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For Recipient's Use			

TACKLING HEALTH INEQUALITIES: what works

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TACKLING HEALTH INEQUALITIES: what works

Aim of the paper

1. The Local Delivery Plan (LDP) Technical Note produced for the service in November, set out the planning requirements for the NHS, including specific requirements relating to inequalities. The aim of this paper is to provide further information on inequalities to support NHS planners and commissioners in doing that. The action outlined in the paper is not mandatory. It is being provided in response to requests from localities to identify action organisations could take that will have a rapid impact on inequalities. It is aimed at all areas but has special relevance to the Spearhead Group of areas. It focuses on the NHS activity which will support achievement of the national health inequalities targets. Further information on health inequalities is at www.dh.gov.uk/healthinequalities

General approach

2. Health inequalities exist in all areas, even in the most affluent ones. For example, where pockets of deprivation show stark differences in health outcomes compared to the national average or even to places close by. So this is an issue which all NHS organisations will recognise as an important local priority. Health inequalities is a long standing and deep seated problem in this country, and many inequalities gaps are continuing to widen. In order to achieve long term and sustainable change we **need to do things differently across a broad swathe of services**.

3. The **action taken needs to be of a sufficient scale to make a difference**. This is consistent both with Derek Wanless's call for a re-balancing of the NHS so that it becomes a health service as well as a sickness service and with the thrust of the White Paper *Choosing Health – Making healthy choices easier*. This paper provides some evidence reflecting the current state of knowledge on what are the **effective NHS interventions which merit investment to narrow inequalities (see Annex 1)**. Many of the effective interventions are not new, but are about targeting National Service Framework and other existing standards where they will make a difference to inequalities. The evidence base needs strengthening on the degree of impact of individual interventions in disadvantaged groups, and **evaluating the impact of action** would be a valuable approach to help build up our understanding of what works.

4. **The Spearhead Group of areas** highlighted by the national inequalities targets on life expectancy, cancer and cardiovascular disease (CVD) mortality account for some **28 per cent of the population,** so achieving these targets is about **large scale change**. There needs to be a step change in the thinking and the action to tackle health inequalities if change of this scale is to take place. This is **not just about short-term initiatives**, but about **mainstreaming action** so that it matches the higher needs of those in disadvantaged areas and groups rather than just those who are most vulnerable.

5. The **work of the NHS is absolutely crucial** to addressing health inequalities and, like many other services, if it does not pro-actively deliver prevention and health services in ways which will narrow inequalities the default position is that it will probably widen them

6. **Services working together in partnership** stand a far greater chance of success. The NHS cannot deliver this alone. Local Authorities are the key partner locally, working through Local Strategic Partnerships with a range of other partners.

Achieving national health inequalities targets

7. The LDP technical note (available on STEIS) set out the requirements as part of the planning process for both national and local target setting. **The national Public Service Agreement targets for DH** http://www.hm-treasury.gov.uk/media/4B9/FE/sr04_psa_ch3.pdf are complemented by **targets across other Government departments** http://www.hm-treasury.gov.uk/spending_review/spend_sr04/psa/spend_sr04_psaindex.cfm which may be useful to engage partners locally. This paper focuses on the DH health inequalities targets.

8. The infant mortality target is socio-economic group based and achievement calls for action in all areas. The inequalities targets for life expectancy, cancer and CVD focus on the areas with the worst health and deprivation indicators: the Spearhead Group. The Public Health White Paper *Choosing Health* set out plans to start roll out of some proposals, such as health trainers and improvements in school nursing provision, in these PCTs. These proposals will be piloted and rolled out in these areas first.

9. The LDP also calls upon the Spearhead Group to make more rapid progress on cancer and CVD mortality rates than the average. Some modelling (available on STEIS) has been done to show what rates might need to be achieved in each PCT to narrow the gap in these mortality rates in the Spearhead Group compared to the average, taking account of current trends. This modelling is provided to assist local health communities in their discussions about plans using their detailed knowledge of local circumstances.

10. The 2010 timescale of the life expectancy, cancer and CVD targets means that we need to focus action to stop premature death for people who already have a disease, or are at high risk of disease i.e. secondary and tertiary prevention. While primary disease prevention and work to reduce the uneven distribution of health determinants will make the largest long-term contribution, the role of primary and secondary care services in management of CVD and cancer risk factors and the management of long term conditions will be very important in achieving the 2010 targets. For infant mortality, it should be possible to make service improvements which will impact quickly, such as smoking in pregnancy and breastfeeding in disadvantaged groups.

11. **Annex 1 sets out the effective interventions which will impact on life expectancy and infant mortality by 2010,** see paragraphs 1.1 et seq for life expectancy and 1.7 et seq for infant mortality. Reducing the prevalence of smoking in pregnancy and in disadvantaged groups is the single most important factor for achieving both these targets. This is because it is the single biggest preventable cause of the socio-economic gradient in infant mortality and life expectancy. It affects low birth weight and, although it takes longer to cause lung cancer, stopping smoking has a more rapid effect on mortality from CVD, stroke and respiratory diseases.

12. For 2010, therefore, this is essentially **a service-oriented agenda** that needs PCTs to focus on tackling cancer, CVD and smoking in disadvantaged groups and areas, because these are the factors, along with respiratory disease, which are driving the lower life

expectancy in the Spearhead Group and other disadvantaged areas. **High quality and quantity of primary care in disadvantaged areas**, reaching out if necessary to particular groups with low service use and high need, can be vital to driving down mortality rates. A **focus on the over-50s** would give the greatest short-term impact on life expectancy, and a focus on **disadvantaged families, mothers and children** would address the infant mortality gap across social groups.

