICEF Baby Friendly Initiative, as the evidence shows that the proportion of babies breastfed at birth increases by more than 10 percentage points on average over four years when hospitals implement these standards. The Baby Friendly Initiative accredits maternity and community healthcare facilities that have implemented best practice for breastfeeding. The Department of Health will immediately commit new resources to support the Baby Friendly Initiative in areas with the lowest breastfeeding rates or the greatest deprivation;

- develop a predictive risk assessment tool for pregnancy, that will support practitioners to personalise and target preventive services and early intervention programmes, systematically identifying families at risk of social exclusion;
- consider how the NHS could better support vulnerable women who are not readily able to access maternity care and explore ways to support strategic health authorities (SHAs) in both assessing needs in their regions and developing appropriately targeted maternity services;

- develop and implement an evaluation of Healthy Start, which was rolled out across the UK from November 2006;
- aim to strengthen the role of health in the FIPs, which provide focused support for families in greatest need;
- continue to deepen the impact of the Healthy Schools programme in supporting schools to contribute to the health and well-being of children and young people – especially the most vulnerable. Building on the existing strengths of Healthy Schools as a universal programme, additional money will be invested in a three-year pilot programme to target additional support at the most disadvantaged. The pilot, to be run in the South West, will work with schools and other education providers to identify local priorities in tackling health inequalities. The pilot will develop strategies – including working with parents, carers and members of the wider community – to bring about healthier behaviour. In particular, the pilot will focus on obesity, mental health, sexual health and substance misuse. Consideration will be given to other ways of further focusing the programme on tackling health inequalities;
- increase the number of health services applying the 'You're Welcome' quality criteria in order to better meet the needs of teenagers. In particular, ensuring that key settings for health information, advice and guidance (such as general practices, school- and college-based services, pharmacies and contraception and sexual health services) fully implement the principles set out in *You're Welcome quality criteria: Making health services young people friendly* (published by the Department of Health in March 2007). The Government will continue to encourage health professionals and their professional bodies to embrace these principles and to embed them within their Continuing Professional Development programmes;
- deliver 3,500 Sure Start Children's Centres by 2010, one for every community, providing integrated support to children under five and their families;
- support the lead role of the health visitor in the implementation of the Child Health Promotion Programme, with support for skills development in the existing workforce to deliver that programme;

- ensure that SHAs consult locally about further schemes for the fluoridation of water, to tackle the problem of tooth decay;
- improve access to high quality antenatal education and preparation for parenthood from early pregnancy. Drawing on the latest evidence and existing good practice, such as FNPs, the government will develop a new programme that can be delivered in a range of settings;
- improve access to targeted and specialist health services for school-age children, by ensuring that all schools provide extended services by 2010. Working with local authorities and health services, schools will focus on the early identification of, and support for, children and young people who have additional needs or who are at risk of poor outcomes. Extended schools will improve access to health services such as speech and language therapy, Child and Adolescent Mental Health Services, and drug and substance misuse advice and support; and
- study the outcomes of the current pilot of the Improving Access to Psychological Therapies programme with children, and explore how it might be strengthened further.

### The impact of equality

- 3.23 Delivering on wider commitments to promote equality and tackling inequalities that result from damaging discrimination are both essential elements of addressing health inequalities. The NHS and the Department of Health have both a statutory responsibility and an opportunity to use their influence to promote equality. The Department of Health has an important role in working with the organisations that commission and provide health and social care services to raise awareness and develop and promote good practice to support the delivery of our vision for equality. A partial Equality Impact Assessment has been produced for the programme set out in this document, and will be used in our planned policy development over the next year.
- 3.24 The Department of Health runs or sponsors a number of change programmes in the NHS, some of which have a workforce development focus. Two of these programmes – Race for Health and Pacesetters – are testing new ways of providing better access, services and outcomes for patients and better working environments that are free of discrimination. Learning from these programmes will help spread good practice on equalities throughout the NHS.

## Pacesetters

**East Midlands Ambulance Service NHS Trust** is planning to hold a summit later this year on emergency services and religion or belief, to:

- generate community interest and engagement in emergency services;
- identify key issues for the trust and the various religious communities served by the trust; and
- foster improved understanding and better relationships between the trust and communities.

The key issues identified at the summit will be pursued and monitored over the course of the following year.

**The Heart of England NHS Foundation Trust** is planning to develop a package of measures to:

- investigate if South Asian patients admitted to the elderly care directorate had previously attended the accident and emergency department and were discharged; and
- better support South Asian families through the discharge and aftercare process, taking particular account of their culture, religion and beliefs.

3.25 The Department of Health Single Equality Scheme for 2008–2011, to be published in summer 2008, sets out what the Department is doing to meet its statutory duties under race, disability and gender legislation – which includes a requirement to have due regard for the need to eliminate unlawful discrimination and to promote equality of opportunity. The Scheme also covers other aspects of equality relating to age, religion or belief, and sexual orientation.

3.26 It is important that public services are in the vanguard of tackling all forms of inequality and discrimination. The NHS should quickly become an exemplar organisation in terms of promoting equality – as an employer, as a service provider and as a commissioner.

### The Department of Health's Single Equality Scheme

The action plan accompanying the Scheme includes a range of initiatives to achieve progress by:

- improving and extending the availability of information on the outcomes of existing and new policies for health and social care to identify priorities for action to promote equality. In particular, the Department will use data based on the 44 indicators for health and wellbeing that will be used to measure progress against the Department's strategic objectives;
- developing and disseminating good practice in stakeholder consultation and involvement – both within the Department and through the health and adult social care system;
- implementing Joint Strategic Needs Assessments and the World Class Commissioning programme;
- improving access and responsiveness in service provision;
- empowering people to understand and use services;
- promoting equality of opportunity within the Department of Health and across the NHS and the social care workforce; and
- improving capacity and capability to meet the statutory duties on equality within the Department, and demonstrating how the Department is holding to account itself and the bodies responsible for promoting equality within the health and social care system.

3.27 The 2007 Disability Rights Commission Report<sup>9</sup> made it clear that people with learning disabilities often receive a poorer quality of service from the NHS. So the Government will use progress in relation to this particularly vulnerable group as a way of testing whether its approach to tackling health inequalities is working.

3.28 The Department of Health will:

- work with the NHS to develop PCT 'exemplar sites' that will exemplify best practice in commissioning NHS services to meet the needs of people with learning disabilities;
- promote a PCT framework to support comprehensive health checks, health action planning and better access to health promotion services for people with a learning disability;

9 Disability Rights Commission (2007) *Equal Treatment: Closing the Gap*

- take forward a Human Rights in Healthcare programme, helping the NHS to recognise and respect the human rights of all patients. The second phase of that work has now commenced. The national advisory group for the programme will convene in July 2008;
  - publish its response to the independent inquiry into the six deaths reported by Mencap, which will set out further actions to be taken; and
  - publish guidance to the NHS on meeting the Disability Equality Duty in respect of people with a learning disability. This will be published in summer 2008.
- families without a working member are more likely to suffer persistent low income, poverty and poor health; and
  - the health of the current working-age population will affect the potential of the next generation too.

3.30 The case for the connection between work, poverty and health is not in doubt. Dame Carol set out in her review that children in workless households are also more likely to experience worklessness themselves in adult life. The challenge now is to break the cycle and, in doing so, to tackle not only income inequalities but health inequalities too.

### Using work to improve well-being and tackle health inequalities

3.29 Health is good for work, and good work is good for health. In her report *Working for a healthier tomorrow*,<sup>10</sup> Professor Dame Carol Black set out a compelling case to act decisively in order to improve the health and well-being of the working-age population. She noted that:

- good work is good for health, reversing the harmful effects of long-term unemployment and prolonged sickness absence;

3.31 A key element is helping more people who are currently without work to move into sustained employment. The activity of the Department for Work and Pensions and Jobcentre Plus is crucial here. The introduction of Employment and Support Allowance for October 2008, and the Pathways to Work programme, which is now available to all new customers across the country, are important steps in enabling people with health conditions or disabilities to work. There is more to be done, in particular, to help people stay in work.

<sup>10</sup> Black, Professor Dame C, *Working for a healthier tomorrow* (2008) TSO

### Tameside Metropolitan Borough Council

Tameside MBC has 9,000 employees in a wide range of occupations, including refuse workers, cleaners, lawyers and office based staff. In 2001, the average number of days lost to absence per employee was 13.2, and Tameside was 26th out of 36 metropolitan councils in terms of managing absence. As a result, a project was initiated to manage sickness absences more effectively, and to promote interventions for health and well-being.

Today, Tameside has reduced the average absence to 8.9 days per employee and are now ranked second. They achieved this by establishing a new standard of absence management and training managers to use it.

The reduction in sickness absence was equal to an additional 141 full-time employees between 2001 and 2007, and led to £1.5 million in savings over three years. Both of these have a direct impact on improving service delivery.

3.32 The Government's response to *Working for a healthier tomorrow* will be published later this year, and Lord Darzi's report on the NHS Next Stage Review, due for publication shortly, will also touch on this issue. Much is being done to unlock the potential for higher productivity and better experience of work, particularly for those with lower incomes – and more can be done.

3.33 The Government will:

- continue to refresh its strategy on health, work and well-being, which includes a focus on people who are living in disadvantaged circumstances;
- develop Dame Carol's recommendation to create a new Fit for Work service, which will deliver earlier interventions

for people who are absent from work due to illness and ensure earlier access to treatment – thereby helping more people to return to work earlier. The Government will pilot this service in less well-off areas where there is the most significant potential to prevent worklessness arising from ill health;

- produce a new mental health and employment strategy to improve support for people of working age suffering from mental health conditions, building on the existing Improving Access to Psychological Therapies programme and related Department for Work and Pensions programmes;
- work with private sector employers to improve the health and well-being of their staff and of the communities of

which they are part. This includes our work with Business in the Community as part of the response to Dame Carol's review, and will include a focus on employers with a major footprint in unskilled work or in more disadvantaged areas (including the development of emotional resilience and skills toolkits for employers of all sizes);

- support the development of new university campuses and higher education centres in the communities which can benefit most and are willing to mobilise partners, energy and resources to unlock rewards for local people and drive economic regeneration;<sup>11</sup>
- continue to increase employment levels, particularly for those from disadvantaged backgrounds, and develop a better skilled, more productive workforce via the UK Commission for Employment and Skills; and
- develop a new partnership between the NHS and Jobcentre Plus to help benefit claimants who misuse drugs to access the right advice and, if necessary, to provide referral to specialist treatment and employment support.

