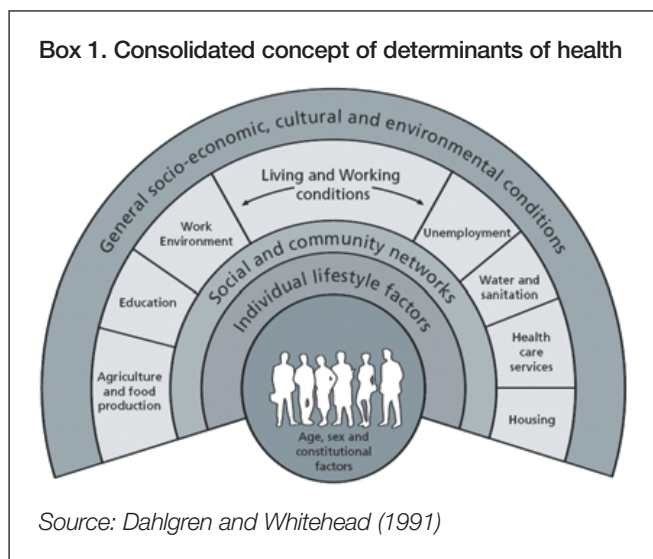


2. Inequalities and Health Policy

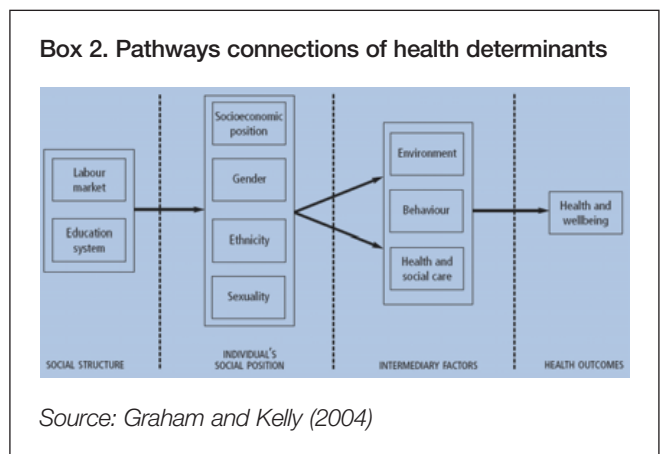
2.1 Understanding Health Inequalities

A clear understanding of health inequalities is paramount for the development of policies and interventions that support all sections of society, as well as directing services, treatment and care in proportion to need. Two pivotal independent UK health inquiries, the Acheson⁹ and Black¹⁰ reports, helped generate extensive debate on inequalities in health, informing policy and action. Socio-economic models of health and inequalities are widely used by Public Health practitioners¹¹. For example, Dahlgren and Whitehead¹² developed a framework that identifies how a range of different factors can impact on personal and community health (Box 1). Whilst an individual has no control over his or her age, sex and genetics, wider determinants of health can effect the likelihood of a person developing a disease, or in dying prematurely. Such determinants of health include:

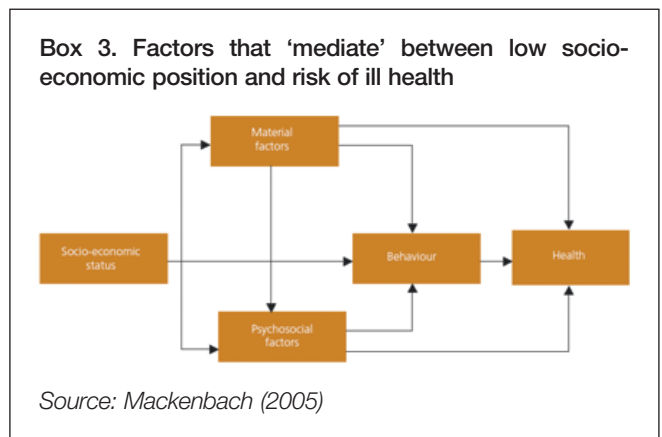
- Individual lifestyle factors: eg. diet, physical activity, smoking, alcohol, drugs, behaviour
- Social and community factors: eg. crime, unemployment, social exclusion, local cultures
- Living and working conditions: eg. housing and air or water quality
- General socio-economic factors impacting on health: eg. poverty and income, economic issues, and educational attainment.