13. NHS interventions will be delivered mainly by doctors and nurses in general practice, midwives and public health nurses such as health visitors working on the ground. New models of health improvement announced in *Choosing* Health, such as health trainers, and strengthening and improving the quality of NHS Stop Smoking services, will be important. Working in disadvantaged areas can be challenging and demanding work. Involving and supporting NHS staff, targeting resources to areas of higher need and implementing *Improving Working Lives* are among the steps that can be taken to attract and retain valuable staff.

Setting local targets

14. *National Standards, Local Action* set out several principles for local target setting which should support tackling health inequalities including: being in line with **local population needs**; **addressing local service gaps**, including by analysing the impact of improving choice and tracking where local services are not meeting patient aspirations; **delivering equity**, taking account of different needs and inequalities within the local population in respect of areas, socio-economic group, ethnicity, gender, age etc on the basis of a **systematic programme of health equity audit** and equality impact assessment; **developing targets in partnership** with other NHS bodies and LAs, patients and service users, based around the whole care pathway. These principles should lead to local targets that will grasp the nettle of inequalities locally, both for within-area inequalities and to improve outcomes towards the national average for those areas with poorer outcomes.

15. **Health Equity Audit** is a developing tool and is a practical approach rather than an exact science. But it does have the potential to bring evidence of gaps in service delivery to certain groups - service inequities, where services are not meeting high needs - to bear on decisions about service investment and organisation. It will be important to use HEA **pragmatically**, choosing issues with **high impact**, avoiding "data paralysis" or a search for perfect data by assessing the evidence on whether it is **"fit for purpose" for the decision being taken**. HEA needs to be conducted with the purpose of tackling health inequalities at the forefront of the discussion. An example of a HEA which reversed an "inverse care" trend is shown at **Annex 2** and there are further examples at www.dh.gov.uk/healthinequalities

16. The **Better Metrics** project www.sasha.nhs.uk/policies/metrics.pdf includes a section on health inequalities measures which can be used to support local target setting. The **Local Basket of Indicators** is included which includes measures relating to a wide range of services, not just NHS services, so they can be used to support partnership working.

17. Following a commitment in *The NHS Plan* (2000) and *Choosing Health* (2004), the **Health Poverty Index** (HPI) http://www.hpi.org.uk/ has recently been launched, combining data on health-related factors including health status, health behaviours, prevention and service access. The work has been progressed by Oxford University and the South East

Public Health Observatory. The HPI tool has been developed as a single summary of health poverty, represented visually by a set of indicators across a number of domains as illustrated at **Annex 3** and soon to show the Spearhead Group as a comparator**.** Partners locally may find its high level summary spider charts and graphs helpful in identifying local priorities and target areas for action.

Annex 1

Effective NHS interventions on life expectancy and infant mortality

Note: the interventions referred to in this annex have been identified as having high and fast impact on health inequalities. The interventions presented are not mandatory for PCTs but are provided to support PCTs in planning how they might achieve a strong performance on relevant LDP lines and to ensure delivery (such as the cancer and CVD mortality lines, including the "Spearhead cut" for these lines).

Life expectancy

1.1 The charts below illustrate the breakdown of the gap between the Spearhead Group of local authority areas and the national average. **Charts 1 and 2** shows the breakdown of this gap by major cause of death for women and men, and **charts 3 and 4** by age group. These give useful pointers to the areas where activity should be concentrated. The life expectancy gap between the areas with lowest life expectancy and the national average is caused principally by premature deaths from circulatory diseases, respiratory diseases and cancers, with smaller contributions from "digestive" diseases – principally chronic liver disease and cirrhosis - suicide and violence in men. The over 50s contribute an estimated almost 80% of the gap in both women and men. . The analysis by age also indicates the importance of addressing mortality in childhood, principally infancy. Deaths under 10 contributed around 10% of the inequality gap, mainly comprised of deaths under 28 days.

1.2 It follows that **the priorities for NHS action which will have the greatest impact on narrowing the gap are therefore achieving faster decreases in mortality from circulatory and respiratory diseases and cancer** in the Spearhead Group of areas, recognising that these major killers exhibit strong social class gradients, and **focusing on the health of the over 50s.** Action on these is underpinned by the availability of **high quality care in disadvantaged areas, especially primary care.**

1.3 The health inequalities element of the **cancer** target is to narrow the gap in inequalities by at least 6% in the spearhead group compared to the national average by 2010. The primary interventions that will deliver this are:

- Delivery of the inequalities element to the smoking target: reducing smoking prevalence among routine and manual groups (from 31% in 2002) to 26% by 2010.
- Improving access to diagnostics
- Reducing delay in patients in disadvantaged groups first going to see the GP (evidence that socio-economic groups have a greater delay in presentation)
- Reducing the delays in onward GP referral
- Increasing the uptake of screening

1.4 The health inequalities element of the **heart disease and stroke** target is to narrow the gap in inequalities by at least 40% in the spearhead group compared to the national average by 2010. The interventions that are most likely to have an impact on reducing death rates from heart disease and stroke by 2010 are predominantly, but not exclusively, treatment

approaches which impact on risk factors for people who already have cardiovascular disease or who are at high risk of developing cardiovascular disease. In order to sustain progress beyond 2010, continued action to address risk factors through primary prevention approaches, as set out in the public health White Paper, *Choosing Health* will also be important. The key interventions to impact prior to 2010 are:

- **managing high blood pressur**e in patients with disease and at high risk of disease (including patients with diabetes), using blood pressure drugs supported by advice and support on diet, exercise and smoking;

- **reducing cholesterol levels** in patients with disease and at high risk of disease (including patients with diabetes), with dietary advice, statins and support;

- **ensuring effective emergency care and treatment for heart attack**, including prompt thrombolysis and prescribing of aspirin, ace-inhibitors, beta-blockers and statins on discharge from hospital;

- **reducing smoking**, particularly for patients with other risk factors, such as diabetes, established disease, or in vulnerable age groups; and

- **improved management of atrial fibrillation**, reducing the risk of stroke.