### Promoting mental health to tackle health inequalities

3.34 Poor mental health significantly increases the risk of poor physical health and premature death – risks of heart disease are estimated to be twice as high for people with depression or mental illness, and one-and-a-half times higher for those who are generally unhappy.<sup>12</sup> It is estimated that mental illness accounts for more days of active health lost per year in the UK than any other health condition.<sup>13</sup>

3.35 In the work planned to support mental well-being, the Department of Health is:

- providing additional support to those suffering from mental illness through the £170 million expansion of the Improving Access to Psychological Therapies programme, to cover a further 900,000 people by 2010–11. The programme will ensure that access is equal for groups who traditionally miss out, for example older people and those from black and minority ethnic communities;
- developing a new vision to address mental health, to follow from the previous National Service Framework for Mental Health, which will use a public mental health approach to promote

11 Department for Innovation, Universities and Skills (2008) *A new "University Challenge" Unlocking Britain's Talent*.

12 Keyes, C. (2004) The nexus of cardiovascular disease and depression revisited; the complete mental health perspective and the moderating role of age and gender, in *Ageing and Mental Health* 8 (3): pp.266–274.

13 WHO (2006) *Burden of Disease Statistics*. [www.who.int/healthinfo/bod/en/index.html](http://www.who.int/healthinfo/bod/en/index.html)

wider mental health and well-being and embrace, as a core theme, the need to address inequalities in access to services and inequalities in mental health itself;

- building on the lessons learned from the Well-Being Nurses programme, exploring how the Department can provide further support to those with mental illness to achieve their maximum physical health and what more the Government can do to support the empowerment of individuals;
- further investing in the Shift programme to reduce the stigma and discrimination experienced by people on the grounds of mental illness. Shift's aim is to create a society in which people who experience mental health problems enjoy the same rights as other people. This means working with young people in schools, with public services like the NHS, with employers, who often still discriminate against people with mental health problems, and with the media;
- considering the recommendations from the forthcoming report of the review of Child and Adolescent Mental Health Services; and
- working with the Home Office on the development of a Violence and Abuse Prevention Plan, focusing on early interventions to reduce the risk of all forms of interpersonal violence and abuse. This will be done in partnership

with the Home Office, the Department for Children, Schools and Families, the Department for Environment, Food and Rural Affairs and Communities and Local Government. It will provide supportive toolkits, protocols, care pathways and commissioning guidance.

### Co-ordinating action on the influences on health

- 3.36 Sir Donald Acheson's inquiry, published in 1998 (see Chapter 2), described how health inequalities are driven by wider inequities. The 2007 status report (see Chapter 2) reported on progress on a range of programmes which the Department knows will have an effect on health inequalities. Yet there is always more to be learned. For example, Dame Carol's report in early 2008 strengthened the case for action on health and work to reduce inequalities in income and health.
- 3.37 The Government also recognised the challenges faced by the most excluded individuals, families and communities in its 2007 report *Reaching out: An action plan on social exclusion*. The programme of work that followed the report aims to support the most socially excluded by driving local action (for example, through the development of PSAs and the associated delivery plans) and piloting new approaches – for example, by testing new ways of delivering services to people with complex needs that cut across traditional service boundaries. The Department of

Health will increase investment in this work so that it is best placed to learn and implement the lessons in future.

3.38 There remains much more to learn and understand. Professor Sir Michael Marmot is chairing a WHO Commission on the social determinants of health, which is due to report later this year. In the meantime, there are immediate steps that can be taken in advance of that report to ensure that the Government is working in a co-ordinated manner to address health inequalities.

3.39 The Government recognises that it needs to tackle the needs of the disadvantaged in many different ways. For example:

- a ten-year plan<sup>14</sup> was launched jointly by the Department for Environment, Food and Rural Affairs and Natural England in February this year to increase opportunities to enjoy the countryside and open spaces. The plan includes measures to provide more accessible, affordable transport, and to ensure that rural businesses and land managers are sensitive to people's needs.
- in October 2007, the Department of Transport published *Towards a Sustainable Transport System* which set out a new approach to policy and decision making within the Department, identifying health, safety and security as a key strategic goal.

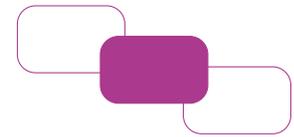
3.40 In addition, the Government will:

- develop the Department's Health Impact Assessment tool, so it can be used more effectively to ensure that all policies support the Government's objective of reducing health inequalities;
- work to assess the impact of climate change on health inequalities and ensure that the Department maximises the opportunities to achieve sustainable development both through a new sustainable development strategy and through programmes such as the new cold weather health warning which will be piloted this year and the new NHS sustainable development unit which will promote and share good practice; and
- ensure that the winning bidders for 'Healthy Towns' have shown the impact of their proposals on disadvantaged and vulnerable groups. The Healthy Communities Challenge Fund is an open competition for funds to develop innovative evaluated approaches to improving physical activity and diet at a community level, announced in *Healthy Weight, Healthy Lives*.

3.41 While the wider influences on health are important, so are the lives people lead. The next chapter sets out how the Government will help people to live healthier lives, building on our developing understanding of the way in which the wider influences on health affect people's behaviour, and how the Government can make a difference.

# 4. The lives people lead





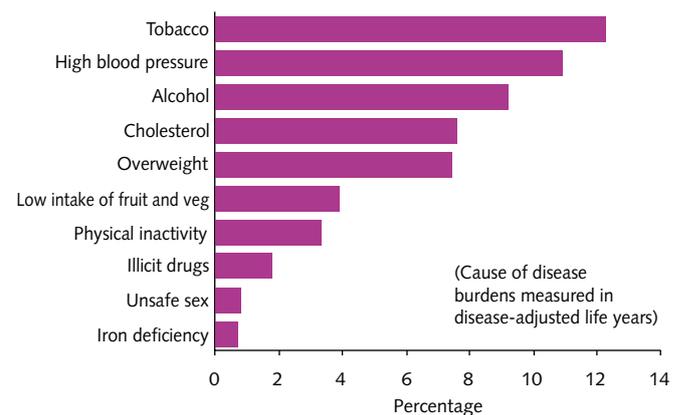
4.1 This chapter describes the work that the Government will do to support people to live healthier lives – especially in those areas where the wider influences on health give rise to specific lifestyles and behaviours that lead to health inequalities. It focuses on tobacco use, alcohol consumption and obesity and considers new programmes to support people in making healthier choices.

### The challenge

4.2 Many inequalities in health are a preventable consequence of the lives people lead – the behaviours and lifestyles that cause ill health and that relate to socio-economic factors.

4.3 If people smoke, consume more calories than they need or misuse alcohol, it has a long-term impact on their health. Behaviours associated with increased risks to health underlie the majority of the disease burden in developed countries (Figure 4.1).

**Figure 4.1: Major burden of disease – 10 leading risk factors in developed countries**



Source: The World Health Report 2002: Reducing risks, Promoting Healthy Life, World Health Organization.

4.4 If all types of health behaviours were distributed evenly across the population, this would itself be a major public health challenge. But they are not, which makes them a major driver of health inequalities. People in disadvantaged groups are more likely to smoke, are more likely to be obese (particularly women) and are more likely to drink alcohol at levels that increase risks to health. Within this group, there is a significant minority of people who have several risk factors, all of which work against their future health – for example, they drink heavily, smoke *and* have a poor diet.

4.5 The size of the challenge is significant. Merely providing more information is not enough to change behaviours that are intimately connected to the wider influences on health: where people are born, the lives they live and the

behaviours and social norms of their peers. All those who develop and deliver public services must become more skilled in the way that they deliver messages and, more broadly, helping people to adopt and maintain healthy behaviours, including early presentation to health services. The Government sets out what it will do on this in Chapter 5.

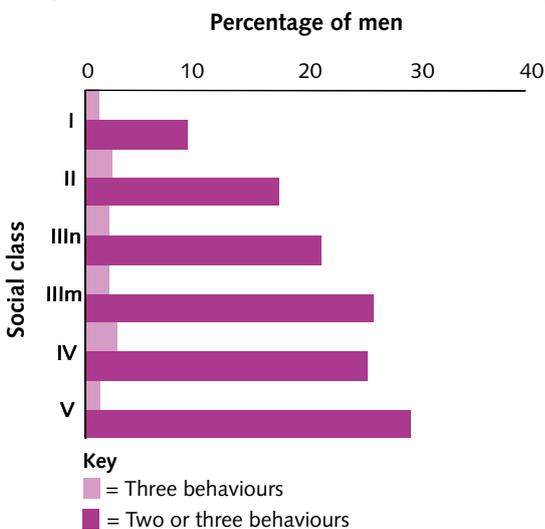
- 4.6 The challenge is to work with people and communities to help them to change their behaviour. This offers the prospect of dramatically reducing health inequalities in this country. It will not be easy and will only be accomplished with consistent and coherent policies over the long term. There

is a dual challenge: to help and support individuals directly, and to change the environments in which they make decisions so that the healthy decisions are the easiest to make, as the recent obesity strategy – *Healthy Weight, Healthy Lives* – makes clear.

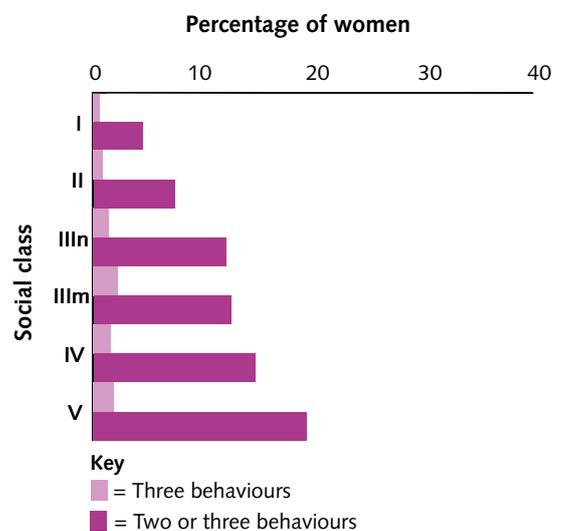
- 4.7 This chapter focuses on the three biggest lifestyle challenges facing the country because these are the areas where most can be done to tackle health inequalities. However, the Government will not restrict its focus to these three behaviours. As the programme of work develops over the next few years, there will be renewed emphasis on tackling the health inequalities

**Figure 4.2: Likelihood of lifestyle risk factors**

For males, 30% in social class V (most disadvantaged) have at least two or three high risk behaviours (smoking, harmful levels of alcohol consumption and poor diet) compared to <10% in social class I (least disadvantaged)



For females, 20% in social class V (most disadvantaged) have at least two or three high risk behaviours (smoking, harmful levels of alcohol consumption and poor diet) compared to <5% in social class I (least disadvantaged)



Source: Department of Health analysis of the *Health Survey for England 2003*

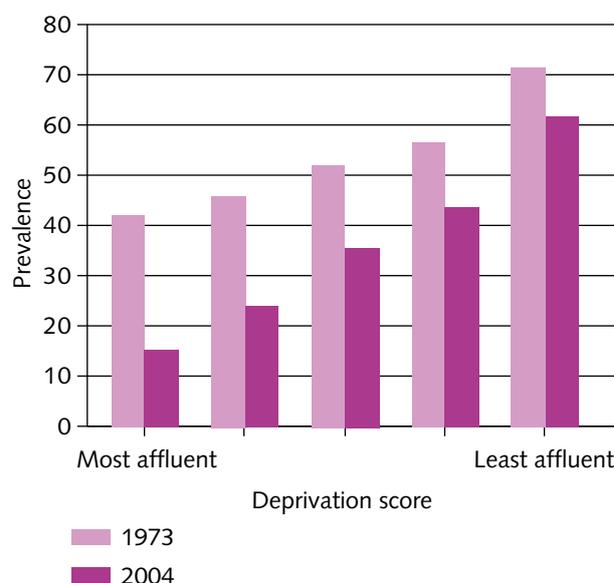
related to drug use and sexual health. The Sexual health and HIV Strategy identified that poor sexual health can have enormous health and economic consequences. A review of this strategy, to be published shortly, will include a focus on vulnerable groups. However, some key areas where more progress needs to be made have already been identified. In order to scale up activity this year, pilot sites will be identified to work with the NHS and voluntary sector; these will reduce undiagnosed HIV by further improving detection and diagnosis in a variety of settings; providing pump-priming funding in selected areas to invest in new information technology for community contraceptive services; and investing in condom distribution schemes for particularly vulnerable groups.