More recently, a pathways approach to determining the important influences on health within a population has been developed¹³. Many researchers view social position as the fundamental cause of ill health. Using a pathways approach (Box 2), important influences on population health are presented in the form of an interlocking framework. Factors such as the education system and labour market, or the structure of society, help shape people's lives. An individual's social position, based on for example socio-economic factors, sex, ethnicity and sexuality, affects their access to resources and relative exposure to health risks. Intermediary factors, including personal behaviour or lifestyle, environmental factors such as poor housing and the provision of health and social care provision, impact on health outcomes or a persons health and well being.



The recent *Health Inequalities: Europe in Profile*⁴ report summarised the indirect 'causal' effects of socio-economic status on health into three specific health determinants; 'material' factors, psychosocial factors, and behaviours, showing that these explanatory factors are interlinked (Box 3). This report also noted that data on the social patterning of 'material' and psychosocial determinants of health are extremely scarce in Europe.



These and many other models of health determinants illustrate how complex interactions between many factors, which require complex solutions, affect not just absolute health but also health inequalities. Introducing the 2003 national strategy on tackling inequalities in health, *Tackling Health Inequalities: A Programme for Action*¹⁴, the Prime Minister stated that:

"...a whole series of cross-departmental action will address the root causes of poor health and health inequalities" (foreword) ... "The Government's aim is to reduce health inequalities by tackling the wider determinants of health inequalities, such as poverty, poor educational outcomes, worklessness, poor housing, homelessness, and the problems of disadvantaged neighbourhoods" (p1).

There is a recognised distinction between determinants of health and the determinants of health inequalities. Policies that tackle health determinants may not in addition deal with their uneven distribution. For example, whilst the prevalence of adult smokers in England has declined sharply in recent decades, from 45% in 1974 to 26% in 2002, policies have failed to reduce the gap

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between the proportion of manual and non-manual workers who continue to smoke¹⁵. The Scientific Reference Group on Health Inequalities noted that tackling health inequalities can be interpreted in a number of different ways and took the view that, in order to interpret inequalities trends, it is important to assess both absolute and relative measures of change⁵:

*“Tackling health inequalities can mean improving the health of disadvantaged groups (tackling **health disadvantage**), reducing health differences between disadvantaged groups and other groups (tackling **health gaps**), and reducing the gradient in health outcomes across all groups in the population, from the most advantaged to the most disadvantaged (tackling **health gradients**).”*

Health policies thus need to address two distinct issues; firstly, to tackle the many wider determinants, or factors which can cause ill health, and to which different groups face varying levels of exposure and secondly, in tackling the causes of health inequalities, to address the uneven distribution of health determinants¹⁶.

2.2 Government Health Inequalities Policy

National health inequalities policy, from setting ambitious Public Service Agreements (PSAs) and NHS Performance Management targets to monitoring by Local Delivery Plans (LDPs) and Local Areas Agreements (LAAs)¹⁸, has progressed rapidly since the late 1990's (Box 4). Tackling health inequalities has, at varying times, focussed either on improving the health of the poorest in society, on narrowing the health gap between the poorest socio-economic groups and the more well off, or on improving health across society. Whilst a focus on improving the health of the poorest targets those in greatest need, such policies do not address inequalities in health across socio-economic groups (the health gradient).

The Government in England has made tackling of health inequalities a priority^{14;17}, namely through:

- Policies that address the underlying wider causes of health inequalities
- Setting national PSA health inequalities targets, relating to infant mortality and life expectancy
- Emphasising the need for joint working and partnership between different public sector and other organisations, and across Government departments

The national health inequalities target, focusing particularly on reducing the gap in life expectancy and infant mortality, was originally defined in the 2002 Government Spending Review and reaffirmed in the Department of Health's *Programme for Action* (Box 4). The PSA targets agreed in the Spending Review of 2004 gave an increased profile to tackling inequalities in health, specifically to address geographical inequalities in life expectancy, cancer, heart disease, stroke and related diseases¹⁸. This was followed by the announcement of the Spearhead Group of Local Authorities and a reformulation of the national targets¹⁹, with the aim of seeing faster progress compared to the original inequalities targets (Box 5). The Spearhead Group is made up of 70 Local

Authorities and 88 Primary Care Trusts (PCTs), based upon the Local Authority areas that are in the worst fifth nationally for three or more of the following five indicators:

- Male life expectancy at birth
- Female life expectancy at birth
- Cancer mortality rate in under 75s
- Cardio Vascular Disease mortality rate in under 75s
- Index of Multiple Deprivation 2004 (Local Authority summary score)

Other Government Department PSA targets are too numerous to include in this report but also have a large impact on health (www.hm-treasury.gov.uk/performance). Partnership working and long-term action have arisen from a number of cross Government initiatives developed to tackle inequalities, such as Neighbourhood Renewal, Sure Start, New Deal for Communities and the New Opportunities Fund. Whilst the actions required for

Box 5. Current National PSA targets for Health Inequalities

To improve the health of the population. By 2010, increase life expectancy at birth in England to 78.6 years for men and to 82.5 years for women.