1.5 The National Service Framework for Coronary Heart Disease sets out other interventions for reducing death rates from heart disease, such as low dose aspirin, revascularisation and lifestyle based interventions. The National Service Framework for Diabetes sets out measures for diabetes, such as prescribing of ace inhibitors and lifestyle based interventions. The National Service Framework for Older People sets out measures for stroke, such as improved emergency care. The key messages from all three are that **high quality local systems for effective chronic disease management of cardiovascular disease are the essential component of strategies to reduce mortality from stroke, heart disease and diabetes**.

1.6 In addition to identification, secondary prevention and effective management of Cancer and CVD risk factors, other effective interventions to address the gap between the Spearhead areas and the average are:

- **Reducing smoking** in Spearhead areas: as for CHD and Cancer, smoking is responsible for the major part of mortality differentials by social class in middle age. Whilst its impact on mortality from lung cancer would be beyond 2010, it does have a more rapid impact on stroke, CVD and respiratory disease so that reductions in smoking prevalence in Spearhead areas now will impact by 2010.

- **Prevention and effective management of other risk factors in the general population and in high risk patients by primary care**: poor diet, physical inactivity, hypertension, obesity and therapeutic interventions including use of anti-obesity drugs according to need.

- Ensuring good availability of **high quality NHS care** in the Spearhead areas, **especially primary care** since this underpins access to the services to prevent and treat cancer and CVD.

- **Improving housing quality** to tackle cold and dampness, particularly for the elderly. Collaborative approaches, for example between primary care, housing improvement agencies and others can be effective.

- **Reducing accidents** at home and on the roads, particularly among the old and young.

- **Targeting over-50s** where the greatest short-term impact on life expectancy will be made, including through maintaining high levels of influenza vaccination for the over 65s.

- **Addressing respiratory deaths** – particularly chronic obstructive pulmonary disease, but also pneumonia. This implies interventions relating to: Smoking; Environmental factors (pollution; housing); Management of affected individuals in primary and secondary care and influenza immunisation. Further information on immunisation is at http://www.dh.gov.uk/PolicyAndGuidance/PolicyAZ/fs/en?CONTENT_ID=4055543&chk=0bMB4s The role of Community Matrons in providing personalised care and case managing patients with complex health problems will be important.

- **Reducing alcohol consumption** to reduce deaths from **Chronic liver disease and cirrhosis** which is closely associated with levels of alcohol consumption but also infection with **hepatitis C**. Alcohol may contribute to the life expectancy inequality gap via other categories eg **accidents, suicide, specific cancers**. Brief intervention therapies in A&E can be important.

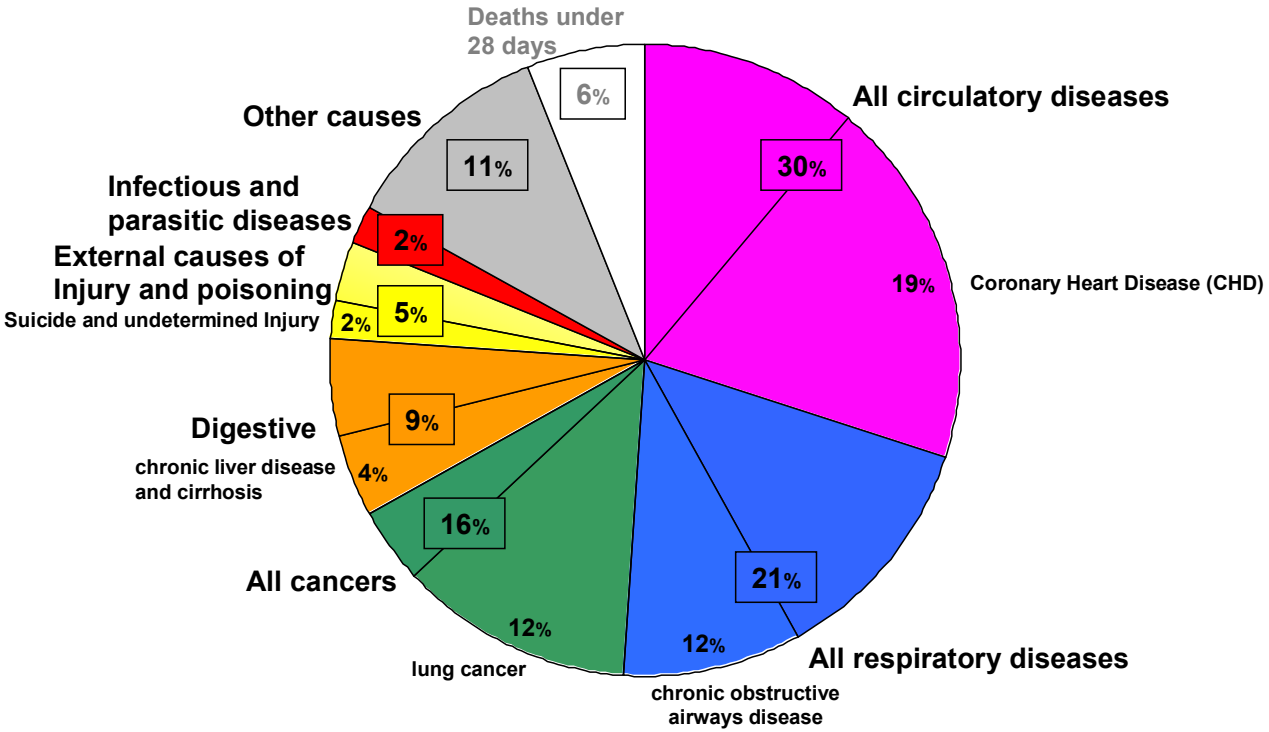
- **Reducing deaths in childhood, particularly infancy,** through a range of interventions to target the main causes of such deaths including smoking, nutrition, accidents, appropriate obstetric and paediatric care, and wider social determinants. Clearly this links closely to delivery of the infant mortality aspect of the PSA target.