## Smoking

4.8 Smoking is responsible for one-sixth of all deaths in the UK. It kills half of all people who smoke. It is the area where behaviour change would make the greatest impact on health inequalities. With smoking, a clear divide remains between the most affluent and least affluent groups (Figure 4.3), and there are significant differences between the genders and different ethnic groups. Around 5% of Bangladeshi women smoke, compared with 25% of

Irish women and over 40% of Bangladeshi men.<sup>15</sup> The number of 11–15 year olds who smoke regularly (9%) has remained unchanged since 2003, but girls are more likely to smoke than boys.

**Figure 4.3: Cigarette smoking prevalence and deprivation in Great Britain**



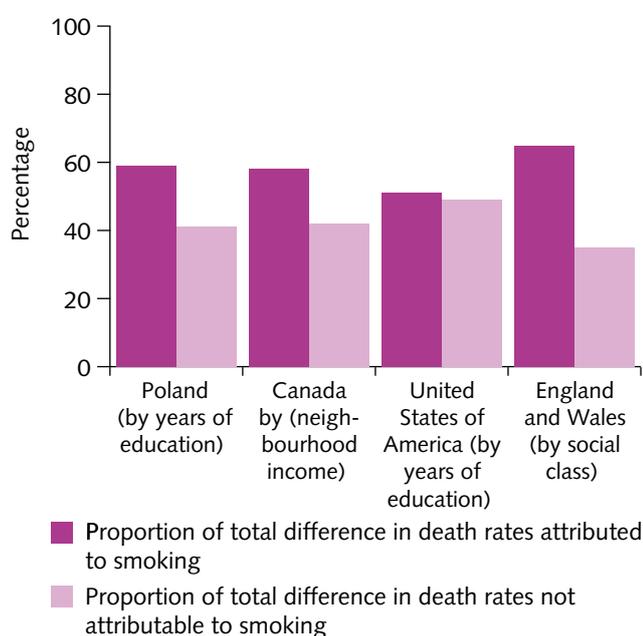
Source: Data from General Household Survey, 1973 and 2004

4.9 Research has shown that smoking is the main cause of differences in death rates in middle age across socio-economic groups.<sup>16</sup> In men, it accounts for 59% of social class differences in death rates between 35 and 69 years.

15 The Information Centre for Health and Social Care (2004) *Health Survey for England. Vol 1. The Health of Ethnic Minority Groups*

16 Jha, P. (2006) Social inequalities in male mortality, and in male mortality from smoking: indirect estimation from national death rates in England and Wales, Poland and North America. *The Lancet* 368 (9533) pp.367–370

**Figure 4.4 Male death rates attributed to smoking and not attributed to smoking (by social class, education or neighbourhood income)\***



\*Annual death rates per 1,000 men aged 35–69

Source: Data From Jha, P. (2006) et al: Social inequalities in male mortality, and in male mortality from smoking: indirect estimation from national death rates in England and Wales, Poland and North America. *The Lancet* 368 (9533) pp367–370.

4.10 Socially disadvantaged individuals are more likely to have grown up in a household with exposure to tobacco smoke at a young age and are more likely to become smokers and to start smoking at a very young age. Children who start to smoke at an early age are at a higher risk of progressing on to misusing other substances such as illicit drugs and alcohol. Someone who starts

smoking at the age of 15 is three times more likely to die of cancer due to smoking than someone who starts in their mid-20s.<sup>17</sup> Socially disadvantaged smokers consume more cigarettes per day and take in more nicotine and tar from each cigarette than less disadvantaged smokers.

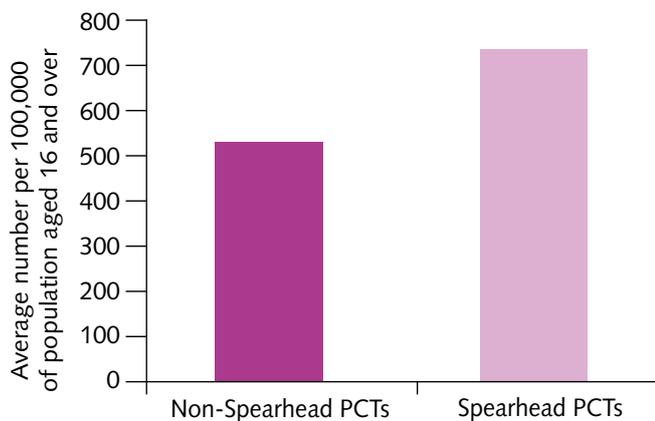
4.11 This explains why reducing smoking is such an important priority for government as whole and, in particular, for achieving the 2010 targets; reducing the socio-economic gradient in smoking is probably the single most effective thing the Government can do to reduce inequalities in health.

4.12 Since smoking kills one in every two people who smoke, the persistence of high smoking levels in the most disadvantaged and other groups is not acceptable, and the Government has already taken sustained action to tackle it.

4.13 Many smokers from disadvantaged groups want to quit smoking. The Department of Health has made a large investment in smoking cessation services and there is recent encouraging evidence that people from disadvantaged areas are as likely to quit using NHS smoking cessation services as others.

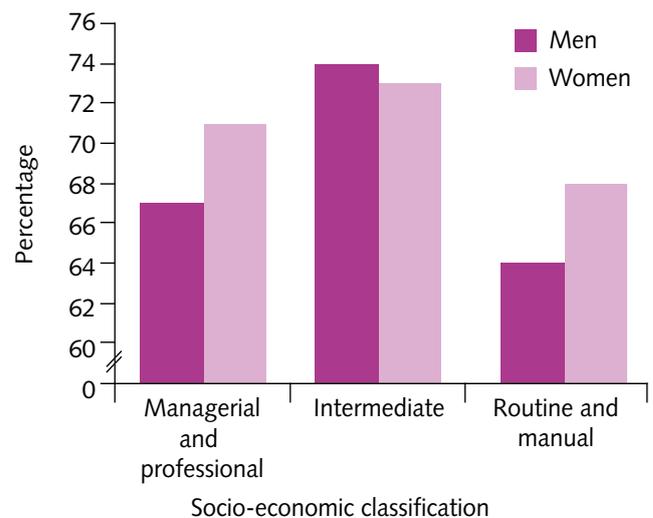
17 Department of Health (1998) *Smoking kills: A White Paper on Tobacco*, Cm4177. TSO

**Figure 4.5: Average number of people successfully quitting smoking by Spearhead and non-Spearhead primary care trusts (PCTs)**



Source: Information Centre for Health and Social Care.

**Figure 4.6: Proportion of smokers who would like to give up smoking altogether**



Source: Goddard, E. (2006) *Smoking and drinking among adults*, General Household Survey 2006, Office for National Statistics.

### Reducing smoking rates during pregnancy in Sunderland

Sunderland, with higher than average smoking rates, employed a midwife to set up smoking cessation services for pregnant women and their families. The service used social market research to develop an effective, user-friendly service. It provided brief advice training to all staff who come into contact with pregnant women and parents of young children, to encourage appropriate referrals and increase uptake. The Government's Sure Start Children's Centre programme funded a further specialist adviser (RGN) to work intensively within the Sunderland Sure Start areas.

All of this meant that Sunderland increased the number of non-smoking pregnant women from 62.1% (2004–05) to 76.7% (2006–07).

4.14 The Government will take further action to build upon this, including:

- developing a new national tobacco control strategy;
- consulting on the next steps in tobacco control, in order to help decide priorities for the new national tobacco control strategy; the consultation will seek new ideas and views on the best ways to reduce smoking rates and health inequalities caused by smoking, protect children and young people from tobacco, support smokers, including pregnant women, who want to quit and help those who cannot quit;
- implementing the new national tobacco marketing strategy, which is aimed at motivating routine and manual smokers to quit smoking and increase their chance of succeeding by using NHS Stop Smoking Services;
- making NHS Stop Smoking Services more accessible and effective and increasing their use in areas and among groups with high smoking rates;
- developing nationally accredited training for NHS Stop Smoking advisers and other healthcare professionals who support smokers to quit;
- supporting communities with the highest smoking rates to implement new multi-agency, community-based tobacco

control programmes; these will combine effective social marketing campaigns and more accessible smoking cessation support with action to reduce the number of young people who start smoking, to enforce legislation on underage sales of tobacco and reduce the availability of counterfeit and non-duty paid tobacco; and

- funding research into new ways to support smokers to quit, how to make smoking cessation more effective and other ways to reduce smoking prevalence.