To substantially reduce mortality rates by 2010 (from the 1995-97 baseline)

- From coronary heart disease and stroke and related diseases by at least 40% in people under 75, with a 40% reduction in the inequalities gap between the fifth of areas with the worst health and deprivation indicators and the population as a whole.
- From cancer by at least 20% in people under 75, with a reduction in the inequalities gap of at least 6% between the fifth of areas with the worst health and deprivation indicators and the population as a whole.
- From suicide and undetermined injury by at least 20%.

To reduce health inequalities by 2010, as measured by infant mortality and life expectancy at birth and underpinned by two more detailed objectives:

- 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.
- Starting with local authorities, by 2010 to reduce by at least 10% the gap between the areas with the worst health and deprivation indicators (the spearhead group) and the population as a whole (Reformulated in 2004)

⁵ Local Delivery Plans (LDPs) are agreed between Primary Care Trusts (PCTs) and all key stakeholders both within the NHS, across local government and with other agencies. PCTs will agree the format of the LDP and ensure sign off with their Strategic Health Authorities (SHAs)

¹⁸ All top-tier authorities will have an LAA in place by 2007, which will be negotiated by the Government Offices for the regions. As well as simplifying funding streams, LAA's are designed to improve local partnerships and limit the number of targets areas have to report on to 60-70 instead of hundreds.

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Box 4. Recent Development of Health Inequalities Policy in England

1998 - The Acheson *Independent Inquiry into Inequalities in Health*⁹ produced 40 recommendations, and contributed widely in informing both the 1999 health strategy *Saving Lives: Our Healthier Nation*²³, and subsequent *Action Report on Reducing Health Inequalities*²⁴. The White Paper *Saving Lives*²³, the then national strategy for Public Health, promoted a combination of individual action on healthy lifestyles, community partnership working and Government policy working together to reduce factors that influence poor health. A key focus was on improving the health of the worst off in society and a narrowing of the health gap.

2000 - *The NHS Plan*²⁵ placed prevention of ill health and the need to address key health inequalities issues firmly on the NHS service delivery and joint partnership working agendas. Action required a focus on the root causes of poor health and inequity, with partnership work, cross agency and Government co-working a priority.

2001 - Ambitious targets to improve health and reduce inequalities were announced²⁶ and have subsequently been adapted and formalised^{27,28} (Box 5). Action required from healthcare providers, Local Authorities, and others; cutting across geographic area, gender, ethnic community, and social group.

2002 - A cross-cutting departmental review on health inequalities was completed²⁹, following public consultation, on actions needed to tackle health inequalities, and meet emerging health inequality targets.

2003 - The Department of Health published its national strategy to tackle inequalities in health. Core themes within *Tackling Health Inequalities: A Programme for Action*¹⁴ were support for families, mothers and children, engagement with communities and individuals, prevention of illness, the provision of effective treatment and care, and the requirement to address underlying determinants of health.

2004 - The Wanless report *Securing Good Health for the Whole Population*³⁰ was released, following earlier interim reports^{31,32}, which assessed the resources required to provide future high-quality health services. Wanless focused on the prevention of ill health, on tackling wider determinants of health, and on the cost-effectiveness of action that can be taken to improve the health of the whole population, as well as reducing health inequalities.

2004 - The Public Health White Paper, *Choosing Health - making healthy choices easier*¹⁷ developed the Wanless themes. *Choosing Health* discussed how public health has historically been diverted into analysing and understanding health problems, rather than identifying practical solutions. The white paper highlights the limited evidence on what works to reduce health inequalities. For example, multiple factors influence health and combine in different ways for different health outcomes and health related habits are key to tackling lung cancer, whilst environmental factors influence road traffic accidents. The need to improve the evidence base as to which interventions have been found to be most effective was considered a priority.

2004 - *The NHS Improvement Plan*³³ implemented improved access to NHS services, extended choice to patients over how and where their treatment is undertaken, and placed a new focus on the prevention of ill health.

2004 - The Treasury spending review announced updated PSA targets aimed at increasing the profile of tackling inequalities in health. These included updated targets to tackle the underlying determinants of ill health and health inequalities, including reducing adult smoking rates; halting the year-on-year rise in obesity among children; and reducing the under-18 conception rates as part of a broader strategy improve sexual health¹⁸.