- **Learning from innovation elsewhere in the NHS.** Ensuring that the learning is spread from effective innovation, for example the City-wide Initiative for Reducing Cardiovascular disease (CIRC) work in Sheffield which has been successful in improving outcomes in disadvantaged areas.

- **Working pro-actively with partners** on issues affecting life expectancy. PCTs should be working through Local Strategic Partnerships, influencing local authorities, schools, communities and a range of other stakeholders so that they are having a positive impact on health and health inequalities. In particular by working to deliver services around the way in which people live their lives so that usage is improved, especially by those in highest need. For example providing Stop Smoking services in pubs and clubs; working with housing providers to ensure that those whose health is at risk from cold, damp housing are given priority through home improvement programmes, and to improve safety at home (smoke alarms, hand rails etc); working with local transport planners to prevent road accidents among old and young, especially in disadvantaged areas.

Local Authorities: Contribution to Life Expectancy Gap in Females

Breakdown by Disease, 2003



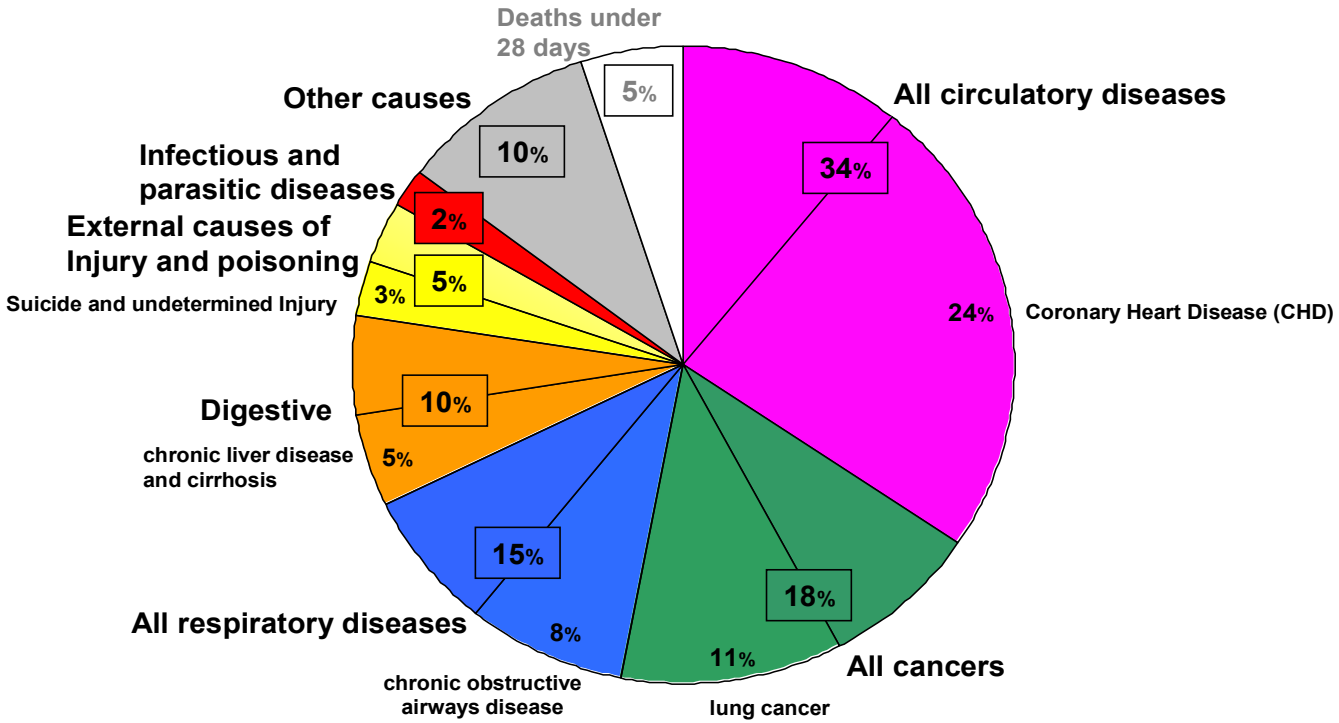
Source: DH-SAT analysis

Road traffic accidents – the distribution of deaths* reduces the size of the gap

* Between the Spearhead Group and England as a whole.