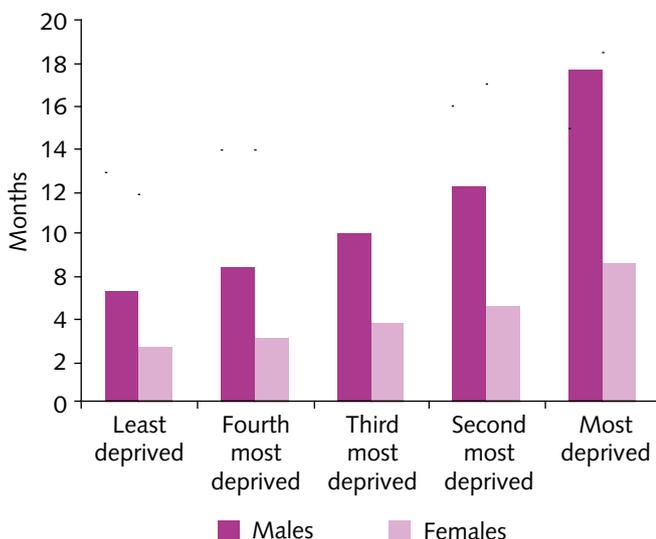
## Alcohol

4.15 There are between 15,000 and 22,000 alcohol-related deaths every year in England. Most of these deaths are premature: on average, every man in this group loses 20 and every woman 15 years of life compared with the average. The social pattern of problem drinking is complex, but disadvantaged communities do have higher levels of alcohol-related mortality, hospital admission, crime, absence from work, school exclusions, teenage pregnancy and road traffic accidents associated with greater levels of alcohol consumption. Within localities, individuals with greatest disadvantage – typically unemployed, low-income older smokers – have four to fifteen times greater alcohol-specific mortality and four

to ten times greater alcohol-specific admission to hospital than the most affluent.<sup>18</sup>

people<sup>19</sup> – another clear example of how directly the conditions in which people live affect health and well-being.

**Figure 4.7: Months of life lost to alcohol by Index of Multiple Deprivation (2004) quintile, England 2003–05**



Source: NorthWest Public Health Observatory, from Office for National Statistics mortality data and mid-year population estimates

4.16 Alcohol misuse also has significant generational effects. Around one million children live in families where one parent misuses alcohol. By the age of 15, young people in families with a parent who drinks at harmful levels have rates of psychiatric disorder between three and four times higher than other young

4.17 Benchmarking local information about the problems caused by alcohol is a key first step in designing intervention policies. The NorthWest Public Health Observatory has developed 'Local Alcohol Profiles for England', a web-based tool<sup>20</sup> that provides for each local authority a profile of deaths, hospital admissions, crimes and accidents related to alcohol. This gives local authorities, PCTs and other partners the information to assess local needs and plan services to reduce inequalities further while they develop Joint Strategic Needs Assessments and Local Area Agreements.

4.18 There is considerable national and international evidence for taking action to reduce the harm caused by alcohol misuse. Specialist alcohol treatment delivers the greatest short-term impact on admissions and mortality because it targets the patients at greatest risk of death or serious disease. Identification and brief advice deliver medium- and longer-term reductions in the kind of 'everyday' drinking that leads to coronary heart disease, liver disease and other problems.

18 North West Public Health Observatory (2007) *Indicators of Public Health in the English Regions 8. Alcohol*. Centre for Public Health, Liverpool John Moores University, 2007.

19 Lynskey MT, et al (1994) The effect of parental alcohol problems on rates of adolescent psychiatric disorders. *Addiction*; 89 pp.1277–1286.

20 [www.nwph.net/alcohol/lape/](http://www.nwph.net/alcohol/lape/)

Evidence shows that for every eight people who receive brief advice, one will change their drinking to within low-risk levels.

4.19 In order to accelerate progress, the Government will:

- implement a programme to reduce, and in time halt, the rise in alcohol-related admissions to hospitals through a coherent and effective set of actions at national and local level, such as health information and marketing campaigns, telephone helplines and websites, and providing training and support for key medical staff and NHS commissioners on how to improve identification of those who need support and provide more effective advice and treatment;
  - create an environment that helps to reduce alcohol-related harm, through cross-government action to:
    - make better use of licensing powers to tackle irresponsible practice within premises which sell alcohol
    - review the impact of the industry's own social responsibility standards
    - review the impact of alcohol pricing and promotion on harms (this will report in August 2008)
- consider further action, including legislation, depending on the outcome of these reviews;
  - support Spearhead areas by providing information, advice and training to local planners and commissioners on needs assessment and good practice, including:
    - using local alcohol data to identify areas of concern and develop services that reduce the harm and costs of alcohol misuse
    - setting up 'early implementer' projects to apply the findings from 52 'identification and brief advice' trailblazers currently under way, to establish how best to achieve NHS-wide implementation of identification and brief advice
    - how to reinforce NHS action through social marketing campaigns and wider community action to support tougher enforcement on underage sales, as well as sharpened criminal justice for drunken behaviour; and
  - sharpen our focus on tackling health inequalities; the Department will raise its level of ambition for the local areas with the highest rates of alcohol-related hospital admissions. In these areas, the National Support Team for Alcohol will provide in-depth analysis and direct support to 'turn around' local

performance within a short period of time. Earlier identification by GPs and during A&E attendance of people who drink too much, followed up by advice and, where needed, treatment, have been shown to be the best way of reducing alcohol-related hospital admissions. The first 5–10 areas covered in 2008–2009 will be able to bid for additional funding over each of the next three years to support these types of local improvements.

4.20 Alcohol treatment is the NHS intervention that has the most immediate impact on hospital admissions and deaths. Currently, access to specialist treatment varies greatly across the country, from 1 in 13 problem drinkers receiving specialist treatment in London, to 1 in 102 in the North East. The Government will consider further the need for the NHS to invest in specialist alcohol treatment centres to expand alcohol treatment to international standards.

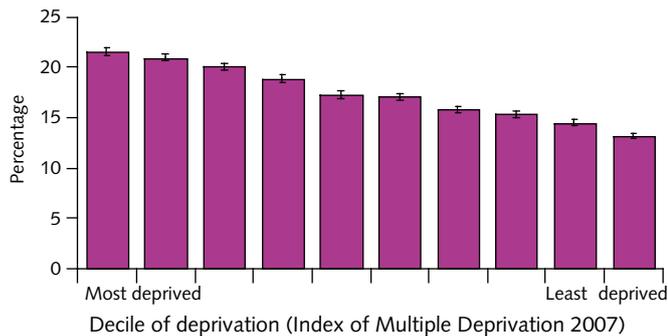
4.21 While the number of 11–15 year olds drinking in England has fallen in recent years, consumption rates among those who do drink have increased and are among the highest in Europe. The National Alcohol Strategy, *Safe. Sensible. Social.* includes a focus on young people and has been followed up by a youth alcohol action plan, published in June 2008 by the Department for Children, Schools and Families.

## Obesity

4.22 Obesity is one of the most important long-term challenges facing the nation's health. The post-war period has seen dramatic changes in the way we live: food is cheaper, more abundant and more convenient than ever; our working lives are physically far less demanding; and technological change has given us a wealth of new ways to entertain ourselves without physical activity. However, this success is increasingly coming at a cost. In England, two-thirds of adults and one-third of children are either overweight or obese, and without action this could rise to almost nine in ten adults and two-thirds of children by 2050.

4.23 Obesity in children has risen by almost 50% in England since 1997, and the country has the third-highest proportion of 13-year-olds who are obese, out of 35 developed countries. The biggest immediate risk factor is family lifestyle: in families where both parents are overweight or obese, children are six times more likely to be overweight or obese compared with children living with parents of a healthy weight. But behind this is a familiar pattern of child obesity rates being linked systematically to family income and socio-economic group.

**Figure 4.8: Prevalence of obesity in Year 6**



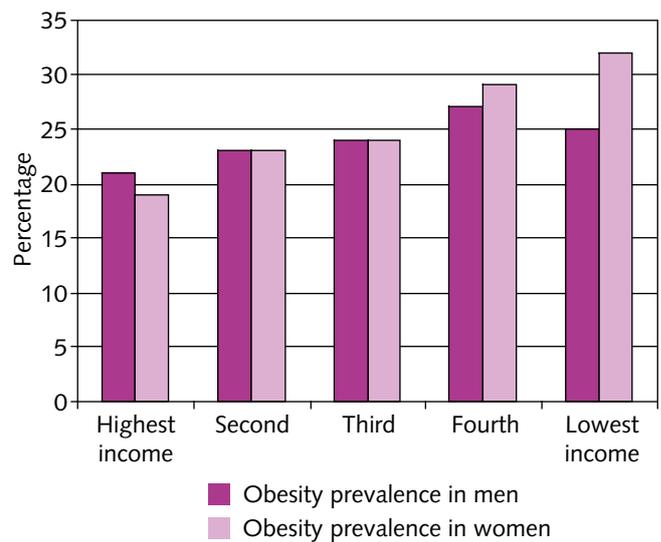
By Index of Multiple Deprivation (2007) score of the Lower Super Output Area of the child's school  
 Source: National Obesity Observatory. Data from National Child Measurement Programme 2006–07

4.24 Obesity presents huge future costs to individuals and wider society. Young, very obese men in their 20s or 30s could lose up to 13 years of their lives if they remain very obese, often by developing type-2 diabetes. Each year, up to one million cases of type-2 diabetes can be attributed to inactivity and obesity.

4.25 Obesity and its risks are not experienced equally across society. For adults, the gradient between socio-economic group and obesity is more pronounced for women than it is for men. This is true in England (Figure 4.9) and across Europe.<sup>21</sup> Reducing inequalities in adult obesity therefore means reducing obesity in women from routine and manual groups in particular. Similarly, people from particular communities face different

challenges. For example, there is evidence that shows that the prevalence of obesity is higher in Pakistani and Bangladeshi communities.

**Figure 4.9: Obesity prevalence in adults by equivalised household income quintile and gender**



Source: The Information Centre for Health and Social Care (2008) *The Health Survey for England 2006*

4.26 The Government has announced an investment of over £370 million in a strategy to halt and turn the tide of obesity in children and adults. *Healthy Weight, Healthy Lives* set out the Government's long-term plans for tackling obesity. A number of actions laid out in this strategy will focus on reducing health inequalities, including:

21 Cavelaars et al (1997) Socio-economic Differences in Risk Factors for Morbidity and Mortality in the European Community: an international comparison: *Journal of Health Psychology* 2: pp.353–372

- the promotion of fresh fruit and vegetables healthy options in convenience stores in Spearhead PCTs; a scheme will be launched in one of the English regions later this year, based on a successful project undertaken in Scotland that increased the amount of fruit and vegetables sold in neighbourhood stores across Scotland;
- focusing the major social marketing plan to combat obesity and overweight on at-risk families and communities, such as those from disadvantaged areas and certain ethnic groups; two of the target groups are based on clusters of people from lower socio-economic groups and other key groups include those from the Pakistani, Bangladeshi and Black African communities;
- the Healthy Start scheme (see Chapter 3) provides healthy food vouchers and vitamin supplements to low-income pregnant women and families with young children. The scheme provides nutritional support to half a million pregnant women and children under the age of four in low-income and disadvantaged families across the UK. This was rolled out across the UK from November 2006, and an evaluation strategy of its impact is being developed.