2004 - Tackling Health Inequalities: the Spearhead Group of Local Authorities and PCTs was announced. This led to a reformulated Life Expectancy target (Box 5). The Spearhead Group of Local Authority Districts and PCTs underpins geographically based Health Inequalities targets for Life Expectancy, Cancer and Heart Disease, Stroke and related diseases¹⁹.

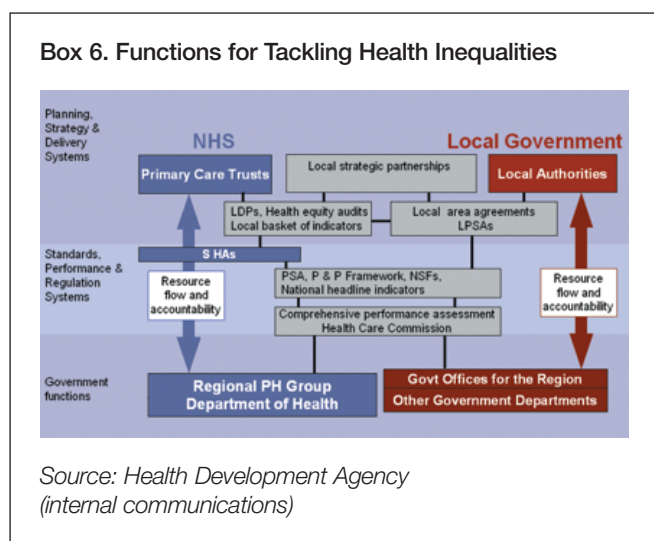
2005 - The Department of Health published *Delivering Choosing Health*¹³ as well as additional action plans *Choosing a Better Diet*³⁴ and *Choosing Activity*³⁵.

2005 - The Department of Health published the Status Report of the Scientific Reference Group on Health Inequalities. The report examined evidence comparing the period 1995-1997 with the period 2001-2003 and concluded that there had been a continued widening of inequalities as measured by infant mortality and life expectancy at birth⁵.

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tackling health inequalities across national, regional and local health and partner agencies are now better defined, it is the mechanisms to define and deliver local action that are crucial for reducing local inequalities. Box 6 shows local and regional (NHS and Government) functions in place for tackling inequalities by linking together various planning, strategy, delivery and performance management systems. Within the North West in 2003, the Government Office *Investment for Health Plan* ²⁰ additionally identified how Public Health practitioners and the NHS can work with other agencies across the region to improve health and reduce inequalities.

In support of monitoring for LDPs and LAAs, several tools and resources exist to support activities to measure, monitor and reduce health inequalities. These include a systematic programme of Health Equity Audits ^v and locally, regionally or nationally produced baskets of indicators ²². The information, analyses and intelligence provided in the following sections of *Where Wealth means Health: Illustrating Inequality in the North West*, and associated datasets and interactive tools made available online (www.nwpho.org.uk/information), are intended to help inform progress on inequalities across all local areas of the North West for use by the NHS, Local Authorities, regional Government and the Department of Health.



Locally focussed plans and partnerships are essential for tackling health inequalities and health improvement, and bringing in line health and Local Authority priorities. In order to promote a vision of central and local Government working together to deliver better outcomes for people and places, *The Future of Local Government - Developing a 10 Year Vision* ²¹ was published in July 2004. Following this, the Office of the Deputy Prime Minister confirmed details of the second round of Local Area Agreements (LAAs) in June 2005. LAAs are made up of outcomes, indicators and targets aimed at delivering a better quality of life for people through improving performance on a range of national and local priorities. These priorities are grouped into four blocks:

- Children and Young People
- Safer and Stronger Communities
- Healthier Communities and Older People
- Economic Development and Enterprise

Local Public Service Agreements ^{iv} will be merged with LAAs and, to provide an incentive to stretch performance, a reward element is payable on achievement of the target. As part of the negotiation process for LAAs at the Strategic Health Authority (SHA) and Government Office level (Box 6) it will be important to link in NHS LDPs and key health targets for reducing health inequalities.

^{iv} A Local Public Service Agreement (LPSA) is a voluntary agreement negotiated between a Local Authority and the Government. The overall aim of LPSAs is to improve the delivery of local public services by focusing on targeted outcomes with support from Government.

^v Health Equity Audits (HEAs) are an essential element of informing service planning and delivery in order to achieve the 2010 target on inequalities. PCTs are performance managed on how well they carry out HEAs.