Local Authorities: Contribution to Life Expectancy Gap in Males

Breakdown by Disease, 2003



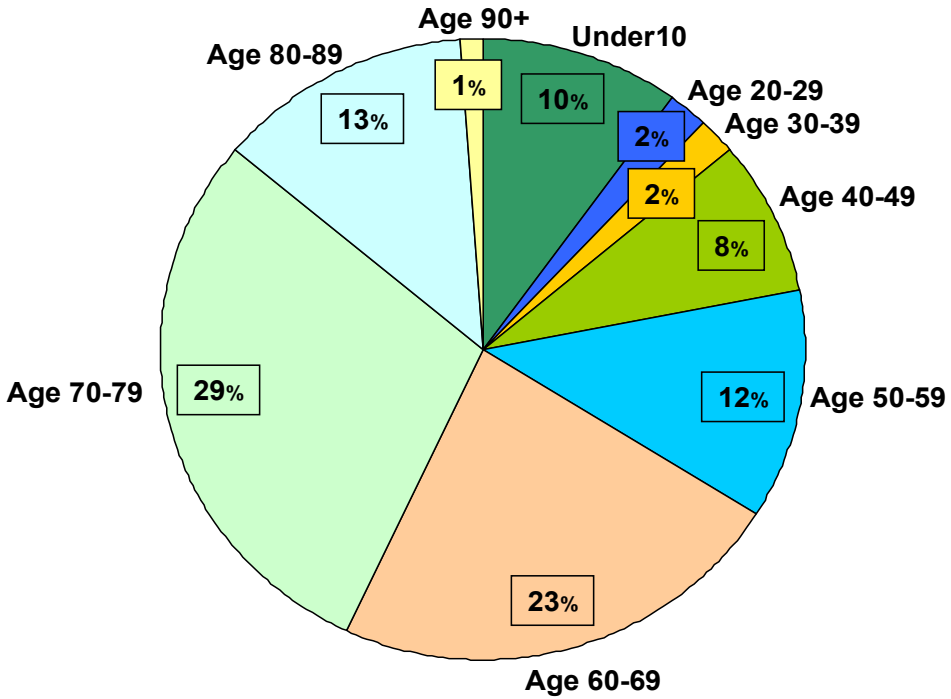
Road traffic accidents – the distribution of deaths* reduces the size of the gap

* Between the Spearhead Group and England as a whole.

Source: DH-SAT analysis

Local Authorities: Contribution to Life Expectancy Gap in Females

Breakdown by Age, 2003

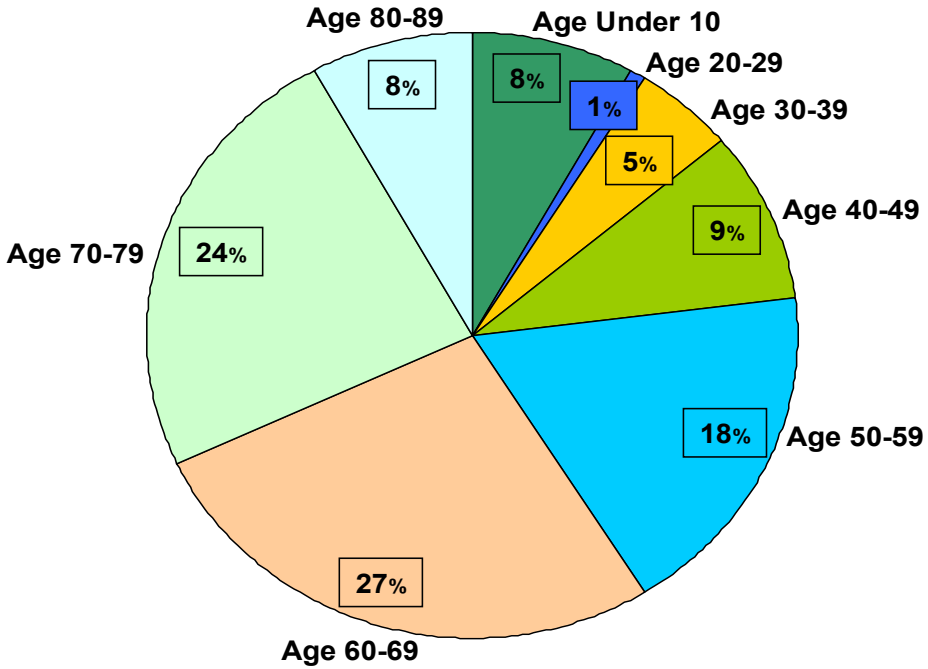


Age 10-19 contributes nothing to the gap

Source: DH-SAT analysis

Local Authorities: Contribution to Life Expectancy Gap in Males

Breakdown by Age, 2003



Age 10-19 contributes nothing to the gap

Age 90 and over – the distribution of deaths* reduces the size of the gap

* Between the Spearhead Group and England as a whole.