4.27 But it is important to go further still in both combating obesity and tackling health inequalities. So, in addition, the Government will test a 'full service' model

of local programmes and services, to both prevent and tackle child and adult overweight and obesity.

4.28 This 'full service' model will build on the focus on childhood set out in *Healthy Weight, Healthy Lives*, and will seek to ensure that all individuals and families have the information, support and services they need to make healthy decisions on food and activity, right from pregnancy through to old age. The Government will identify areas with the highest levels of child and adult obesity where the model will be tested, with the aim of halting, and potentially reducing, the prevalence of obesity in these areas. The model will include:

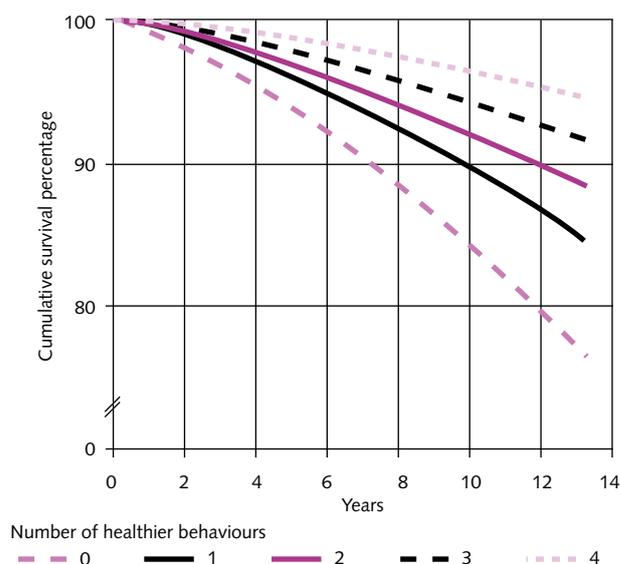
- enhanced support for children and families, including links to the introduction of the Baby Friendly Initiative in hospitals (see Chapter 3); continued support and training for staff in Sure Start Children's Centres to engage with parents on health, exercise and nutrition (building on the successful HENRY project); and a strengthened Healthy Schools programme in these areas, with a more intensive focus on encouraging healthy eating and ensuring that all children and young people achieve the recommended levels of physical activity;

- ensuring high rates of participation in the National Child Measurement Programme, and explore the automatic referral of families with at-risk children to a session with a healthcare professional, to fully assess their health status and agree on the next steps;
- information, incentives and greater local service provision supporting all adults to take healthier decisions on eating and activity. This could include local action promoting better nutritional information in all food settings; encouraging more walking, cycling, swimming and other forms of physical activity; and major workplace health initiatives. It would also encompass the testing of reward schemes that encourage healthy behaviours in those who are most at risk. For older people, the introduction of free swimming for those over 60 will promote healthy weight, provide weight-bearing exercise for those with arthritic conditions and have wider health benefits in relation to independent living in later life and the prevention of falls; and identification and provision of personalised support for the most at-risk adults. At the core of this, the Government will look at the opportunities for linking the new vascular risk assessment and management for 40–74-year-olds, to work with the NHS on the commissioning of and referral to both physical activity and adult weight management interventions.

### Multiple risk factors for poor health

4.29 Research following 20,000 people between 1993 and 2006 shows that those having four healthier behaviours (not smoking, drinking in moderation, not being physically inactive and a reasonable vitamin C consumption indicative of a good fruit and vegetable intake) had a mortality risk equivalent to being 14 years younger, compared with those with none of these good behaviours. Put simply, multiple poor behaviours multiply the health risks that people face (Figure 4.10).<sup>22</sup>

**Figure 4.10: Clustering of lifestyles and its impact on mortality**



22 Khaw K-T et al (2008) *Combined Impact of Health Behaviours and Mortality in Men and Women: The EPIC-Norfolk Prospective Population Study*, Public Library of Science 5(1)

4.30 There is also a clustering of 'risk conditions' in lower socio-economic groups. Therefore, support given to help individuals to change lifestyles must be developed in the context of the conditions in which people live their lives.

4.31 As Figure 4.2 shows, multiple poor lifestyle behaviours are more prevalent in groups from lower socio-economic groups. People with multiple behaviours that put their health at increased risk therefore need even more support than those with just one risky behaviour. If services can be targeted towards those at risk, there is a high potential return in terms of improved health and reduced health inequalities.

4.32 Engagement in community and family life can help people to remain independent into old age and overcome potential risk factors such as poverty. The Government will commission a broader research programme to understand the reasons why multiple health behaviours (good and bad) occur, what affects how hard it is to change these behaviours, and how to intervene effectively in order to help people make positive changes and reduce their risky behaviours.

4.33 Some people adopt several poor health behaviours in response to emotional and mental distress. Adverse childhood

experiences and living in a poor environment contribute to poor mental health and for some, excess eating, alcohol, drugs or tobacco are used to ameliorate mental health symptoms. Therefore, over the next year, the Department will set out a public mental health approach to promoting mental well-being to enable individuals and communities to develop healthy lifestyles.

### Health literacy

4.34 Health literacy represents the cognitive and social skills that determine the motivation and ability of individuals to gain access to, understand and use information in ways that promote and maintain good health. This means much more than transmitting information and developing skills to undertake basic tasks. It is also necessary to improve people's access to, and understanding of, health information and their capacity to use it effectively supports improved health.<sup>23</sup>

4.35 Recent research has demonstrated that the risk of poor health literacy is strongly linked to having low educational attainment and low general skills.<sup>24</sup> Health literacy is associated with other inequalities and is a factor that underpins health inequalities. For example:

<sup>23</sup> Kickbusch, I.S. (2001) 'Health literacy: Addressing the health and education divide' *Health Promotion International* 16, pp.289–297

<sup>24</sup> Hammond, C. and Feinstein, L. (2006) *Are those who flourished at school healthier adults?* Research Report 17, London: Centre for Research on the Wider Benefits of Learning

- the greater the health literacy of an individual, the greater the likelihood of eating at least five portions of fruit and vegetables a day, of being a non-smoker and of having good self-rated health; and
- high literacy is associated with understanding the symptoms of diabetes and the ability to control blood sugar.

4.36 Skilled for Health is a joint Department of Health/Department for Innovation, Universities and Skills programme that promotes literacy, language and numeracy and better understanding of health which helps parents to give their children the best start in life. The Government will extend the Skilled for Health programme to adults with poor basic skills whose health literacy and health status is likely to be poor. This programme has been developed and tested in a wide range of settings and sectors.

4.37 Additionally, the Government has a range of programmes which help individuals to embed health literacy from an early age. This includes improvements to school food, personal, social and health education (PSHE) lessons and the Healthy Schools programme.

4.38 The Department of Health will continue its work to develop a better understanding of how people view their own health, the behaviours that affect their health and

how they interact with health services. The Department will build its knowledge of how attitudes to risk differ between different population groups and how common factors may be found that will allow more effective targeting of policy initiatives. This will build on existing work to support a deeper understanding of how to engage effectively with different groups and communities. The Department will:

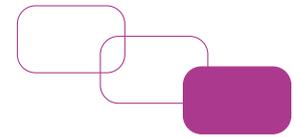
- enhance its work on social marketing, so that it communicates with people from all communities in ways and settings that are both meaningful and help individuals gain a better understanding of their own health;
- include a specific module on attitudes to health within the MORI 'real trends' survey and build on the Healthy Foundations large-scale research in order to create a more sophisticated understanding of people's behaviour and what motivates them to improve their health. Together, these work-streams will provide the insight required to target health improvement programmes and services in a way that is most appealing to those who need them most; and
- investigate where good practice, which drives better outcomes through partnership, is demonstrated at local level and draw on this to develop local or

national solutions that promote active engagement and collaboration with the public.

4.39 All these programmes to help people change the way they live their lives are important, but they will not be successful unless the right services are available to people when they are needed. This is not merely a question of location and opening hours. Services will only be effective when they are based on a thorough understanding of what people – especially the most disadvantaged people – want from services, and when they reach out to people in way which is appealing and feels relevant.

## 5. The services people use





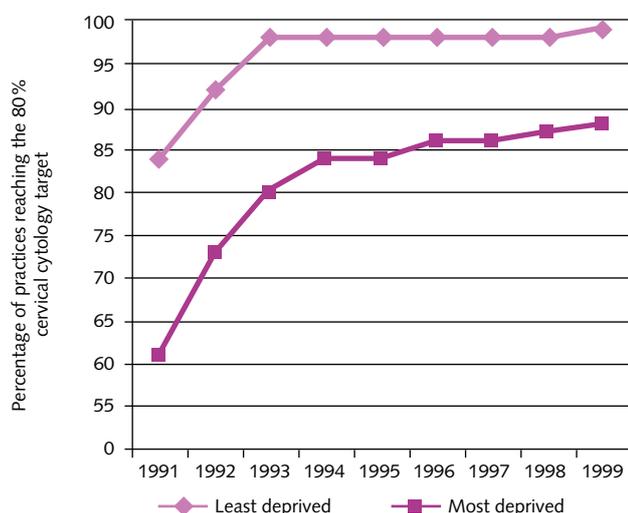
- 5.1 This chapter sets out action to make the health services that people use more focused on tackling health inequalities and more accessible and responsive to the needs of all the people that they serve. It focuses on the role of primary care; shaping services through commissioning in partnership; how services can more effectively reach out to different individuals and communities; and the need to promote equality through all NHS services.
- The challenge**
- 5.2 As the Government renews the focus on achieving the 2010 target, it is important that services – in particular the NHS – are designed and targeted so that they work effectively for the people who need them most.
- 5.3 NHS services have a crucial part to play in the delivery of the 2010 targets. People living in areas of disadvantage tend to receive less high-quality care and less preventative care than people in areas of relative affluence. For example, people living in areas of disadvantage present later with some forms of cancer.
- 5.4 These variations are not just associated with disadvantaged areas. They can reach right across society. People from black and minority ethnic groups have different experiences of, and outcomes from, care. For example, South Asian and black groups have two to five times higher prevalence of diabetes, yet receive poorer care, than white people.<sup>25</sup>
- 5.5 The NHS has an important role in delivering the targets on health inequalities yet, in some cases, the people most in need of healthcare have the most difficulty accessing it.
- 5.6 Action has already begun to tackle these issues, and Lord Darzi's NHS Next Stage Review will have more to say in this area. The challenge now is to build on the achievements so far and ensure that they are embedded in local systems and practice.
- 5.7 This chapter focuses on four areas where it is vital that progress is made. These are: using primary care to reduce health inequalities; commissioning services in partnership to reduce health inequalities; creating services which reach out to individuals, groups and communities in order to meet their needs; and using NHS services actively to promote equality.

<sup>25</sup> Department of Health (2001) *Health Survey for England 1999: The health of minority ethnic groups*, London, Department of Health

## The role of primary care services in reducing health inequalities

5.8 GP practices have already been highly effective at reducing health inequalities, in particular through improving access to specific services. For example, differences in uptake in cervical cytology rates closed markedly in the 1990s and GP practices are now routinely achieving the target of over 80% of eligible women having received a smear.

**Figure 5.1: The difference in cervical cytology uptake between deprived and affluent areas halved between 1991 and 1998<sup>26</sup>**



5.9 There is accumulating evidence that the Quality and Outcomes Framework shows a narrowing of achievement between GP practices in more and less disadvantaged

areas. Nonetheless, in England, better health outcomes are recorded where there are relatively more GPs per head of the population. This is supported by evidence from the USA which shows that access to primary care reduces the effects of poverty on self-reported health status.<sup>27</sup>

5.10 The NHS Next Stage Review *Interim Report*,<sup>28</sup> published last October, set out a number of proposals to provide more equitable access to GP services and to improve patient choice. These included bringing over 100 new practices into the 25% of primary care trusts (PCTs) with the fewest primary care clinicians and greatest health needs, and developing GP-led health centres in all PCTs. These new services will be paid for through a new £250 million access fund and PCTs will undertake open and transparent procurements during 2008–09. The Government expects the first new services to be seeing patients before Christmas 2008.

5.11 Practice Based Commissioning has a pivotal role, through GPs working with clinicians and other community partners to drive service improvement and innovation around the needs of individuals and communities. GP practices are at the frontline of delivering patient care and can use their significant knowledge of the local

26 National Primary Care Research and Development Centre (2007) *QOF spotlight* (November)

27 Shi, L. et al (2004) Primary Care Experience and Racial Disparities in Self Reported Health Status, *The Journal of the American Board of Family Practice* 17 pp.443–452

28 [www.dh.gov.uk/en/Healthcare/OurNHSourfuture/index.htm](http://www.dh.gov.uk/en/Healthcare/OurNHSourfuture/index.htm)

population to identify and target specific individuals or groups with particular needs and provide a stronger focus, working with appropriate community partners, on improving their health outcomes and well-being.

5.12 But there is more that primary care can do. As part of the work on the NHS Next Stage Review, the Department is developing a Primary and Community Care Strategy, which will set out how the Government can support the NHS and clinicians in achieving more personalised, integrated and better quality services within a more enabling environment created by the Government.

5.13 This will mean much closer collaboration between the NHS and local government, between different groups of clinicians in primary, community and specialist health services, and between health and well-being partners to develop more joined-up services. These will improve patient experience, especially for people with complex and multiple needs, but should also allow greater flexibility for the system to respond to individuals' needs. The strategy seeks to help the local NHS empower patients, so that they have more choice and control over the care they receive and have better information available on which to base decisions. The strategy further embeds a shift in focus for

### **Improving male life expectancy in Birmingham through primary care**

The Birmingham PCTs have worked through the Birmingham Health and Well-being Partnership, to use Local Area Agreement partnership funding to set up a cardiovascular disease prevention programme to help address their inequality gap in male life expectancy. Specific work includes:

- reviewing patient data to identify unregistered patients and those at high risk;
- targeted check up offers to high-risk patients in 12 priority wards;
- offering screening in community venues; and
- offering Heart MOTs in community pharmacies in target areas.

As at the end of April 2008, 21,197 people had been contacted and 7,097 people had attended screening sessions, of which 4,425 had high risk factors.

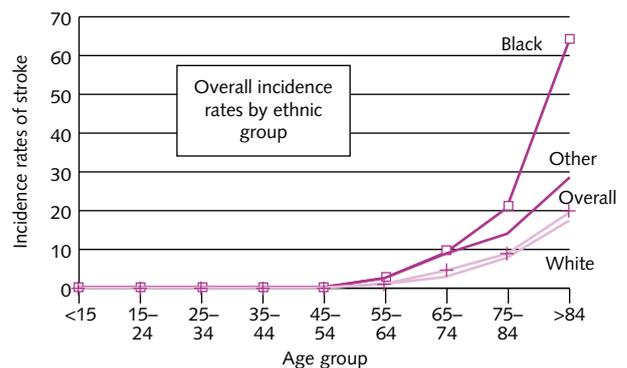
Improving uptake of vascular screening will be particularly beneficial to black and minority ethnic groups, for instance South Asian and African Caribbean groups, who can have higher rates of vascular disease.

local partners to continue to strive for healthier communities, built on a partnership between the individual and the services they access. And the strategy will set out how we can continue to drive up quality across the board, recognising the key role for commissioners, but also giving frontline clinicians more responsibility and accountability for the care they provide.

5.14 Primary care is becoming increasingly important, as the NHS moves from a system focused predominantly on treatment and cure to one that looks first to prevention. As an example, the Department is preparing to roll out the vascular checks programme to assess risk levels for vascular diseases.

5.15 Vascular disease includes coronary heart disease, stroke, diabetes and kidney disease. It currently affects the lives of over 4 million people in England and is responsible for a fifth of all hospital admissions. It is the largest single cause of long-term ill health and disability, impairing the quality of life for many people. The burden of these conditions falls disproportionately on people living in disadvantaged circumstances and on particular ethnic groups, such as South Asians. Vascular disease is strongly related to health inequalities.<sup>29</sup>

**Figure 5.2: Incidence rates of stroke**



Source: Wolfe, A. et al (2002) Incidence and case fatality rates of stroke subtypes in a multi-ethnic population: the South London Stroke Register. *J. Neurol. Neurosurg. Psychiatry*; 72; pp.211–216.

5.16 Enough is known about the risks of these diseases to be confident that a systematic assessment of risk of all people aged 40–74 would be clinically and cost effective. Coupled with advice, support and, if necessary, preventative medication, this has the potential to significantly reduce the premature death, disability and health inequalities caused by vascular conditions.

5.17 However, in developing this initiative the Department of Health has been acutely aware of the possibility that it could tend to increase health inequalities rather than tackle them – if, for example, it appealed more to people already motivated to take care of their own health, or simply to those seeking reassurance rather than those with higher levels of risk.

29 Chaturvedi, N. (2003) Ethnic differences in cardiovascular disease. *Heart* 89 (6) pp.681–686

5.18 The Department is currently working with those who will be responsible for delivering the checks and with other stakeholders (for example those in the third sector) to design a delivery programme that is aimed at ensuring that those groups most likely to benefit from risk assessment and active risk management are sought out and included in this programme. This will be achieved, in part, through support from the Improvement Foundation and the experience of the National Support Team for Health Inequalities, referred to in Chapter 2.

5.19 One aspect of prevention that is often overlooked is the strain that caring can place on peoples' health – particularly if they are already facing other disadvantages such as poverty, isolation and unsuitable accommodation. The Prime Minister will publish a strategy on supporting carers in summer 2008, which will set out how the Government will increase support to the carers who are most vulnerable to health inequalities, including young carers. The strategy will include a number of targeted measures to address some of the issues raised by carers during the recent consultation, including:

- greater provision of planned breaks;
- increased support for young carers in inappropriate caring roles; and

- increasing professional awareness of the problems associated with caring, particularly in terms of the pressures that caring can place on the mental and physical health of the carer.

### Commissioning in partnership

5.20 PCTs – especially in their role as commissioners – are the most powerful agent to reduce health inequalities. The Government expects PCTs to:

- commission services based on evidence of need, not historical patterns of spend, and to performance manage contracts with providers and develop new provision accordingly;
- work with GPs, pharmacists, dentists and optometrists to ensure that primary care services reflect the needs of – and reach out to – people in relatively disadvantaged groups;
- commission and develop community health services in ways that are responsive to the needs of people in disadvantaged groups;
- act as local leaders on health inequalities, bringing together all the different local organisations – such as local authorities and all the partners in Children's Trusts – that can make a difference; and

- support and supplement the new regulatory system, by using information intelligently to identify services which are not reducing health inequalities.

5.21 Commissioning is a crucial function within the reformed NHS. However, it is one which is widely acknowledged to be in need of further development. The Department of Health and NHS programme of World Class Commissioning (WCC) is now advancing rapidly and aims to transform dramatically the way health and care services are commissioned. The Department has already set out the vision for World Class Commissioning including the competencies of a world class organisation. Patient engagement and greater clinical involvement are key throughout the commissioning process. Increased clinical and patient input will ensure that services are more closely designed to meet patient needs. By encouraging new services and providers, and promoting greater choice, world class commissioning will open up new opportunities for innovative local care solutions – centred around the needs of the patient. By further strengthening relationships between key local partners such as PCTs and local authorities, commissioning will ensure better links between different aspects of patient care, ensuring the provision of highly personalised and effective care packages.

5.22 As part of the World Class Commissioning programme, the Department is now developing a commissioning assurance system to hold commissioners to account, to reward performance and development and to ensure that health outcomes are improving. This will build upon the WCC competencies and vision to provide more specific and focused commissioning support that will accelerate the delivery of this strategy. To support the development of WCC, SHAs are leading on making support and development resources available to PCTs. In addition, the Department of Health is developing a national framework for Board development which will be available for all PCTs by the end of August. The WCC system will be fully operational by 2009, with assessment of PCTs starting from the autumn of 2008.

5.23 But local partners often need tools and support to help them deliver on their responsibilities. The Department will invest further in the National Support Team and IDeA programmes (see Chapter 2) so that their expertise can be rolled out to more areas. The Health Inequalities Intervention Tool now covers all local authorities. In addition, the Government will put in place a wider programme of work, with the aim of creating sustainable local systems that can systematically address health inequalities. The Government will:

- In partnership with the SHAs, the wider service, and via public service improvement agencies, develop ongoing support for commissioning to tackle the immediate and wider determinants of health inequalities, both within and across communities.
- work across departments to consider how investment in improvement systems can most efficiently support local change. Strategic Health Authorities and Regional Improvement and Efficiency Partnerships (RIEPs), alongside Department for Children, Schools and Families investment in children's commissioners, will develop support for commissioning skills. The Department of Health will also work with Communities and Local Government (CLG) through the National Improvement and Efficiency Strategy;
- consider how Health Impact Assessments can be used more systematically and consistently. The Government expects this to be done at national policy level, for particular projects, for Local Area Agreements and as part of the World Class Commissioning process to ensure that the impact on health inequalities is rigorously assessed. The Government will improve the way these assessments are carried out by providing access to modelling tools which help to predict the potential impacts of various actions

on life expectancy and the burden of disease, as well as providing easy access to the evidence base through the Public Health Desktop and other support for carrying out these assessments; and

- develop the SHAPE (Strategic Health Asset Planning and Evaluation) application to provide further analysis of demographics, including public health data, and clinical analysis, including disease incidence by geographical location. This will further help to underpin local health inequalities strategies.