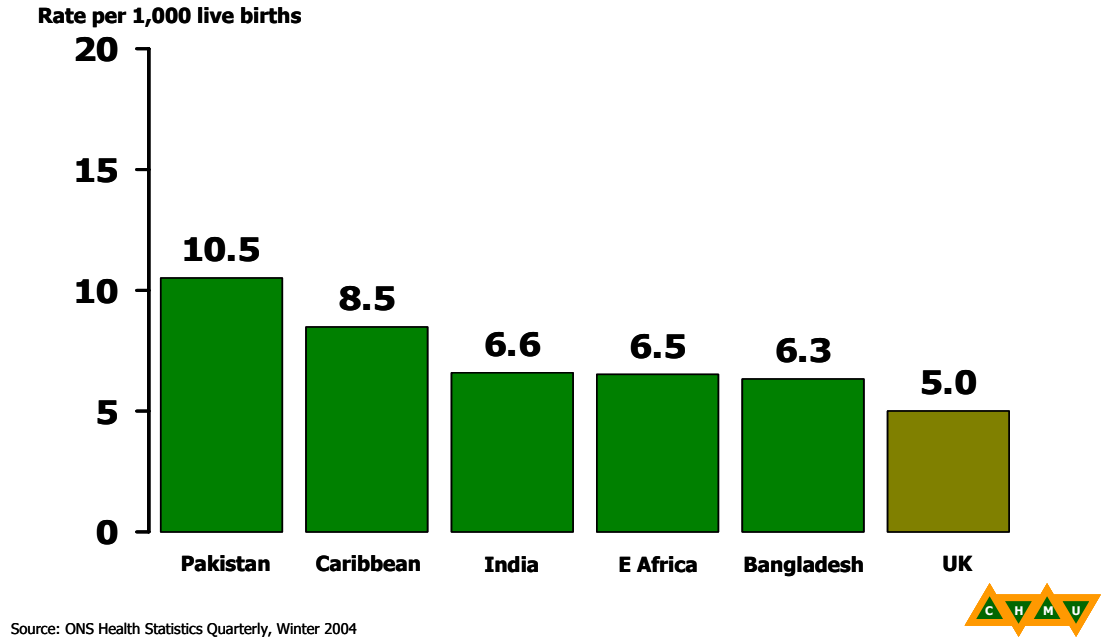
Source: DH-SAT analysis

Infant mortality

1.7 Addressing health inequalities is a key theme of the Children's National Service Framework. Deaths under one year of age total about 3,000 per year. The two major causes of neonatal deaths are 'immaturity related conditions' and 'congenital malformations' and both show a strong social class gradient. The social class gradient is greater for post-neonatal deaths. Just under 50% of all post-neonatal deaths are accounted for by two causes: 'signs, symptoms and ill-defined conditions' (predominantly SIDS) and congenital anomalies.

1.8 Although the numbers are small nationally, there is a strong ethnic dimension in infant mortality. For example infants born in England and Wales to women born in Pakistan had a mortality rate of 10.5 per 1,000 live births in 2003 (more than twice the national average) and for those with mothers born in the Caribbean, the mortality rate was 8.5 per 1,000.

Chart 3 Infant mortality rate
by mother's country of birth, England & Wales, 2003



Source: ONS Health Statistics Quarterly, Winter 2004

1.9 The underlying determinants of mortality and ill-health in infants include:

- **low birth weight**: this shows a steep social class gradient.
- **maternal smoking**: this increases the risk of a wide range of adverse outcomes including death from Sudden Infant Death Syndrome and infections in infancy. In particular, **smoking in pregnancy** is the most significant of very few known modifiable risk factors in the prevention of low birth weight (Kramer, 2000).

- **paternal smoking**: this is also associated with increased risk of SIDS and some infections.
- **maternal anthropometry/nutritional status**: short stature, low pre-pregnancy body mass index and low weight gain during pregnancy are risk factors for low birthweight and are more common among women from lower social groups.
- **failure to breast feed**: human breast milk provides complete nutrition for the first critical months of life and protects against common childhood infections and diseases, including gastro-enteritis and respiratory infection. Breastfeeding shows a strong social class gradient. Only 59% of mothers from social class V initiated breastfeeding in 2000 compared to 91% of mothers from social class I. Guidance has been issued to all midwives and health visitors in the form of a resource pack *Infant Feeding and Child Nutrition* to help promote good practice in infant feeding particularly breastfeeding. The resource pack is available at www.dh.gov.uk under maternal and infant nutrition.
- **quality and quantity of health care** available, and in particular addressing any barriers to access for Black and minority ethnic groups, teenage parents or others who need additional support.
- **maternal age**: many of the likely risk factors for infant deaths are increased in teenage mothers who are, for example, 25% more likely than average to have a baby weighing less then 2,500 grams; the effect of halving the number of **teenage births** would by itself achieve an estimated 10% of the target reduction in infant mortality rates. Information on the Teenage Pregnancy Strategy is on the Teenage Pregnancy Unit website
- **Immunisation take-up**: there is a social class gradient to take-up and practices serving populations living in socially deprived areas were less likely to achieve high completion rates
- **the physical environment** including housing conditions
- **the family and social environment**: poverty; lack of social support; parental mental health, drug, and alcohol problems

1.10 Based on these facts, **effective areas for interventions to narrow the gap** in infant mortality are:

- **Reducing smoking in pregnancy in disadvantaged groups**, focussing also on paternal smoking. This should include achievement of the LDP target on smoking in pregnancy, including addressing the high number of mothers in some areas where smoking status is "not known"
- **Improving nutrition in women in disadvantaged groups** of childbearing age, for example by ensuring full uptake of Healthy Start food vouchers by pregnant women in disadvantaged areas
- Reducing **teenage pregnancy** which is strongly correlated with socio-economic status
- Increasing **breast-feeding initiation and duration rates in disadvantaged groups** as breastfeeding rates are much lower in these groups
- Providing **effective ante-natal care** (including screening and immunisation) and promoting **early ante-natal booking in disadvantaged groups**
- Improving the quality **of midwifery, obstetric and neonatal services**
- **Maintain immunisation coverage** and improve service planning for **increased uptake in disadvantaged groups**. Children and families that remain

unimmunised, or not fully up to date with their immunisations, are more likely to live in disadvantaged areas.

- Effective education about ways to promote health, eg **immunisation**, focussing on disadvantaged groups.
- Provision of high quality **family support for disadvantaged groups** (eg through health visitors) including particular efforts to address risk factors for Sudden Infant death – parental smoking, sleeping position and adverse social circumstances.