### Empowering individuals

5.24 In the past, the NHS expected people to use services if they needed them. As set out in Chapter 4, some people find it more difficult to access appropriate services than others. The Department of Health will work with local health services and communities to ensure that the improvements in primary care, screening and other areas reach the people who need them most.

5.25 There are a number of ways to reach out to different groups and communities and techniques and programmes must be carefully geared to their needs. Chapter 3 described action to engage with people through their work. Chapter 4 set out proposals for improving health literacy – the capability of individuals to understand

their own health needs and the actions they need to take to look after their own and their family's health. This section sets out how Health Trainers and, more generally, the use of social marketing techniques can be used to make sure that services reach people who are most disadvantaged.

5.26 Health Trainers reach out to people who are in circumstances that put them at a greater risk of poor health. They work with them to assess their health and lifestyle risks, helping to build their motivation to change. They have facilitated behaviour change and provided advice, motivation and practical support to individuals in their local communities since

2006, initially in Spearhead areas and now right across the country. The programme is an excellent example of national strategy, local delivery and partnership working.

5.27 There is already evidence that Health Trainers can have a significant impact at the local level on disadvantaged groups and individuals. The Department of Health will:

- roll out Health Trainers to every community, and extend their reach with an additional network of health champions who will operate as an outreach team, facilitating uptake of Health Trainer services and other interventions, as appropriate;

### **Building community capacity for health through Health Trainers**

Health Trainers help improve the lifestyle of the clients they work with. The trainers provide people with:

- clear, up-to-date information about lifestyle and health, including what might affect their health and well-being;
- help to identify things to improve their health and well-being;
- help to identify services and people who might be able to help them, by signposting or referring on to appropriate services;
- opportunities to develop their knowledge and skills about health and well-being by enabling access to information, advice and support; and
- help to identify how their way of life might affect their health and well-being and help them to make the changes they want to.

All of this helps improve the client's health and general well-being.

- explore how Health Trainer programmes can develop in new settings such as Jobcentre Plus offices, hospitals and Sure Start Children's Centres;
- explore the potential for extending the reach of health trainers with children and young people and beyond working-age adults; and
- continue building the evidence base to ensure that the programme has the maximum impact on reducing health inequalities.

5.28 People are more likely to change their behaviour if they recognise the benefits and they choose to change voluntarily. The Department knows that:

- multiple approaches work better than single interventions;
- using intermediaries or partners builds trust – as people can often be distrustful of messages from the Government; and
- greater acceptance is key – by adapting the message to the audience and targeting information and messages in ways people want to receive them they are more likely to take action.

## Engaging communities

5.29 The NHS cannot reduce health inequalities on its own. The place-shaping and community empowerment agenda that was set out in the Local Government White Paper *Strong and Prosperous Communities*<sup>30</sup> challenges the NHS to invest, with local authority partners, in longer-term programmes that will transform people's lives, and ultimately their health. Health services are frequently in touch with those at greatest future risk of poor health and other types of disadvantage and can use this contact to help people to navigate the wider services that help them lead healthier and less risky lives.

5.30 Third sector organisations are particularly well placed to engage with those that are hardest to reach. They are often founded and run by people with direct experience of a particular need or disadvantage which allows them to reach out to others more effectively. This gives them a special understanding of, and commitment to, the needs of the community which makes them very effective partners in the delivery of health and care services.

<sup>30</sup> Department for Community and Local Government (2006) *Strong and Prosperous Communities: The Local Government White Paper*, TSO

## LINKs

A new system of Local Involvement Networks (LINKs) began to be established in April 2008 – supported by £84 million in funding over the next three years. Introduced as part of the Local Government and Public Involvement in Health Act 2007, the same legislation also abolished Patients' Forums.

Because LINKs are open to local voluntary and community groups, they provide an opportunity for the third sector to play a much greater role in the decisions that shape care and treatment. LINKs will help local organisations get attention for neglected issues, maximise the impact of their efforts, influence those who make decisions about new or existing services and help the community speak with a stronger local voice.

5.31 One of the strengths of third sector organisations is their ability to respond flexibly to circumstances and to change the way they operate to tailor their services to users' needs. They are also able to cut across traditional boundaries to provide a joined-up service to people with varied or complex needs. Their strength at a local level to work within the community and engage with individuals and statutory organisations for the benefit of individuals cannot be underestimated. For example, third sector organisations have been very effective at working together with mental health Community Development Workers at a local level and with members of black and minority ethnic communities to improve awareness of mental health issues, break down barriers and improve take-up of services at an earlier stage.

5.32 The Empowerment White Paper to be published by Communities and Local Government later this year, will emphasise

the Government's commitment to ensuring that local people have more power over their lives. It will give people a greater say over local services and a part to play in their local communities – empowering citizens in areas that really matter to them such as housing, health, crime and anti-social behaviour – and will promote work, enterprise and citizenship, and revive civic society. The White Paper will empower citizens and users by increasing local accountability: giving more power and influence to citizens and communities; enabling clear routes to influence services; and utilising existing networks such as LINKs to support and mobilise engagement.

5.33 Alongside this, the Government will invest in support for voluntary and community sector organisations to develop community engagement programmes which the NHS and social care can use to improve their own engagement with local communities.

## Making services equitable

5.34 The founding principles of the NHS is to provide healthcare to all, irrespective of race, gender, religious beliefs, age, sexual orientation, disability, socio-economic or other grounds. However, it has not necessarily recognised the greater health need of individuals who suffer disadvantage on these grounds or been proactive in promoting its services to these groups.

5.35 This is changing, as equality legislation enacted over recent years means that all individuals and population groups should have equal opportunity to benefit from health services. For instance:

- care should be accessible in line with people's need;
- people's experience of care should be equally good; and

### Cheshire and Merseyside Partnerships for Health (ChaMPs)

ChaMPs Public Health Network produced *Top tips for healthier hospitals* to encourage and support acute, specialist and mental health NHS trusts in Cheshire and Merseyside to make a positive contribution to improving public health.

*Top tips for healthier hospitals* was the first in a series designed to support partners in focusing on the actions they can take to improve health, and has been modelled on *10 High Impact Changes for service improvement and delivery: A guide for NHS leaders*.

*Top tips* draws together evidence, national policy and targets with examples of local good practice. It aims to highlight the important impacts that factors like diet, alcohol misuse, and poor mental health and well-being can have on hospital services.

There are practical suggestions for effective interventions in each priority area for both patients and staff: smoking cessation services and a smoke-free environment; healthy eating; physical activity; sensible drinking of alcohol; improving mental health and well-being; and sexual health.

To improve mental health and well-being, Southport and Ormskirk Hospital NHS Trust developed a staff charter that aims to embed their dignity at work ethos. In setting up a staff counselling service and a confidential medication service the Trust is supporting staff to deal with conflict. The occupational health service works closely with Human Resources and staff to offer support and assistance in the management of sickness absence, and in the development of flexible working policies in the Trust. ([www.nwph.net/champs/publications](http://www.nwph.net/champs/publications))

- the care that individuals and different communities receive should be of equal quality.

5.36 In line with the recognition that work is an important aspect of people's lives that can improve health, the Department of Health is developing a work programme to increase the number of adults with mental health problems and learning disabilities in the NHS workforce by March 2011. As well as increasing the numbers employed, this work programme will also seek to ensure that systems and processes are in place to sustain delivery beyond March 2011. There is good practice in the NHS and this will be identified and shared and their positive experiences built on through engagement with key stakeholders.

5.37 Although there is no corresponding legal duty regarding age equality, it is important that the needs of older people are not overlooked. As a first response to this, the Department will develop a prevention package for older people, as announced recently, that sets out national service entitlements for older people aimed at improving their health and quality of life, through improving the awareness and uptake of services by older people.

5.38 The services available – and truly accessible – to people can make a real difference to health inequalities. But unless the commissioners of services are working with an empowered community and with

the right systems and incentives, they will find it difficult to create these services. That is why the next chapter focuses on empowering people to influence their local services, and creating systems and incentives which drive commissioners to shape services in a way which reduces health inequalities.



## 6. Meeting the future challenges



6.1 This chapter sets out what will be done to embed a continual focus on health inequalities across the Department of Health, wider government and the local NHS, health and social care system and partners. It considers what needs to be done to build a sustainable local system and what further support is needed for local partners. Finally, the chapter sets out the further work that needs to be done to build a consensus on what should happen after 2010.

### The challenge for 2010

6.2 Over the last decade there have been strong and consistent threads in health policy of giving people more choice and say over the services they receive; of local commissioners taking responsibility for meeting the needs of their citizens; of greater freedom for services to meet the needs of individuals, and building empowered and resilient communities.

6.3 As Chapter 2 has shown, there have been significant improvements in the health of the population nationally, but closing the gap between the most disadvantaged communities and society as a whole remains a challenge. It requires a systematic and sustained approach from all partners.

6.4 The strategic challenge for 2010 is to consolidate the learning and gains from our current approach, with a focus on scaling

up the tools that will achieve this. This document has set out how the Government will strengthen support to local areas so that this challenge can be met.

6.5 Many of the tools and structures are now in place, such as Joint Strategic Needs Assessments, Local Strategic Partnerships and Local Area Agreements. National Support Teams are being scaled up and local areas will be expected to use the improvement architecture detailed in the National Improvement and Efficiency Strategy to develop systems of effective leadership to drive and support change.

6.6 Local partnerships across the country have seized upon the health inequalities issue and are making significant progress on improving the health of their more disadvantaged communities. This is true for communities with Spearheads but also those without. For example, the four SHAs without Spearheads have all made commitments to actions that will reduce health inequalities in their NHS Next Stage Review vision documents.

### Non-Spearhead SHA Strategic Visions for Health Inequalities

- **South Central SHA** has committed to delivering better health for everyone, to achieve a level of health in 2018 that is at least as good as that in any region in Europe. It will achieve this through reducing inequalities for instance by increasing formal screening and vaccination programmes, particularly for those groups likely to benefit most and expanding occupational health services, including a service provided in primary care to support rehabilitation back to work. Care pathways will include referral to occupational health services for rehabilitation back to work.
- In **East of England SHA** each PCT, working with partners, will be required to reduce the difference in life expectancy between the poorest 20% of communities and the average in each PCT through a programme of social marketing and interventions including smoking cessation, physical activity, antenatal care and early years support, sexual health services, alcohol harm reduction, and population screening. In addition, the number of smokers will be cut by 140,000 and PCTs and their local partners will have to focus on reducing the prevalence of smoking in the most deprived areas and population groups.
- **South-West SHA** aims to reduce the current gap in life expectancy between the worst and best areas in the South West by one third and to reduce smoking levels to equal the best in Europe by 2013 whilst reducing the prevalence of smoking in manual groups to that of the non-manual group. It will also ensure that uptake rates for breast and cervical screening of at least 80% in all its local communities and halt the rise in hospital admissions for alcohol-related harm, and achieve a downward trend by 2013.
- **South-East SHA's** Health Inequalities Strategy 2008–11 seeks to raise life expectancy for the most socially disadvantaged by 18 months and within PCTs to reduce the life expectancy gap between the lowest and highest by 10% and will reduce the inequalities and social exclusion that are both a cause and effect of mental illness.

## The strategic challenge beyond 2010

6.7 Now is the right time to build a sustainable system and prepare for the future with a rigorous focus on reducing health inequalities across all areas of Government and at every level, from national to neighbourhood. This will be achieved through:

- further enhancing the tools, incentives, accountabilities and leadership required to reduce health inequalities;
- building and making the evidence base widely available;
- ensuring that all communities focus on reducing health inequalities;
- setting a new objective for post-2010; and
- working more closely across government level on reducing inequalities in health.

## Getting the system right – levers, tools and incentives

6.8 Public services are moving from silo-working to working in partnership to meet the challenges that can only be effectively tackled by coherent actions across government and society as a whole. Health inequalities are one of these key challenges. To meet it means bringing together the right levers, tools and

incentives to create a public service system that acts to drive down health inequalities. Action will be focused on four areas:

- the local performance framework – including Operational Plans, Local Area Agreements and Joint Strategic Needs Assessment, creating the foundations for stronger commissioning;
- tools and support – including investment in improvement systems, support for commissioners and strengthening the health inequalities element of health impact assessment;
- ensuring that financial allocations are more transparently related to health inequalities and improving and aligning formulae that direct resources with the metrics that measure health inequalities locally; and
- developing the leadership and workforce to deliver locally.

6.9 Earlier chapters have set out the potential of the new local performance framework, commissioning, tools and support. The new performance framework is a key landmark in moving towards greater partnership working between health, local authorities and other partners such as Children's Trusts.

- 6.10 Research by the Health Services Management Centre<sup>31</sup> reports good progress on Joint Strategic Needs Assessment in the first year. Implemented correctly, it can give a voice to those who are seldom heard and to those with greatest need, helping to raise community aspirations for improvement. Chapter 5 has spelt out how World Class Commissioning, in partnership with local authorities and others, will be the key lever to turn these community-focused plans into action.
- 6.11 The Department of Health's NHS Vital Signs are the key performance indicators of the NHS. These will be developed so that they can be analysed by socio-economic group, ethnicity and other dimensions of inequality. These will be increasingly important over time, ensuring that the data used in holding commissioners and providers to account are appropriately designed for different population groups, as part of the wider commitment to equality.
- 6.12 To support the healthcare system to deliver reductions in health inequalities, it is important that PCT financial allocations reflect local need. The Department asked its Advisory Committee on Resource Allocation (ACRA) to consider how best to reflect health inequalities within their work. ACRA have recommended, and the Department has accepted, a separate health inequalities formula to guide PCT allocations in 2009–10 and 2010–11. This will make adjustments to allocations much more transparent. ACRA and the Department will continue to work together to ensure that communities facing the greatest challenges receive a fair share of resources.
- 6.13 There is enormous enthusiasm for tackling health inequalities locally: health inequalities are at the centre of SHA strategic visions that have recently been published as part of the NHS Next Stage Review. Leaders at all levels of public service must challenge the system to shift from meeting historical demand to a more dynamic approach based upon identifying and addressing need and the wider influences on people's lives. Local authorities and PCTs must offer the least able in society the chance to achieve the health outcomes that everyone should expect.
- 6.14 The capacity, capability and roles of the health inequalities workforce need to be maximised if health inequalities are to be tackled. The Department of Health will therefore undertake a review of the future requirements of the health inequalities workforce and leadership.

31 Ellins, J. and Glasby, J. (2008) *Implementing Joint Strategic Needs Assessment: pitfalls, possibilities and progress* Health Services Management Centre; University of Birmingham

## Building the evidence base

6.15 A system with better partnership working and the incentives to reduce health inequalities needs much stronger and more widely available evidence to underpin its actions.

6.16 The Department will:

- continue to invest in evidence both through the National Institute of Health Research National Programmes and the Policy Research Programme, and also through collaborations with other funders – for example the National Prevention Research Initiative and the UK Clinical Research Collaboration's Public Health Centres of Excellence;
- ensure that NICE public health guidance will cover many important new areas of relevance to health inequalities, including better health in the workplace, preventing smoking in children and reducing preventable mortality from heart disease in disadvantaged groups; and
- ensure that from later this year, the Public Health Desktop provides easy access to the data and growing evidence base on health inequalities.

6.17 The Government will further build on the current evidence by:

- developing a mechanism to systematically pool evidence locally and from across the world to examine what works in reducing health inequalities. The Government will work with international partners to better understand what works and to influence the international agenda to shape the global forces that impact on inequalities;
- building on the step change in research and development activity and the increase in funding for research on health inequalities that have taken place since the publication of *Choosing Health*.<sup>32</sup> The Government will identify priorities for future funding by mapping key existing research and development investments across the policy framework, and exploring how to address the priority gaps that emerge; and
- reviewing how health inequalities data can be presented and disseminated more effectively to both the public and local services.

32 Department of Health (2004) *Choosing Health: Making healthy choices easier*. Cm 6374

## Health inequalities as a focus for all

6.18 The Spearhead approach – focusing effort on the most disadvantaged communities – was clearly the right place to start. But, as more has been learnt about what works, and the Government seeks to meet the challenges of conditions such as obesity, which are spread throughout our society, it is clear that over the next few years all areas must continue to focus on and prepare to tackle health inequalities within their own communities. This will be an extension of the current approach of reducing the inequalities in health between communities.

6.19 Given the current target only lasts until 2010, it is also important to refresh the strategic objective for reducing health inequalities. The current targets have been very successful in creating momentum and innovation to reduce health inequalities. This has been exceptionally valuable. With the right tools, levers, evidence and learning in place, there is now an opportunity to go further. Health services will work in partnership to tackle health inequalities across the country with a focus on quality of life, as well as on mortality and length of life addressing health inequalities across the spectrum as well as continuing to focus on the most disadvantaged. To do this, the Government aims to develop an objective post-2010 that:

- maintains a focus on the areas with the highest infant mortality and lowest life expectancy but which is also relevant to the populations of all PCTs and local authorities as a whole;
- reflects the quality of life as well as years of life; and
- captures changes across the gradient of health inequalities, in all communities.

6.20 The work of developing this objective will be led by Sir Michael Marmot. To support this, the Department of Health will:

- commission a review of the progress since the Acheson Inquiry that will include an assessment of policy against the best global evidence;
- carry out this work with a wide range of partners, including other government departments, local organisations, professionals and academics; and
- determine what objective, metrics and levers the Government should develop for the period after 2010.

## Working more closely at government level

6.21 It is clear that the Department of Health and the NHS cannot reduce health inequalities in isolation from other public services. The *Programme for Action* provided a good model that improved the

coherence of Government programmes and the new duties around Joint Strategic Needs Assessments and the development of Local Area Agreements and Local Strategic Partnerships have made it easier to deliver jointly designed and jointly provided public services.

#### 6.22 The Department will lead work across government to:

- commission work to promote more effective working across organisations and institutions to tackle multiple problems. Getting the right incentives for organisations so that they feel able to invest in programmes where the benefit is realised elsewhere or many years later is a longstanding challenge for government. For example, the Government knows that investment in early years has a lifetime beneficial impact across health, employment and criminal justice, but the incentives for additional investment are not always easy to discern. Given the multiple factors that drive health inequalities, the Department of Health will lead joint work to develop incentives and levers that encourage organisations to work together;
- work with the Government Offices, SHAs and Regional Improvement and Efficiency Partnerships (RIEPs), to use the Vital Signs and Local Area Agreement process and wider

intelligence to target improvement support in areas that need it, including those outside the current Spearhead areas. The role of SHAs and RIEPs will be central to this work;

- ensure that the cross-government mandatory impact assessment, which includes health impact assessment, is strengthened by emphasising the importance of considering health inequalities, so that the impact of cross-government policies on health inequalities are further understood and taken into account in policy-making;
- develop the case for a future coherent and consistent Public Service Agreement (PSA) and funding strategy for the reduction of health inequalities, ensuring that accountabilities are joint and clear. Given the importance of wider programmes in tackling health inequalities, it is sensible that the Government considers, across the board, where investment will make the greatest impact. The Government will aim to maximise the impact of investment, not only on health inequalities and on wider inequalities too;
- develop a joint approach to accountability for any further PSA. The Department of Health can support the NHS to improve the way it commissions, designs and delivers services, but the causes of health inequalities lie in the

circumstances of people's lives and their lifestyles. For a future PSA to be delivered successfully, the accountability structures need to take into account the multiple factors that drive health inequalities. Sustained improvement in health inequalities will be achieved through joint accountability; and

- work with the Audit Commission and other inspectorates to implement Comprehensive Area Assessment (CAA), which will provide the first independent assessment of the prospects for local areas and the quality of life for people living there. With health and well-being, reducing inequalities and discriminatory outcomes for all members of the community central to CAA, it will build on the improvement in councils stimulated by CAA to drive better outcomes for people by supporting improvement priorities in local area agreements.

## The future

6.23 As the 2010 target nears, it is appropriate to look back and review what has been learned so far. Three things stand out most clearly:

- health inequalities are a complex, deep and stubborn problem; but
- significant progress has been made and now is the time to consolidate this and be more ambitious still; and
- it is important to build on the genuine commitment and enthusiasm across society, to create a society that is fairer and healthier for everyone.

6.24 Each chapter has reviewed the issues and challenges at the heart of the problem. A pattern emerges that helps to explain this problem's persistence. Self-perpetuating cycles exist between poor health and the wider influences on health; poor health and the lives people lead; and poor health and the services people use. Everything in this document, and the work that must now follow, is geared toward breaking this pattern.









© Crown copyright 2008

288271 1p 1.500 June 08 (CWP)

Produced by COI for the Department of Health

If you require further copies of this title visit

**[www.orderline.dh.gov.uk](http://www.orderline.dh.gov.uk)** and quote:

28271/*Health Inequalities: Progress and Next Steps* or write to:

DH Publications Orderline

PO Box 777

London SE1 6XH

**E-mail: [dh@prolog.uk.com](mailto:dh@prolog.uk.com)**

Tel: 0300 123 1002

Fax: 01623 724 524

Minicom: 0300 123 1003 (8am to 6pm, Monday to Friday)

[www.dh.gov.uk/publications](http://www.dh.gov.uk/publications)



**50% recycled**  
This is printed on  
50% recycled paper