To support the achievement of the target, all of these activities should ensure that the greater needs of families in lower socio-economic groups are being met, and that attention is paid to the needs of families from Black and minority ethnic groups with high infant mortality rates, ensuring services reflect needs arising from culture, language and religion. Tackling health literacy can also support better health outcomes. From 2006-07 DH will be supporting PCTs with funding and advice to run a local programme under the joint DH/DfES Skilled for Health. project which is designing and testing embedded health learning in adult basic skills programmes Sfh.mailbox@dfes.gsi.gov.uk

Quality and quantity of primary care services

1.11 The availability of high quality primary care services in disadvantaged areas underpins narrowing health inequalities. Low expectations, poor access and late presentation in the stages of disease or in pregnancy will all be critical factors in premature mortality. The effectiveness of interventions will also be important. Access is not just about geographical issues, improving access also needs to take account of factors such as different attitudes and beliefs in different groups, the multiple needs of individuals, accessibility of services, for example transport issues especially for non-car owners etc.

1.12 Action can be taken to ensure that the quality and quantity of primary care available to people in disadvantaged groups and areas is at least as good as that in affluent areas and groups. Four primary medical care contracting routes are now available to enable PCTs to commission or provide services for their local populations - General Medical Services (GMS), Personal Medical Services (PMS), Alternative Provider Medical Services (APMS) and Primary Care Trust Led Medical Services (PCTMS). These routes give PCTs considerable flexibility to increase capacity, and to develop services which offer greater responsiveness to the specific needs of the community – for example, by addressing need in areas of historic under-provision, improving access in areas with problems with GP recruitment and retention, and enabling the re-design and re-configuration of services such as developing nursing locally. The new primary medical care contracting arrangements offer enormous potential to develop new ways to meet a growing demand for health , with more flexible services, greater choice, increased specialist activity, and improved range and quality of services and services tailored to local needs.

1.13 Health Equity Audit can be used to look at equity of access to services according to need. Consideration can be given to whether improvements in access take account of cultural and social factors, or querying if LIFT projects are happening in areas of highest need within a PCT or are maximising their impact on health. In

planning any new programme it should be tested to see what effect it will have on inequalities and, if it is likely to widen the gap, specific measures should be put in place to address that.

1.14 The role of the NHS as a good corporate citizen can contribute to local regeneration, using its economic muscle through employment and procurement policies, the capital build, and training and skills programmes to support local economies and make the best use of the extra investment in the NHS. Further information on regeneration is (including guidance from DH and the Neighbourhood Renewal Unit is at http://www.doh.gov.uk/healthinequalities/ and further information is at http://www.neighbourhood.gov.uk/ and http://www.renewal.net/

Health Inequalities Unit
January 2005

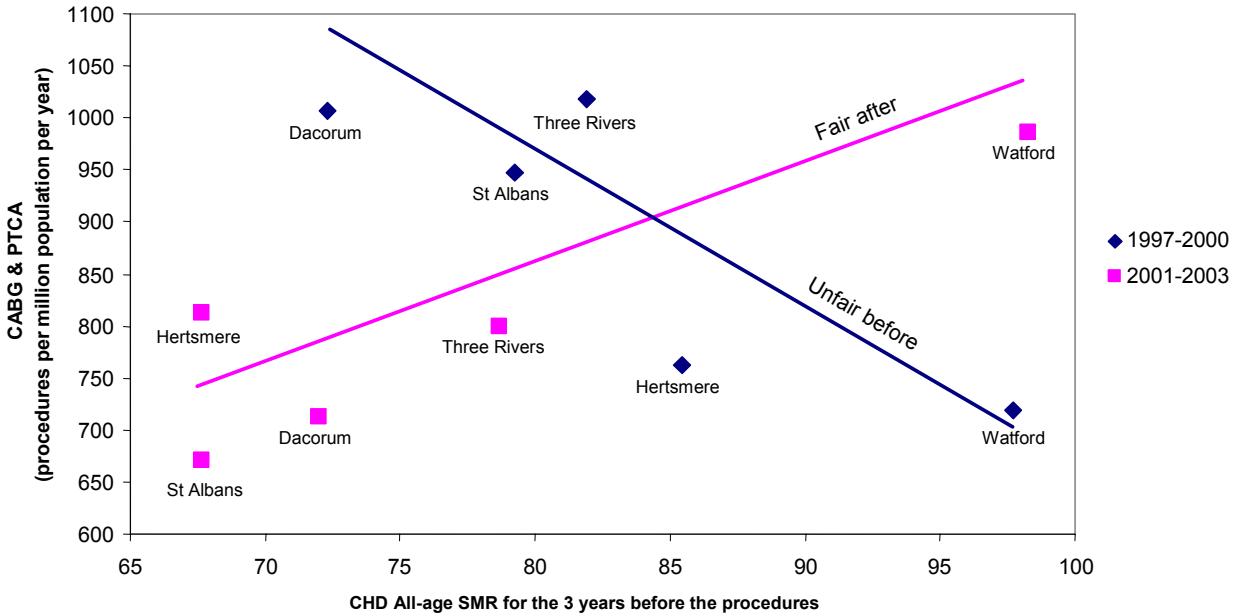
Annex 2

Health Equity Audit Example

CHD NSF Linked Equity Improvement in West Hertfordshire

- The introduction of the NSF in West Hertfordshire focused upon equitable development of cardiology services.
- This included a £300,000 shift in recurrent resources towards areas of highest need.
- The next chart shows an improvement in the fairness of the distribution of coronary revascularisation procedures before and after the introduction of the CHD NSF in West Hertfordshire.

The Improvement in West Hertfordshire Coronary Revascularisation Equity Before and After Introducing the CHD NSF

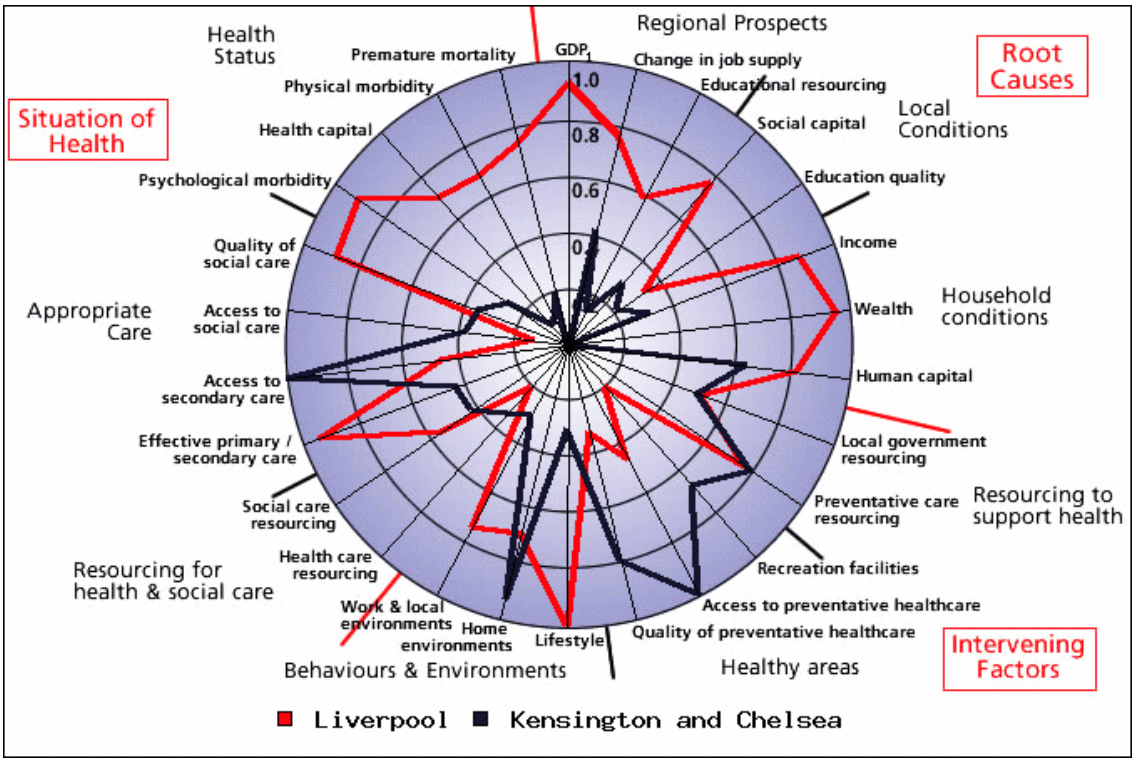


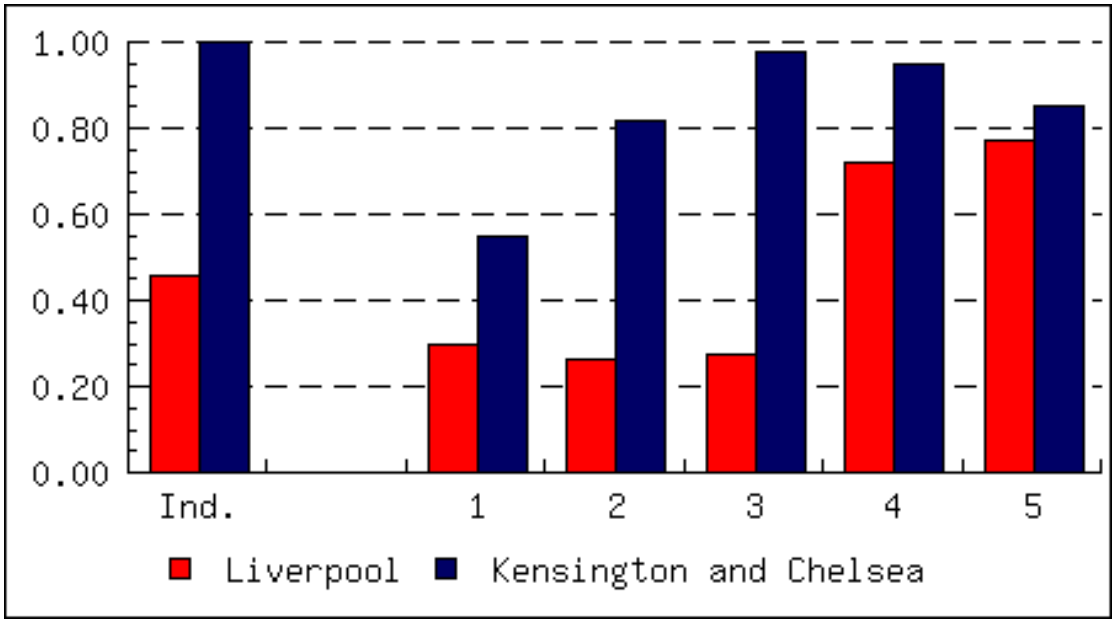
Source: Local finance information system and ONS; all denominators are based on Census 2001 projections

Annex 3

Health Poverty Index illustrations of data presentation

The Health Poverty Index was launched in November 2004. The HPI provides summary key information on differences in health and health outcomes between areas and area types, with differences over time and between population sub-groups in development. The HPI's interactive website uses "spider" charts, bar charts and data tables to present the information in an easily accessible way. www.hpi.org.uk





Ind = Access to preventative healthcare

1 = Flu vaccine uptake

2 = Effective vaccination service

3 = Breast screening uptake

4 = Cervical screening uptake

5 = Access to health visitor